NHS Fife Public Health & Wellbeing Committee

Mon 10 January 2022, 14:00 - 15:00

MS Teams

Agenda

14:00 - 14:00
0 min

1. Apologies for Absence

Tricia Marwick

14:00 - 14:00
0 min

2. Declaration of Members' Interests

Tricia Marwick

14:00 - 14:00
0 min

3. Minutes of Previous Meeting held on Monday 15 November 2021

Enclosed *Tricia Marwick*

Item 3 - Public Health Wellbeing Committee Minutes 15 November 2021 - Unconfirmed.pdf (8 pages)

14:00 - 14:00
0 min

4. Matters Arising / Action List

Enclosed *Tricia Marwick*

Item 4 - Public Health & Wellbeing Action List - 10 January 2022.pdf (2 pages)

14:00 - 14:10
10 min

5. GOVERNANCE / ASSURANCE

5.1. Testing & Tracing Update

Enclosed *Dr Joy Tomlinson*

Item 5.1 - SBAR Testing and Tracing Update.pdf (4 pages)

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

Enclosed *Nicky Connor*

Item 5.2 - SBAR Flu Vaccine & Covid Vaccine (FVCV) Programme Update.pdf (18 pages)

5.3. Update on CAMHS & Psychological Therapies

Enclosed *Nicky Connor*

Item 5.3i - SBAR Update on CAMHS.pdf (5 pages)
Item 5.3ii - SBAR Update on Psychological Therapies.pdf (6 pages)

5.4. Developments of Draft Committee Workplan

Enclosed *Dr Joy Tomlinson*

Item 5.4 - SBAR Developments of Draft Committee Workplan .pdf (5 pages)

14:10 - 14:30
20 min

6. STRATEGY / PLANNING

6.1. NHS Fife Population Health & Wellbeing Strategy Update

6.1.1. Public & Staff Engagement

Enclosed *Margo McGurk*

Item 6.1.1 - SBAR Population Health & Wellbeing Strategy - Public & Staff Engagement.pdf (12 pages)

6.1.2. Public Health Intelligence and Overview

Enclosed *Dr Joy Tomlinson*

Item 6.1.2 - SBAR Population Health & Wellbeing Strategy - Public Health Intelligence and Overview.pdf (8 pages)

6.2. Anchor Institution Programme Board

Enclosed *Dr Joy Tomlinson*

Item 6.2 - SBAR Anchor Institutions Programme Board.pdf (6 pages)

14:30 - 14:45
15 min

7. QUALITY / PERFORMANCE

7.1. Integrated Performance & Quality Report (IPQR) Review Process

Enclosed *Margo McGurk*

Item 7.1 - SBAR IPQR.pdf (3 pages)
Item 7.1 - IPQR.pdf (46 pages)

14:45 - 14:50
5 min

8. ANNUAL REPORTS

8.1. Fife Child Protection Annual Report

Enclosed *Janette Owens*

Item 8.1 - SBAR Fife Child Protection Annual Report.pdf (8 pages)

8.2. Adult Support & Protection Biennial Report 2018 - 2020

Enclosed *Janette Owens*

Item 8.2 - SBAR Adult Support and Protection Biennial Report 2018 – 2020 Update Report.pdf (5 pages)
Item 8.2 - Appendix 1 - Biennial Report 29.10.2020.pdf (18 pages)
Item 8.2 - Appendix 2 - ASPC Report Q2 Jul to Sep 2021.pdf (4 pages)

14:50 - 14:55
5 min

9. LINKED COMMITTEE MINUTES

9.1. Minutes of Public Health Assurance Committee dated 20 October 2021 (confirmed)

Enclosed *Dr Joy Tomlinson*

Item 9.1 - Public Health Assurance Committee dated 20 October 2021 (confirmed).pdf (7 pages)

14:55 - 14:55
0 min

10. ESCALATION OF ISSUES TO NHS FIFE BOARD

14:55 - 15:00
5 min

11. ANY OTHER BUSINESS

15:00 - 15:00
0 min

12. DATE OF NEXT MEETING - TUESDAY 8 FEBRUARY 2022 AT 10AM

Fife NHS Board

Unconfirmed

MINUTE OF THE NHS FIFE PUBLIC HEALTH & WELLBEING COMMITTEE MEETING HELD ON MONDAY 15 NOVEMBER 2021 AT 2PM VIA MS TEAMS

Present:

T Marwick (Chair)
M Black, Non-Executive Director
R Laing, Non-Executive Director
C Potter, Chief Executive
W Brown, Employee Director
Dr C McKenna, Medical Director
M McGurk, Director of Finance & Strategy
J Owens, Director of Nursing
Dr J Tomlinson, Director of Public Health

In Attendance:

N Connor, Director of Health & Social Care
L Cooper, Immunisation Programme Director *(agenda item 5.2)*
Prof. P Donnelly, University of St Andrews *(agenda item 6.2)*
S Fraser, Associate Director of Planning & Performance
Dr G MacIntosh, Head of Corporate Governance & Board Secretary
J McLean, Director of Regional Planning *(agenda item 6.2)*
F Richmond, Executive Officer to the Chief Executive & Board Chair
H Thomson, Board Committee Support Officer (Minutes)

The Chair welcomed everyone to the meeting.

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 received from member C Cooper, Non-Executive Director.

2. Declaration of Members' Interests

There were no declarations of interest made by members.

3. Minutes of Previous Meeting held on Friday 15 October 2021

The minutes from the previous meeting was **agreed** as an accurate record.

4. Matters Arising / Action List

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

5. GOVERNANCE / ASSURANCE

5.1 Covid Testing and Test & Protect

The Director of Public Health provided an overview and advised that the governance for Covid-19 Testing and Test and Protect contact tracing programmes sits within our Test & Protect Steering Group who report into the Executive Directors Group. The key elements of the programme, as described in the paper, were highlighted. It was noted that longer term plans are in discussions at national level, and further guidance is anticipated in the coming months.

Following a request to clarify reference to 'distressing' calls in relation to contact tracing, it was advised that this relates to recognition that advice asking people to self-isolate, is potentially more difficult now the furlough scheme has ended. It was noted that tracing staff are highly skilled at providing advice and supporting citizens.

It was questioned if there is a risk to the overall programme now that contact tracing has moved to use of digital tools and shortened scripts to manage high case numbers. In response it was advised that scripts are set nationally. It was noted clear and specialised clinical advice to the public has been retained.

The risk with the reduction in surveillance data being collected was questioned. It was advised that although we do not have the same epidemiological information, digital self-tracing is used for straightforward cases and that makes it easier for the public to seek advice. It was confirmed that from a clinical perspective, the advice provided by contact tracers is robust and is focussed on keeping people safe.

Committee members discussed the implications of any increase in demand over the Winter and the concern for staff retention. It was reported that the contact tracing structure has flexibility to respond through use of both local contact tracing team and a national team with surge capacity. It was advised that building on positive feedback from iMatter, the Public Health Staff Health & Wellbeing Group have been exploring additional support for contact tracing staff.

Further clarification was provided about the potential for further expansion of the local contact tracing team. It was noted the team are now fully staffed and there are no immediate pressures.

The Committee **noted** the Covid Testing and Test & Protect update and took assurance from the actions described above.

5.2 Flu Vaccine & Covid Vaccine (FVCV) Programme

The Director of Health & Social Care advised that the FVCV programme delivery is progressing well, and we continue to remain agile in terms of supporting response. The programme is discussed at the weekly Gold Command meetings, Executive Directors Group meetings and the weekly Programme Board meetings.

It was reported that an announcement had just been made today to accelerate the booster programme and extend it to 40 – 49 year olds and 16 – 17 year olds. Assurance was provided that robust plans are already in place, and current cohorts are progressing well. Workforce risks will be considered and managed.

A short paper to highlight the extensions announced today will be provided to the Board for their meeting on 30 November 2021. It was noted a verbal update will be provided at the meeting on the most recent position on the programme's delivery.

Action: Director of Health & Social Care

The position on Military Aid to Civil Authority (MACA) support was questioned, and it was advised that the MACA support has been in place for two weeks and will continue until 1 December 2021, at this time. A request is being put forward to the National Delivery Group to extend their deployment. 10 people are supporting and complementing our workforce and are based across two main sites.

The Committee **noted** the detail in the paper regarding the assurance for ongoing planning and delivery of the Autumn/Winter Vaccination plan.

5.3 Management of Vaccine Incidents

The Director of Public Health provided an overview on the process of review should there be any irregular vaccine incidents.

Assurance was provided that a summary of the outcome of the Local Adverse Event Review, once completed, will go to the necessary Committees. Assurance was also provided that immediate actions would be implemented. It was noted, it required, a lesson learned summary will be provided following the review.

Further detail was provided on the small number of incidents stated in the paper. It was noted that due diligence and an audit within NHS Fife discovered the incidents, and, through this, an issue was identified in the national system in recording and how this was inputted. This has now been updated.

The Committee **noted** the report on the Management of Vaccine Incidents and took assurance from the process described within.

5.4 Update on Children & Adolescent Mental Health Services (CAMHS) and Psychological Therapies

The Director of Health & Social Care provided an overview on the CAMHS section of the paper.

There have been challenges with recruitment which have impacted on the improvement trajectory. A revision to the trajectory, and a proposal to eradicate waiting lists by December 2022, is being sought, which is three months ahead of target. The proposed change has been carried out in collaboration with Public Health Scotland and the Scottish Government.

The team are continuing to ensure the mental health needs of children and young people are being addressed, despite ongoing pressures on time to treatment.

An overview of Psychological Therapies was provided, and it was advised that new roles and different roles in relation to supporting workforce pressures and challenges is being brought forward. A focus will be on access to the service and addressing the

backlog on the longest waits. Psychological Therapies performance will continue to feed through the IPQR for continued oversight and to monitor scrutiny on a monthly basis.

Committee requested further description of the future posts within CAHMS. In response it was advised that entry posts are being considered, with a view to developing these into more specialist roles. Work is also ongoing with other professions and looking more widely at the clinical team that can support delivery.

An historical underspend from the Health & Social Care Partnership in terms of mental health was highlighted and it was questioned if recruitment had been delayed. It was advised there had been challenges in recruiting specialist posts and assurance was provided that resources and funding are being targeted where they are required to be in terms of delivery of outcomes. An update on progress of recruiting mental health roles was provided.

Committee discussed the average and long waiting times, for both CAHMS and Psychological Therapies, and it was queried how patients with the longest waits are being tackled. It was agreed that long waiting times is an area that requires improvement, and within CAHMS there is a focus is to ensure those on the waiting list are supported. In relation to Psychological Therapies, work is ongoing to explore how group activity can now be carried out, particularly for those who have been on the waiting list the longest.

It was reported that recruitment challenges have a direct impact on meeting performance trajectories, and a risk was highlighted in this area. It was noted access to other services/networks, such as in the third sector, is available to support individuals. Assurance was provided that work is ongoing to support those who are on waiting lists. More information was requested regarding support for those on waiting lists, and planning in place to tackle the longest waits. An update will be brought back to the next meeting.

Action: Director of Health & Social Care

It was advised that it had been agreed that mental health aspects of the assurance committees workplan, would move from the Finance, Performance & Resources Committee to this Committee.

The Committee **noted** the CAMHS and Psychological Therapies reports, noting that a further update on measures and policies to tackle the longest waits would be considered at the Committee's next meeting.

5.5 Corporate Calendar / Committee Dates

The Committee **noted** the proposed Committee dates, which would be sent to members via the electronic calendar.

5.6 Review of Draft Committee Workplan

The Director of Public Health advised that further discussions are required to gather views and to identify any gaps or duplication in the workplan. The Chair agreed to discuss further with the Committee Chairs on the committee and requested a short paper on developments of the workplan, on a monthly basis, until March 2022.

Action: Chair / Director of Public Health

The Committee **noted** the draft Committee Workplan.

6. STRATEGY / PLANNING

6.1 Mental Health Strategy – Progress Update

The Director of Health & Social Care provided an overview of the Mental Health Strategy. It was advised that progress is still being made in terms of delivery and examples of transformation are outlined in the report.

Further detail was provided on the move from the day hospital model to developing community teams for older adults and it was advised this is being carried out in a more person-centred way to support delivery.

Committee discussed the recruitment challenges for increased psychological therapy type interventions and the need to increase training and development. It was advised that there are elements of psychological therapies that include investment in other parts of the workforce. In terms of young people, and through our 'Our Minds Matter' framework, close working is ongoing with schools, psychologists, CAHMS, Social Work Services and other relevant services.

Following a question, it was advised that outreach services are starting to progress, following the pandemic and remobilisation of services. It was a noted that discussions are ongoing within the voluntary sector.

An overview was provided on the development of the Band 4 role and supporting the workforce, and this will complement aspects of the Mental Health Strategy in terms of the recruitment challenges.

Suggestion was made to explore having dedicated residential addiction facilities within Fife and discussion about wider specialist services for eating disorder. It was noted that rehabilitation centres for eating disorders is a regional service commissioned and agreed in Lothian. It was noted there is a connection with eating disorders and trauma. It was advised there is additional investment to support people with eating disorders, and this forms part of the mental health recovery work around eating disorders.

The Committee **noted** the report and received **assurance** that:

- The service continues to deliver the main strategic ambitions
- The service will refresh the Mental Health Strategy for Fife in line with learning post-pandemic and new national requirements.

6.2 East of Scotland Regional Health Protection

The Director of Public Health introduced the East of Scotland Regional Health Protection report and provided background on the programme of work for the East of Scotland.

Committee recognised the challenge of reaching an agreed model for out of hours work, recognising the variation across different professional groups for remuneration of out of hours work. It was advised that a paper has been submitted to the Scottish Government that outlines the difficulties and challenges. It was noted there are various ways to compensate staff for out of hours work, and the model will be agreed through partnership.

It was confirmed that the future regional model will not require staff to change to a centralised location. There is recognition that local connections with Local Authorities and Hospitals are necessary to delivery of the service in each Board area.

It was reported that senior nurses are looking at training and education across the region. Communications and links have been forged with Public Health Scotland who are also looking at revamping training and education across Scotland, particularly for nurses. Close working with Public Health Scotland will be ongoing and will include updating an existing framework for Health Protection Nurses and developing appropriate training and education for all workforce within Health Protection Services. It was noted there are a number of online education and training packages that can be used to support staff, along with more formal educational offerings.

It was requested the detailed paper be presented to the Area Partnership Forum, before it is progressed to the Board.

The Committee **discussed** the paper and **supported** progression to NHS Fife Board for decision.

6.3 NHS Fife Population Health & Wellbeing Strategy Development

Public and Staff Engagement

The Director of Finance & Strategy advised that at the recent Board Development Session, the Board supported direction of travel on the four strategic priorities for the public and staff survey. A final version of the survey has now concluded and is with a third party to be put into a final online format before being approved by the Chief Executive.

The Committee **supported** development of the survey and noted an update will be brought back to the next meeting.

Action: Director of Finance & Strategy

Public Health Needs Assessment

The Director of Public Health outlined the Public Health Needs Assessment as detailed in the paper.

It was agreed to have the NHS Fife Population Health & Wellbeing Strategy Development as a standing agenda item for the next six months. The next iteration of

the paper will include an appropriate reflection of the discussions at the Board Development Session in November 2021.

Action: Director of Finance & Strategy / Director of Public Health

The Committee **noted** the progress made on the development of the Population Health and Wellbeing Strategy.

7. QUALITY / PERFORMANCE

7.1 Integrated Performance & Quality Report (IPQR)

The Director of Finance & Strategy advised that a review of the current mandated measures and targets within the IPQR has been carried out and suggested measures are outlined in section 2.3 of the paper.

It was noted that there is an opportunity to identify areas which are currently not reviewed and include them in the IPQR, such as the Covid Vaccination Programme, screening programmes, management of long-term conditions and the Mental Health Strategy Programme. It was questioned if these measures could overlay with Indices of Multiple Deprivation (IMD) data to review performance across all areas and identify specific areas of deprivation. It was noted that the rate limiter for data should be considered, the frequency of reporting and whether the data is available locally or nationally, to ensure that the data is meaningful and progress in performance can be effectively tracked.

It was agreed that a meeting be set up between the Executive Lead of the new Public Health & Wellbeing Committee, with the Chairs and equivalent Executive Leads from the Clinical Governance Committee and Finance, Performance & Resources Committee, to discuss alignment across the various measures within the current IPQR, and to discuss introducing potentially new measures not presently included.

Action: Head of Corporate Governance & Board Secretary

The Committee **discussed**, **examined,** and **considered** the NHS Fife performance as summarised in the IPQR, with respect to its frequency of presentation and enhancement of its content to suit the goals and remit of the committee.

8. LINKED COMMITTEE MINUTES

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

8.1 Minutes of the Public Health Assurance Committee dated 20 October 2021 (unconfirmed).

8.2 Minutes of the Fife Partnership Board dated 17 August 2021 (unconfirmed).

9. ESCALATION OF ISSUES TO NHS FIFE BOARD

There were no issues from this meeting to escalate to NHS Fife Board that otherwise are not covered appropriately within the minute.

Date of Next Meeting: Monday 13 December 2021 at 3pm via MS Teams.

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

PUBLIC HEALTH & WELLBEING COMMITTEE – ACTION LIST

Meeting Date: Monday 10 January 2022

NO.	DATE OF MEETING	AGENDA ITEM / TOPIC	ACTION	LEAD	TIMESCALE	COMMENTS / PROGRESS	RAG
1.	15/11/21	**Update on Children & Adolescent Mental Health Services (CAMHS) and Psychological Therapies**	More information regarding support for those on waiting lists, and planning in place to tackle the longest waits, to be brought back to the next meeting as an update.	**NC**	10/01/22	On agenda.	Closed
2.	15/11/21	**NHS Fife Population Health & Wellbeing Strategy Development - Public and Staff Engagement**	The Committee supported development of the survey and an update to be brought back to the next meeting.	**MM**	10/01/22	On agenda.	Closed
3.	15/11/21	**NHS Fife Population Health & Wellbeing Strategy Development - Public Health Needs Assessment**	The next iteration of the paper to include an appropriate reflection of the discussions at the Board Development Session in November 2021.	**JT**	10/01/22	On agenda.	Closed
4.	15/11/21	**NHS Fife Population Health & Wellbeing Strategy Development**	It was agreed to have the NHS Fife Population Health & Wellbeing Strategy Development as a standing agenda item for the next six months.	**MM / JT**	Monthly basis until May 2022	Workplan updated.	Closed
5.	15/11/21	**Review of Draft Committee Workplan**	A short paper on developments of the workplan, on a monthly basis, to be provided until March 2022.	**JT**	Monthly basis until March 2022	Workplan updated.	Closed

NO.	DATE OF MEETING	AGENDA ITEM / TOPIC	ACTION	LEAD	TIMESCALE	COMMENTS / PROGRESS	RAG
6.	15/11/21	**Flu Vaccine & Covid Vaccine (FVCV) Programme**	A short paper to highlight the extensions announced to be provided to the Board for their meeting on 30 November 2021. A verbal update also to be provided at the meeting on the most recent position on the programme's delivery.	**NC**	Board meeting on 30/11/21		Closed
7.	15/11/21	**Integrated Performance & Quality Report (IPQR)**	It was agreed that a meeting be set up to discuss alignment across the various measures within the current IPQR, and to discuss introducing potentially new measures not presently included.	**GMacI**	In advance of the next Committee meeting	Meeting held on 3 December 2021.	Closed

NHS Fife

Meeting:	**Public Health & Wellbeing Committee**
Meeting date:	**10 January 2022**
Title:	**Testing and Tracing Update**
Responsible Executive:	**Joy Tomlinson, Director of Public Health**
Report Author:	**Abbi Noble, Public Health Intelligence Team;** **Sharon Crabb, Interim Service Manager**

1 Purpose

This is presented to the Public Health & Wellbeing Committee for:

- Assurance

This report relates to a:

- Emerging issue
- Government policy/directive

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

- Effective

2 Report summary

2.1 Situation

PCR testing continues through all existing means including at testing sites, provided by the UK Government, Scottish Ambulance Service, and our community testing sites where required. Winter plans are in place to ensure testing at sites remains accessible through the next few months.

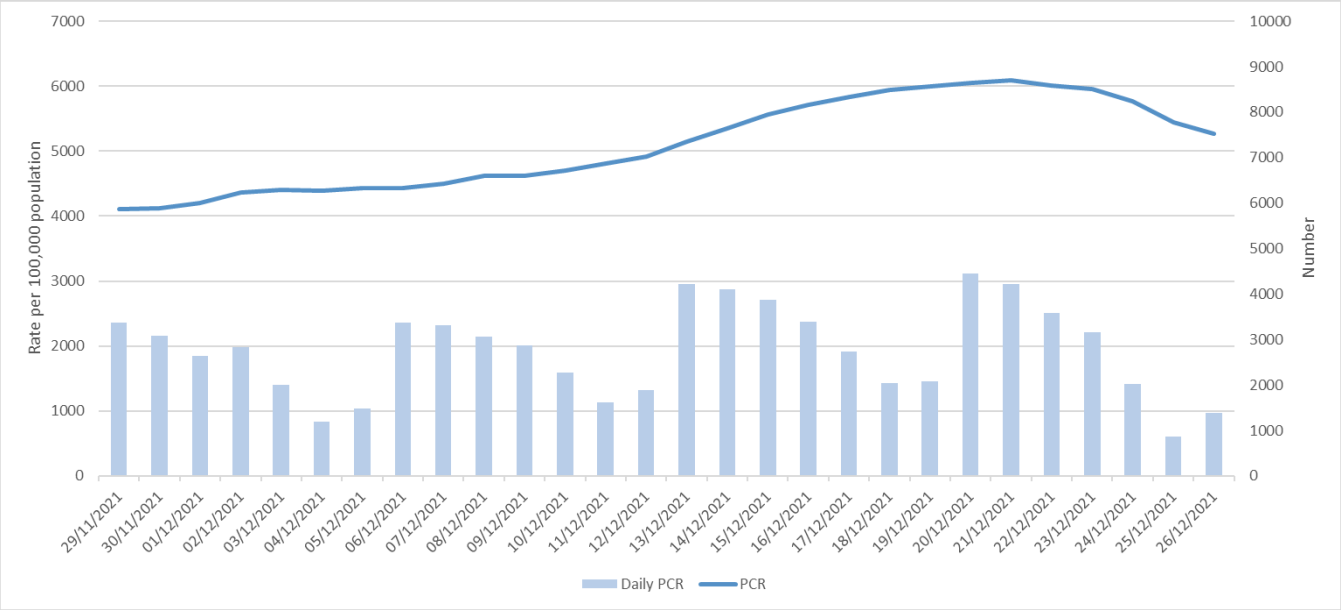
2.2 Background

Chart 1 shows that within the last four weeks testing rates have been increasing throughout December (please note there was reduced testing availability on the 25th and 26th of December). The volume of PCR tests undertaken demonstrates positive public behaviours of compliance and engagement.

2.3 Assessment

In the seven days to the 26th of December 19,555 PCR tests were undertaken by Fife residents, an average of almost 2,800 a day. Of these 18.4% returned a positive result compared to 20.8% nationally. Test positivity has shown an increasing trend in the last month rising from 10.8% at the start of December. The PCR result determines the number of cases of COVID-19 in Scotland.

Chart 1: Fife Resident PCR Test Results; daily number and 7-day rolling total rate to 26th December 2021



2.3.1 Quality/ Patient Care

The continuation of Test & Protect over the winter months will reduce the risk of transmission from COVID 19 in our communities. This will benefit individuals from avoidance of illness and also have a positive benefit to non-COVID 19 healthcare provisions. PCR testing continues for priority groups, those residing in Care homes through whole home testing and areas of essential workers e.g. Health and Social Care.

The NHS Fife Test & Protect Oversight Group, provides oversight of testing locally, working in alignment with national guidelines and expectations.

2.3.2 Workforce

Scottish Government funding for testing has recently been extended to June 2022. This is welcome confirmation however challenges remain around recruitment and retention due to short contract length and the uncertainty regarding future plans for the service.

Contact Tracing workforce support is provided through Mutual Aid and working agreement with the National Contact Centre.

Work is ongoing with Human Resources colleagues, to issue each member of staff within the Contact Tracing workforce and wider Public Health Team individual letters of agreement to contract/temporary deployment/deployment extensions until end of September 2022 with an end of agreement update.

2.3.3 Financial

Scottish Government has extended funding for Targeted Community Testing capacity over the winter period into the first quarter of 2022/23.

Contact tracing is also an ongoing service requirement that the Scottish Government continue to fund.

2.3.4 Risk Assessment/Management

Testing is fully integrated within Public Health Governance and management systems. Scottish Government funding longer term intentions is not known beyond June 2022.

Contact Tracing contract extension financial risk assessment and organisational acceptance has been agreed by EDG for those with contracts exceeding 24 months within NHS.

2.3.5 Equality and Diversity, including health inequalities

Availability and provision of testing and contact tracing is across the whole population and siting of testing facilities is discussed weekly. Testing and contact tracing EQIA return completed for Scottish Government Sept 2020. Uptake reviewed weekly across priority groups. Review of testing equality planned.

2.3.6 Other impact

N/A

2.3.7 Communication, involvement, engagement and consultation

This paper has been developed in consultation with Public Health Intelligence.

2.3.8 Route to the Meeting

Some content within 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.

- Public Health and Wellbeing Committee

2.4 Recommendation

- **Assurance** – For Members' information only.

3 List of appendices

N/A

Report Contact

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NHS Fife

Meeting:	**Public Health and Wellbeing Committee**
Meeting date:	**10 January 2022**
Title:	**FVCV Programme Delivery Update**
Responsible Executive:	**Nicky Connor, Director of Health and Social Care**
Report Authors:	**Lisa Cooper, Immunisation Programme Director** **Emma Strachan, FVCV PMO Project Manager**

1 Purpose

This report is presented to Public Health and Wellbeing Committee for: Assurance and support

This report relates to a: Government policy/directive

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

- Safe
- Effective
- Person Centred

2 Report summaries

2.1 Situation

The purpose of this report is to provide an overview of the festive delivery progress within Fife following a review of activity, detailing the updated national guidance and the resulting approach to planning and delivery taken by the team in regard to the FVCV Autumn/Winter programme. The current position as a result of the festive delivery and some future considerations for noting are also detailed.

There have been recent updates to national guidance from the JCVI and resulting direction from the CMO meaning acceleration of the programme has been essential to manage the risk to public health now posed by the Omicron variant.

The Public Health and Wellbeing Committee is asked to consider this report for discussion and support, note the progress and updated information regarding the development of the programme.

2.2 Background

National programme board updates, JCVI and CMO guidance continues to direct the effective planning and delivery of the FVCV Autumn/Winter programme. Throughout December, a number of updates have been guided nationally affecting both Tranche 1 and 2.

Due to developments and emerging concern surrounding the Omicron variant, further national direction was received prior to end of year 2021 on timescales, vaccine prioritisation and eligibility. CMO letter 37 (appendix 1) was received confirming guidance on a number of these developments which is outlined in the assessment below.

Current priority has recently been guided across five key cohorts which are outlined below including a continued current focus on boosters for all adults aged 18 and over.

2.3 Assessment

As noted, there have been a number of key developments released nationally throughout the month of December which significantly impacted on local planning assumptions. A summary of these are outlined below,

CMO Letter 37 Update

- 2nd doses for 12-15 cohort were advised to be paused until boosters are offered to all eligible adults over 18 years
- The remaining flu programme, including secondary school children and adults aged 50-64 not at risk was advised to be delayed until the over 18 booster programme was completed
- Waiting period post vaccination was temporarily reduced to 5 minutes as per approval via national FVCV clinical governance group and UK CMOs. PGDs and National Protocols were received to support this and have been progressed through local governance arrangements

CMO Letter 39 Update (Appendix 2)

- The Scottish Intensive Care Society Report published on 13 October 2021, highlighted that of the 89 COVID-19 positive pregnant women who were admitted to critical care between December 2020 and end September 2021, 88 were unvaccinated, 1 was partially vaccinated, and none were fully vaccinated. Wave 3 has seen increased numbers of pregnant women being admitted to hospital and moderate to severe COVID-19 symptoms requiring critical care, with clinicians reporting a particular peak in September.
- The CMO in the letter of SGHD/CMO (2021) 39 has requested that all Boards undertake actions detailed on page 2 of the letter with the aim to ensure maximising the opportunities to recommend vaccination to pregnant women and increase uptake of vaccination.
- The committee are assured that all actions are being undertaken with a SLWG in place

National Update

- Direction was received to accelerate booster offering to all adults aged 18 and over for completion by 31st December
- Boosters for age group 18+ could be booked via the national self-registration portal as of 13th December
- 2nd doses for 16-17 cohort continued to be offered due to progress already achieved and to avoid public confusion across this cohort

Based on the developments above, health boards were therefore asked to increase capacity via two routes,

1. Offering additional booster appointments throughout month of December (excluding key festive dates)
2. Provide drop-in capacity from 15th December where possible across clinics for the over 40s and high-risk cohorts (Fife had already commenced this approach)

December Revised Planning
Fife continued to deliver as originally planned for current cohorts but modelled on projected eligibility by end of December.

Programme leads met daily over this period to assess programme position in alignment to the recent developments ensuring that safe and effective operational delivery was achieved. From Monday 20/12/21 the daily meeting transitioned to a daily bronze vaccine delivery oversight group reporting and escalating via silver command within the HSCP and jointly to the FVCV programme board which met twice weekly over the last 2 weeks of December.

Initial planning assumptions advised an additional 47K people (approx.) within Fife would be due a booster by end of December. The team were confident that the programme was in a position to continue delivery with regular review of scheduling and workforce planning. Capacity across clinics within Fife was increased at pace, which was commended nationally due to quickness of response to national ask.

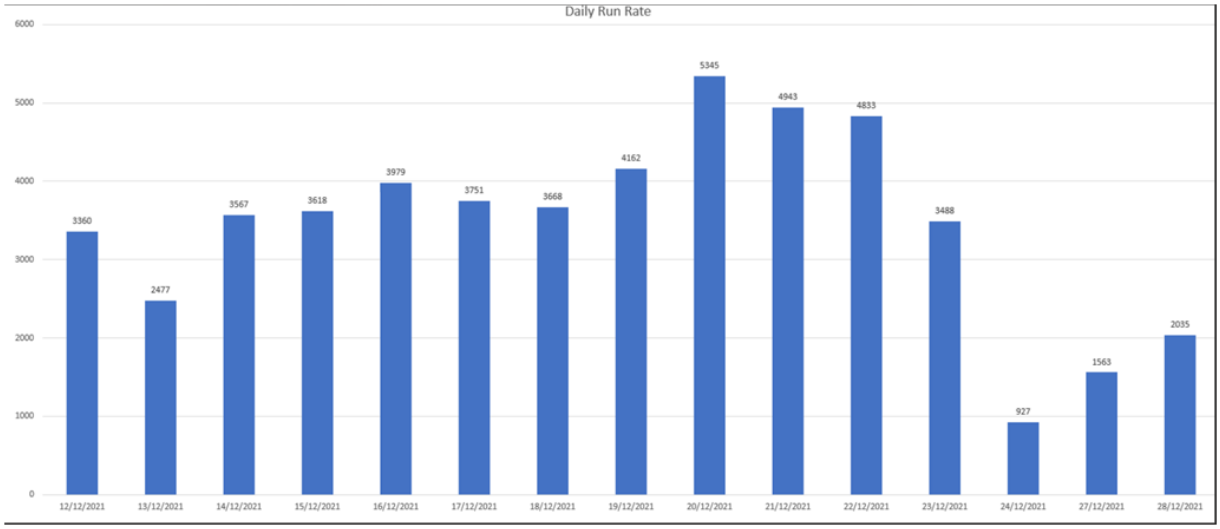
Programme Acceleration

National assessment on the run rate across all health boards took place (determined by number of appointments available per day), to estimate the increased pace required in each health board to achieve 80% uptake. This assessment indicated that NHS Fife would require a 50% daily increase in daily appointments.

Based on the national minimum uptake, four scenarios were worked through to assess feasibility for programme delivery considering pace, national direction and workforce capacity. In the agreed scenario, the programme worked towards an 80% uptake between 14th December and 9th January with an excess of 19k appointments available to accommodate any mop up required and allow resilience in anticipation of staff absence.

Prior to the 14th December, the average daily run rate in Fife was 2105 doses. Fife's average daily run rate made effective from 14th December to 31 December inclusive, was 3,596. Therefore, capacity was increased by 70% during this period, beyond the 50% (3150 run rate) ask from Scottish Government

As demonstrated through the graph below, a combination of booked and drop-in appointments led to significantly higher vaccination activity, particularly from the 14th December through to the 23rd December.



Scheduling

The national self-registration portal was released for adults aged 18 and over to book appointments and uptake was monitored closely at a local level to ensure a flexible and responsive approach and that clinic capacities could be managed accordingly with robust comms in place to support. Assessment nationally of uptake via the self-registration portal continues, to determine the need for potential of scheduling appointments via lettering. The national scheduling system continues to operate with local teams responsible for preparation of cohort files, and resolving any operational issues.

In respect of national decision to offer drop-in activity to over 40s and at-risk groups only, a decision was taken locally to vaccinate any eligible individuals out with these cohorts who may present for vaccination at any clinic. This approach was supported across all programme work streams to ensure all eligible individuals are vaccinated. It was felt this action mitigated the higher risk of individuals not following through with vaccination should they be refused. Local comms were developed in alignment to national comms promoting drop-in clinics for adults over 40 and at-risk individuals. This position has since shifted nationally to promote all eligible cohorts for drop-in clinics including all those 18+.

Venues and Logistics

Due to pace of acceleration required, it was agreed that the most effective way to accommodate the national ask was to extend vaccination stations across selected existing clinics where possible. There were no risks identified with capacity in clinics at the time due to increased capacity planning. This enabled the programme to respond quickly and safely.

It was recognised as a risk nationally and locally that with the emphasis being placed on

drop ins and challenges accessing the online portal and national helpline, queues were anticipated to develop.

Nationally comms were developed to communicate this risk and manage public expectation. Local comms were also adapted and with processes agreed at pace to support effective and safe queue management. It was also anticipated that the reduction to 5 min observation would also support effective flow.

Pharmacy

It should be noted that the waiting time reduction to 5 mins was an off-label change which was raised as a risk to the programme board. This was thoroughly assessed by Pharmacy and other professional leads to ensure the revised change could be implemented operationally as quickly and safely as possible.

Vaccine supply was confirmed as stable with national confirmation of more stock being released to boards week commencing 20th December to safely cover activity until early January 2022.

Festive Delivery Success

Based on the revised delivery planning implemented over the Festive period outlined above, programme leads have met week commencing 3rd January 2022 to review the Festive planning and the effectiveness of this. It has now been confirmed that Fife successfully achieved the Scottish Government target of vaccinating 80% of eligible citizens over 18 years of age with their 'booster by the bells'.

As 31st December 2021 was reached, Fife had reached 80.3% uptake (excluding drop-in activity) which was higher than the national average of 78.1%. Drop-in activity has continued throughout the festive period and has proved to be effective in providing flexibility during this time for the citizens of Fife.

It is also useful to note that a significant response of positive feedback has been received recently via Care Opinion regarding the vaccination programme evidencing professional, person centred care delivery.

Current Position

Since the acceleration of the booster programme over the festive period, there has been a significant reduction noticed in self-registration activity and uptake week commencing 3rd January. Due to this, drop in capacity has been extended across all community clinics to ensure there are ongoing opportunities available to maximise uptake.

January 2023 Delivery Priorities

Following recent national direction, there are now 4 national key priorities to be focused on from a delivery aspect.

- Primary 1st and 2nd doses for those still to come forward
- Individuals eligible for booster dose including those who are severely immunosupressed
- 2nd doses for 12 –15 cohort
- 1st doses for 5-11 at risk cohort

It should be noted that Fife are currently in a strong position regarding Flu vaccinations for secondary school children as this work was completed prior to being placed on hold for the festive period.

5 – 11-year-old at risk cohort

A Short Life Working Group has been convened to begin planning for the recent national direction to vaccinate Fife's at risk 5 – 11-year-old cohort. The cohort size has yet to be confirmed and will determine some of the key planning assumptions being worked to.

It has also been guided nationally that a clinic-based setting is preferred for this cohort to avoid segregation within the school environment and to protect confidentiality. A 10-minute appointment time with 15-minute wait, post vaccination, is also anticipated. Dedicated child friendly clinics will also be established across 7 of the existing community clinics across Fife.

Further considerations around venue location, accessibility and comms are currently being assessed by programme leads. An inclusive approach to this cohort will also be taken to ensure children unable to attend community clinic for health reasons, children being cared for and those from deprived areas will be able to access their vaccinations.

Tranche 2 Delivery Progress

Significant progress has now been made with cohorts across Tranche 2 while continuing to offer an 'Evergreen' option through drop-in activity where possible. It should also be noted that bespoke work is also taking place to continue offering sea workers the opportunity to be vaccinated within drop-in clinics. The COVID immunisation team are also carrying out significant outreach opportunities to refugee and homeless groups.

Fife are continuing to assess planning assumptions and clinical activity in alignment to emerging national developments ensuring all work streams are operating safely and effectively to maximise operational capacity.

Further detail on progress for specific cohorts and aspects of the delivery follow:

Severely Immunosuppressed

JCVI guidance received advised that severely immunosuppressed individuals should receive a booster dose at a minimum of 3 months following completion of their primary course. Those who have not yet received their third dose may be given the third dose immediately to avoid further delay as long as there is an interval of 8 weeks since their

second primary dose. A further booster dose can be administered at 12 weeks, in line with the clinical advice on optimal timing. Boosters for this cohort were therefore scheduled for end of December with the 27th and 28th ring-fenced for this cohort.

Scheduling plan to direct as many SI appts to specific clinics to protect the health of and minimise risk for this cohort being exposed to queues due to demand now anticipated.

A targeted approach was taken with this cohort and all eligible individuals were issued with an appointment letter however uptake has been lower than expected with a DNA rate of 25%. This has been escalated nationally as there are concerns there was some confusion amongst this cohort regarding their eligibility and timing for their booster.

Housebound

A number of logistical and staffing challenges presented throughout the vaccination of this cohort which resulted in a 2-week delay to launch against planned activity however delivery has progressed significantly with 96% of housebound individuals having now received their vaccinations. Referral work will continue to ensure any new housebound patients are vaccinated.

A review of process for those referred via the national helpline is currently underway as there is no opportunity nationally for bespoke data collection to support boards. This results in additional work locally and programme leads are currently working to align this pathway.

Over 80s

The majority of over 80s vaccinations have now been successfully completed with a current total of 17,871 (92%) Flu/Covid booster/third dose vaccinations having been administered. Mop up activity is being progressed.

Over 18s Public Programme

Co administration of Flu and Covid-19 vaccinations commenced 25th October to the wider public for individuals eligible by age group in alignment to direction from the JCVI.

Uptake for cohort ages 40 – 49 and 50 - 59 has gradually increased following an initial slow start. Increased national comms were rolled out in the form of text messaging and blue letter reminders to all eligible individuals who remain unvaccinated. Eligibility for boosters has been extended as per national guidance noted above with boosters for all adults over the age of 18 commencing 15th December.

The summary table below (as of 07/01/22)shows progress to date across each of the age group cohorts and their respective commencement dates.

Cohort	Commenced	Progress	% Uptake 3rd dose/booster
Age 70 – 79	25th October	35,964	98%

Age 60 – 69	25th October	44,519	95%
Age 50 – 59	15th November	46,190	84%
Age 40 – 49	27th November	30,334	66%
Age 30 - 39	13th December	21,209	48%
Age 18 - 29	15th December	17,945	33%

2.3.1 Quality/ Patient Care

The Board has now exceeded 788k total doses administered in the COVID vaccination with a focus primarily now on the 5 key priorities outlined above within tranche 2. Drop ins are planned to continue to allow ongoing access for Tranche 1 vaccine delivery e.g., those still to access 1st or 2nd dose and will be scheduled at times when planning activity allows. Drop ins continue to be advertised via current channels including NHS Fife website.

The emerging data surrounding the Omicron variant has resulted in the recent directional changes outlined above and Fife will continue to respond to new developments as guided nationally to provide a safe and effective service to all citizens in Fife.

A clinical oversight and assurance group now meets fortnightly to provide assurance regarding safe delivery of the Immunisation programme.

2.3.2 Workforce

There was a recognised risk re uptake or non-attendance to planned appointments and therefore staffing above capacity. This was however reviewed and managed daily. An additional lead nurse was also identified to support training and recruitment in alignment to the accelerated pace.

At this time, there are no immediate concerns or pressures regarding workforce within the programme. There have been lower numbers than expected absent over the festive period which has helped considerably and recent changes nationally regarding isolation periods will also continue to significantly reduce pressure from a workforce aspect.

Military Aid to Civil Authority (MACA)

It has now been confirmed that military personnel will be extended until 28th February 2022. There has been some change in personnel over the month of December with new vaccinators requiring training. There should be an over net increase in MACA support.

2.3.3 Financial

The programme continues to work closely with Finance colleagues to track and report on expenditure. Additional costs identified throughout the planning stages of the FVCV

programme are being reported accordingly. This is complex to manage and a cohesive approach to ensure effective financial governance of all programmes is evolving. As previously advised proportional recurring funding has been awarded and a workforce strategic plan being progressed with a paper to be brought to EDG for decision within the next week.

2.3.4 Risk Assessment/Management

Potential risks were raised in relation to the programme acceleration in that,

1. There is a risk that individuals from other health boards may book their vaccinations within Fife which could increase on capacity. There are no border arrangements for vaccine delivery and this is a national decision. It has been agreed that this will be closely monitored within the planning meeting to assess whether capacity planning required to be adjusted.
2. There is a risk that the spread of the Omicron variant results in difficulties for individuals to book appointments or having to reschedule which could impact on the expected activity for the next 3 weeks and the resulting mop up potential, this has been escalated to the national clinical governance and delivery group.

2.3.5 Equality and Diversity, including health inequalities

The established inclusivity group will continue to lead delivery of EQIA actions and direct specific outreach activities to ensure access for all eligible.

A review of specific location data is currently underway to assess opportunities for a more targeted approach where required.

2.3.6 Communication, involvement, engagement and consultation

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

National assets have been received in support of the recent developments with adjustments being made accordingly in response to local uptake and matters arising.

There is currently work being progressed to develop comms via a local radio station to maximise opportunities in publicising the vaccination programme.

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

2.4 Recommendation

The NHS Fife Public Health & Wellbeing Committee are invited to take **assurance** from the report, to **discuss** the progress achieved and updated information regarding the programme, and developments in the approach.

Report Contact

Nicky Connor
Director of Health and Social Care
nicky.connor@nhs.scot

Chief Medical Officer Directorate

E: vaccinationsdelivery@gov.scot

Dear Colleague(s)

COVID-19 VACCINATION PROGRAMME: SUPPORTING FURTHER ACCELERATION OF THE BOOSTER PROGRAMME:

- **PRIORITISATION OF COVID-19 BOOSTERS ABOVE PRIMARY COURSE FOR 12 TO 15 YEAR OLDS**
- **DE-PRIORITISATION OF THE FLU VACCINATION PROGRAMME**
- **TEMPORARY REDUCTION IN THE 15 MINUTE OBSERVATION PERIOD TO 5 MINUTES FOR mRNA VACCINATIONS**

KEY OBJECTIVES

1. This letter provides an update on the delivery of the COVID-19 vaccination programme to support further acceleration of the booster programme in response to the Omicron variant.

BACKGROUND

2. Emerging evidence about the Omicron variant has underlined the importance of accelerating the COVID-19 booster vaccination programme. The Omicron variant is spreading rapidly and it is important that those eligible receive a booster dose, or a primary vaccination if they are currently unvaccinated.

From the Chief Medical Officer

Professor Gregor Smith

15 December 2021

SGHD/CMO(2021) 37

Addresses

For action

Chief Executives, NHS Boards Medical Directors, NHS Boards Primary Care Leads, NHS Boards Directors of Nursing & Midwifery, NHS Boards Chief Officers of Integration Authorities Chief Executives, Local Authorities Directors of Pharmacy Directors of Public Health General Practitioners Practice Nurses Immunisation Co-ordinatorsOperational Leads

For information

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

Further Enquiries

Policy Issues
COVID Vaccination Policy
TeamVaccinationsDelivery@gov.scot

Medical Issues
Dr Syed Ahmed
Syed.ahmed@gov.scot

Pharmaceutical and Vaccine Supply Issues

3. The latest evidence would indicate that the rate of Omicron infections has a doubling time of at least two to three days. Recent evidence from the UKHSA would indicate that two doses of the vaccine, particularly if those doses are the AstraZeneca vaccine, is not sufficient to prevent symptomatic disease. But this is substantially increased through the administration of an mRNA booster vaccine.

4. Health Boards have already undertaken significant work to support acceleration of the vaccination programme and a number of actions have been agreed to increase the pace of delivery yet further.

NHS NSS National Procurement:
NSS.fluvaccineenquiries@nhs.scot

Prioritisation of COVID-19 boosters above primary courses for 12 to 15 year olds

5. The vaccination programme continues to ensure that the most vulnerable are protected. Emerging evidence on the Omicron variant points towards a need to continue protecting the most vulnerable groups first.

6. Whilst it remains important that second doses are provided for those aged 12 to 15 years old, given these are a slightly less clinical priority their administration should be undertaken after the booster dose is offered to those aged 18 and older. We anticipate that this is likely to be from early January 2022 onward and therefore in line with the most recent Joint Committee on Vaccination and Immunisation (JCVI) advice on vaccination deployment in relation to Omicron, which proposes second doses for 12 to 15 year olds as a secondary measure following rapid deployment of boosters.

7. However, Health Boards should continue to offer the vaccine to 16 and 17 year olds given deployment is already well underway and to pause this would be both disruptive and counterproductive. Not least as 44% of this group have now either received a second dose or have an appointment booked, and this cohort should therefore be completed as originally planned.

De-prioritisation of the flu vaccination programme

8. Data from Public Health Scotland (PHS) suggests that the vast majority of those in high risk groups (those over the age of 65, those under 65 who are at risk, and frontline health and social care workers) have already been offered the flu vaccine. Uptake rates are higher than for the entirety of last year's season.

9. The current level of seasonal flu in Scotland is below the baseline expected for this time of the year. Measures including social distancing,

hand washing and face coverings will continue to have a high protective effect against seasonal flu and other respiratory illnesses.

10. On this basis, Health Boards should cease co-administration of the flu vaccination alongside the COVID-19 programme within community COVID-19 vaccination clinics (apart from opportunistic flu vaccination for anyone in the remaining over 65 cohort and higher risk groups).

11. This guidance applies to the new cohorts who were added to the flu programme during the pandemic. The offer to the following groups will cease:
    - teachers, nursery teachers and pupil facing support staff (in both local authority and independent settings),
    - the prison population, prison officers and support staff who deliver direct detention services,
    - those aged 50 to 64 years old without underlying risk factors.

12. These groups are not currently prioritised in JCVI advice nor the Green Book Chapter 19 for flu vaccination. Flu vaccination for the 50 to 64 age group was similarly ceased during the 2020-21 winter programme to support COVID-19 vaccination efforts, with no detrimental impact in subsequent of flu prevalence.

13. Health Boards should also pause the deployment of flu vaccines to secondary school pupils until after the current booster programme is completed, and where this has still been ongoing, staff involved in that delivery should be moved into the adult community clinics.

14. Health Boards should continue to offer the flu vaccine to those at risk who were routinely offered it prior to the pandemic. Flu vaccinations for these individuals should be offered through community pharmacies, midwives, GP practices as appropriate and opportunistically through domiciliary care and/or care home settings as appropriate. These groups include:
    - pregnant women,
    - those over 65 years of age,
    - those with underlying health conditions,

Temporary reduction in the requirement for a 15-minute observation period to 5 minutes for mRNA vaccinations

15. As stated in the Green Book Chapter 14a, according to the Summaries of Product Characteristics for Pfizer BioNTech and Moderna vaccines, it is recommended that all recipients of the Pfizer BioNTech and Moderna vaccines are kept for observation and monitored for a minimum of 15 minutes.

16. The UK Chief Medical Officers have recommended suspension of this requirement as a temporary measure. The CMOs suggested that there is a need to boost as much of the population as possible before the peak of

the Omicron wave, or provide first vaccination to those with no prior protection. They advised that it is likely this will significantly reduce the number of people becoming ill, hospitalised and dying. The CMOs also recommended that this temporary measure should be operationalised in line with the needs of each of the four nations. This temporary suspension in individuals without a history of allergy has also been agreed by the Commission on Human Medicines.

17. For Scotland, the FVCV Clinical Governance Group have considered this opinion in the context of the programme in Scotland and guidance from the Resuscitation Council (2021) on anaphylaxis, and, as part of operationalising the CMO advice in Scotland, have proposed reducing the observation time for all COVID-19 mRNA vaccines to a minimum of 5 minutes following administration of the vaccine, rather than removing it entirely, in line with the Resuscitation Council's guidance. Supply in these circumstances will be off-label.

18. The Clinical Governance Group (CGG) meets every two weeks and will review the overall arrangements on an ongoing basis. All currently deployed vaccines have proven to be safe with low rates of severe side effects. As with all vaccines occasional cases of anaphylaxis have been reported. The rates are slightly higher in the case of mRNA vaccines from Pfizer/BioNTech and Moderna but overall they are still very rare. There have been no deaths from anaphylaxis reported in the UK to date. This position will be kept under review.

19. As a result, the existing 15-minute wait for all mRNA COVID-19 vaccines should be reduced to a minimum wait of 5 minutes.

20. Those with a history of allergic reactions should be managed in line with Green Book advice and everyone who is vaccinated should be provided with verbal and written advice on allergic reactions including what actions to take if they become unwell.

OPERATIONAL DEPLOYMENT

21. As a result of these changes the following operational changes are required:
    - Create additional booster appointments for December, with the exception of 25 and 26 December. This capacity should be made on NVSS on Tuesday 14 December to allow people to book appointments on line with revised portal opening dates. This should result in significant additional capacity in the case of most boards, in line with the modelling run rate percentages and daily run rates.
    - Drop in access to be opened from Wednesday 15 December for those who are over 40 years of age and previously higher risk cohorts.

COMMUNICATIONS

22. Messaging explaining the changes will be sent to Health Boards and Vaccine Planning Leads for sharing with the public.

ACTION

23. Health Boards are asked to:
    - prioritise the booster offer over second doses for those aged 12 to 15 years, in line with previous advice on prioritisation from PHS and the FVCV Clinical Governance Group;
    - cease co-administration of the flu vaccination alongside the COVID-19 programme;
    - note and implement the temporary reduction of the 15 minute observation period for mRNA vaccines to a minimum of 5 minutes.

I remain very grateful for your continued support and ongoing efforts in relation to the national COVID-19 vaccination programme.

Yours sincerely

Gregor Smith

Professor Gregor Smith

Chief Medical Officer

Appendix 2: CMO Letter 39

Dear Chief Executives,

COVID-19 IN PREGNANCY – VACCINATION

You will recall that I wrote to you in August to highlight the change in vaccination policy for pregnant women, and we are now strongly advising pregnant women to get the COVID-19 vaccination as the best way to protect themselves and their baby from serious illness. The JCVI have also advised that pregnant women can get the COVID-19 booster.

Recent data on vaccine uptake in pregnant women, published on 3 November by Public Health Scotland, showed that from the start of the vaccination programme to 30 September, 16,229 pregnant women have been vaccinated. The uptake of the vaccine amongst pregnant women is consistently lower than uptake among the general female population in the same age groups. Of the 3,992 women who delivered their baby in September 2021, 34% had received any COVID-19 vaccination prior to delivery. By age group comparison, 46% of women aged 35-39 who delivered their baby in September 2021 had received any COVID-19 vaccination compared to 87% of women aged 35-39 years in the general population. It is not possible to give a precise percentage of number of pregnant women who are vaccinated, as women who have entered maternity services recently may have been vaccinated prior to pregnancy, and we expect that by spring next year the majority of women using maternity services will be vaccinated before becoming pregnant, however as vaccine uptake rates are lower amongst younger people, there will be a continuous need to promote the uptake of the vaccine in pregnancy.

The Scottish Intensive Care Society Report, published on 13 October, highlighted that of the 89 COVID-19 positive pregnant women who were admitted to critical care between December 2020 and end September 2021, 88 were unvaccinated, 1 was partially vaccinated, and none were fully vaccinated. Wave 3 has seen increased numbers of pregnant women being admitted to hospital with moderate to severe COVID-19 symptoms requiring critical care, with clinicians reporting a particular peak in September.

From the Chief Medical Officer
Professor Gregor Smith

16 December 2021

SGHD/CMO (2021) 39

Addresses

For action
Chief Executives, NHS Boards Medical Directors, NHS Boards Primary Care Leads, NHS Boards Directors of Nursing & Midw ifery, NHS Boards Chief Officers of Integration Authorities Chief Executives, Local Authorities Directors of Pharmacy Directors of Public Health General Practitioners Practice Nurses Immunisation CoordinatorsOperational Leads

For information
Obstetric Clinical Directors, Heads of Midw ifery, Board Vaccination coordinators
Chairs, NHS Boards Infectious Disease Consultants Consultant Physicians Chief Executive, Public Health Scotland NHS 24

Further Enquiries to:

Kirstie Campbell, Unit Head, Maternal and Infant Health

kirstie.campbell@gov.scot

I ask you to take forward the following actions, which are aimed at ensuring we are maximising opportunities to recommend vaccination to pregnant women and increase take up.

1. Please remind healthcare workers including GPs, midwives, obstetricians and any other healthcare staff meeting pregnant women to **make each contact count**. This means recommending vaccination in pregnancy and providing information on the risks to the women and their babies from not being vaccinated (RCOG provide a decision aid to support these conversations which has been distributed in hard copy to all maternity units in Scotland).
2. Please provide advice around vaccine delivery **in antenatal settings** – for example a bespoke vaccination clinic in a maternity unit in Newcastle saw 100 pregnant women vaccinated within their maternity unit in 1 week, compared to the local vaccination centre who vaccinated only 30 pregnant women in 1 month.
3. Clarify with your vaccinators the advice that if first dose was AZ pre-pregnancy, then **second dose should be AZ** to counteract mixed messaging about use of only Pfizer or Moderna during pregnancy, which is leaving many pregnant women only partially vaccinated.
4. JCVI have recently advised that pregnant women should now be considered as a **clinical risk group and part of priority group 6** within the vaccination programme.
5. They have also advised that those aged under 18 who are pregnant, should receive **primary vaccination in line with other groups at high risk** (two doses at an eight-week interval.
6. All pregnant women are eligible for **boosting from 3 months** after completion of their primary course.
7. Vaccination should be deferred for four weeks after COVID-19 infection.

The Royal College of Obstetricians and Gynaecologists have recently updated their Guidance for healthcare professionals on COVID-19 infection in pregnancy https://www.rcog.org.uk/globalassets/documents/guidelines/2021-12-06-coronavirus-covid-19-infection-in-pregnancy-v14.2.pdf including guidance on vaccination in pregnanc y (published 6 December). This guidance highlights that more than 275 000 women in UK and US have had a COVID-19 vaccine in pregnancy with no concerning safety signals. In light of the latest UKOSS figures which suggest only a small number of pregnant women are receiving the correct medical treatment including when they are in hospital, even when critically unwell, UKTIS and RCOG have developedan information sheet/infographic (published 7 December) to supplement the RCOG guidance above. I would be grateful if you could

circulate this guidance to all health professionals who have contact with pregnant women, including maternity staff, GPs and vaccination staff.

The Scottish Government, Public Health Scotland and NES have developed a range of guidance and training materials for clinicians and staff, and online and hard copy guidance for pregnant women. Messaging about vaccination during pregnancy is being promoted through media campaigns and by Ministers and clinical leads.

I welcome your continued support on this issue.

Yours sincerely

Gregor Smith

Professor Gregor Smith
Chief Medical Officer

NHS Fife

Meeting:	**Public Health & Wellbeing Committee**
Meeting date:	**10 January 2022**
Title:	**Update on CAMHS**
Responsible Executive:	**Nicky Connor, Director & Chief Office of Fife Health & Social Care Partnership**
Report Author:	**Rona Laskowski, Head of Complex and Critical Care Services**

1 Purpose

This is presented to the Public Health & Wellbeing Committee for:

- Assurance

This report relates to a:

- Government policy/directive

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The Public Health and Wellbeing Committee of 15th November 2021requested further information regarding the support offered to individual children, young people and their families who are waiting for services, and additionally, sought further clarity on the planning underway to address the longest waits.

This report provides detail on both matters.

2.2 Background

Following a programme of enhanced support from the Scottish Government's Mental Health Performance & Improvement team to Fife CAMHS (2019-2021), there was acknowledgment that there was insufficient staffing capacity to meet both the National Referral to Treatment target and reduce the existing CAMHS waiting list.

The SG Performance & Improvement Team identified that the initiatives that had been put in place by Fife CAMHS made the most efficient use of the existing resource however additional capacity was required to achieve sustained improvement against year on year increasing referrals.

Investment provided by Fife HSCP in April, and subsequently Scottish Government, in June 2021 was deployed to increase the existing workforce capacity to meet both ongoing demand, the minimum standard of 18 weeks as set by the Referral to Treatment Target (RTT) and the temporary resource required to reduce the longest waits.

This initial investment aimed to recruit 8 permanent staff and 2 temporary staff to address the deficit in capacity and provide a short term resource to target the longest waits. Recruitment of all staff by July 2021 was projected to achieve an RTT of 90% seen within 18 weeks by June 2022 and the number of children waiting over 18 weeks reduced to zero within 12 months of full recruitment.

2.3 Assessment

Addressing the Longest waits:

Recruitment:

Recruitment activity has been underway since April 2021 to increase clinical capacity within CAMHS to directly address the waiting list backlog and meet the ongoing new demand for the service. 6 recruitment cycles has resulted in the service appointing 7 permanent staff, with individuals incrementally taking up post from 23rd August 2021, with all due to be in post by January 2022.

2 temporary posts were recruited to in April 2021to address the longest waits. These appointments had a positive impact with all waits being reduced to under 52 weeks by June 2021. Both of these post holders resigned in August 2021 to take up promoted posts in other services. Successful re-recruitment of these vacancies has been achieved with post holders due to take up position in February 2022.

Recruitment has proved challenging, impacted by the consequences of the pandemic and the unintended competition from other NHS Boards, who have also received additional investment through the SG Mental Health Recovery & Renewal funds for the same purposes.

Resource Allocation:

In order to maintain the progress made towards reducing the longest waits the service has re-provisioned specific professional groups within CAMHS (clinical psychology) to provide interventions for those children and young people who have experienced the longest waits. New starts have also been allocated both priority new appointments and casework from the waiting list in order to avoid an incremental increase in waiting times.

The allocation of resources is balanced against being able to respond to a significant increase in children and young people presenting with urgent and priority needs with

associated risk: typically severe eating disorders, significant self harm and suicidal behaviours.

Impact on Waiting Times Trajectory:

Due to the difficulties with recruitment, the initial projection for achieving the RTT and eradication of Waiting List beyond 18 weeks was revised. This revision was developed in collaboration with the Public Health Scotland (PHS) embedded analyst with delivery now reported to be October 2022 for eradication of the waiting list over 18 weeks and an RTT of 90% achieved and sustained by December 2022. (Table 1)

This projected trajectory has been submitted and approved by the Scottish Government as part of the Fife CAMHS Improvement Plan.

The Scottish Government target for the removal of all waiting lists over 18 weeks is March 2023.

Despite the challenges experienced in recruiting and retaining staff, Table 1 demonstrates an actual activity that exceeds the projected performance.

Table 1: RTT & Waiting list Trajectory based on Planned Recruitment by November 2021

Quarter ending	Sep-20	Dec-20	Mar-21	Jun-21	Sep-21	Dec-21	Mar-22	Jun-22	Sep-22	Dec-22
Projected Performance (RTT%)	70%	70%	70%	70%	77%	70%	75%	75%	85%	90%
Achieved RTT	70.4%	85.8%	73.0%	79.5%	82.1%	-	-	-	-	-
Predicted: Waiting 36+ weeks (backlog)	76	104	134	164	144	112	62	32	2	-28
Achieved: Waiting 36+ weeks	76	112	63	38	73	-	-	-	-	-

Support for children on the CAMHS waiting list:

All children and young people who are referred to Fife CAMHS and who meet the National CAMHS referral Threshold are offered either a priority appointment or are added to the CAMHS Waiting list pending a routine appointment.

Those children identified as requiring urgent intervention are seen on the day of referral if required by CAMHS Urgent Response Team (CURT) or CAMHS Intensive Therapy Service (ITS). These children would typically present with either significant risk to themselves or be experiencing severe mental health issues.

Children and young people who are identified as requiring a priority appointment are asked to attend an initial Risk Assessment Clinic to ensure appropriate support is available and the clinical team can respond in a safe and timely way to their specific needs.

For those children who are not identified as a priority, a proportion are offered an assessment appointment with a CAMHS Primary Mental Health Worker. This assessment provides a specialist assessment and formulation of their individual need, considers alternative service providers that may best meet their needs or provides interim resources to support children whilst they wait for their CAMHS appointment. These interim resources can include self help resources, referral to alternative providers such as school nursing, school counselling or third sector providers. In addition the Primary Mental Health Worker assessment also provides a risk assessment that indicates whether they are safe to wait or if a more urgent appointment is required.

For those children who are placed directly onto the CAMHS waiting list for a routine appointment, an opt in letter is sent which identifies the estimated time that may be required to wait along with a list of alternative services and resources that can be accessed if they are not prepared to wait.

Those waiting are also advised that should there be a deterioration in their mental health they should seek support from their original referrer and if appropriate, request that their referral is expedited.

Fife CAMHS also acknowledges how distressing it can be to wait for extended periods and therefore write at intervals throughout the year to all families who have waited over 4 months to acknowledge the delay, provide the advice offered at opt-in and highlight again the alternative resources that are available to children, young people and families.

Children, young people and families are encouraged to access the wider system of supports available, such as school counselling, whilst waiting for a CAMHS appointment. All Children and young people who have waited over 52 weeks are tracked and any additional support is recorded against these referrals.

2.3.1 Quality/ Patient Care

The improvement in the reduction of waiting times, and delivery of the national specification will continue to improve patient care.

2.3.2 Workforce

Increased capacity within the CAMHS workforce will lead to improved stability and retention of skills, plus enhanced career pathways within the specialty.

2.3.3 Financial

There are no additional financial implications arising from this report .

2.3.4 Risk Assessment/Management

There is significant reputational risk if performance is not improved.
There is a risk of workforce migration from Adult Mental Health services to CAMHS.

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

Initial proposals were developed in conjunction with Scottish Government Mental Health Division, Performance & Improvement team and previous approval from the NHS Fife Executive Directors Group.

2.3.8 Route to the Meeting

- Public Health & Wellbeing Committee: 15.11.21.

2.4 Recommendation

- **Assurance** –members of the Public Health and Wellbeing Committee are asked to note the report.

3 List of appendices – N/A

Report Contact
Rona Laskowski
Head of Complex and Critical Care Services
Email: Rona.Laskowski2@nhs.scot

NHS Fife

Meeting:	**Public Health & Wellbeing Committee**
Meeting date:	**10 January 2022**
Title:	**Update on Psychological Therapies: Position at October 2021**
Responsible Executive:	**Nicky Connor, Director & Chief Officer of Fife Health & Social Care Partnership**
Report Author:	**Dr Frances Baty, Head of Psychology Service**

1 Purpose

This is presented to the Public Health & Wellbeing Committee for:

- Assurance

This report relates to a:

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

This aligns to the following NHS Scotland quality ambitions:

- Safe
- Effective
- Person Centred

2 Report Summary

2.1 Situation

The report - *Psychological Therapies: Position at October 2021* was considered by the Public Health and Wellbeing Committee on 15 November 2021. The report included figures on the current waiting list for psychological therapies (PTs). In response to this report, the committee requested "*more information regarding support for those on waiting lists, and planning in place to tackle the longest waits".* The current report provides information in response to this ask.

2.2 Background

Meeting the needs of the longest waiting people is a priority for psychology services in Fife. The Scottish Government is supporting Board areas to tackle the backlog on PT waiting lists and has allocated Mental Health Renewal and Recovery funding for this purpose. The challenge for services across Scotland is in recruitment of staff with the necessary degree of psychological expertise to be able to meet the needs of people with complex presentations. It is such patients,

who require highly specialist psychological therapy or interventions from a clinical/counselling psychologist over a period of several months, who are waiting the longest in Fife.

2.3 Assessment

Updated position on longest waits

Figure 1 shows a further reduction in October 2021 of the numbers waiting over 53 weeks. However, Figure 1a shows an increase in the number of people waiting over 104 weeks. Clinicians see patients in order (unless they are expedited on clinical grounds). The numbers of people waiting over 104+weeks is not reducing because the tier of service where the demand-capacity gap is greatest is for people requiring highly specialist therapy from a clinical or counselling psychologist.

Figure 1

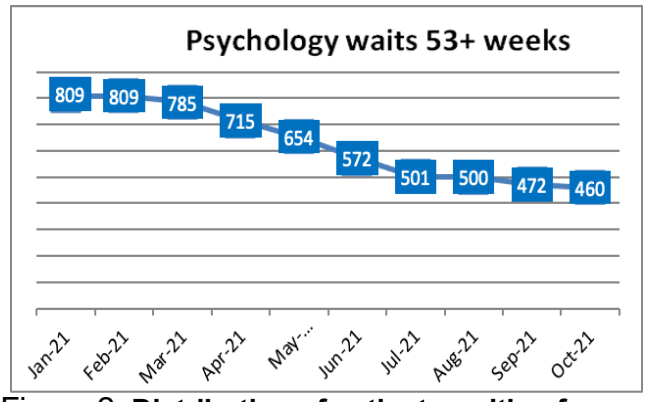


Figure 1a

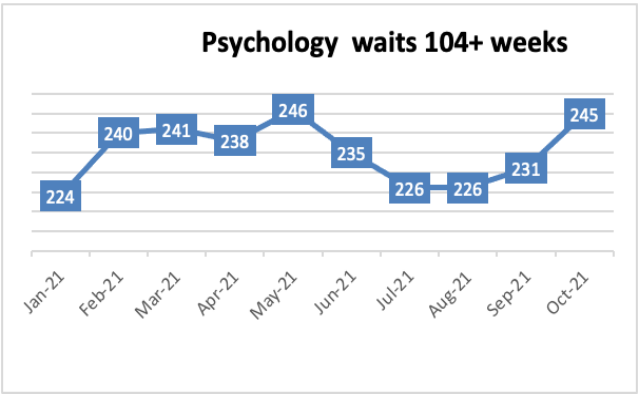
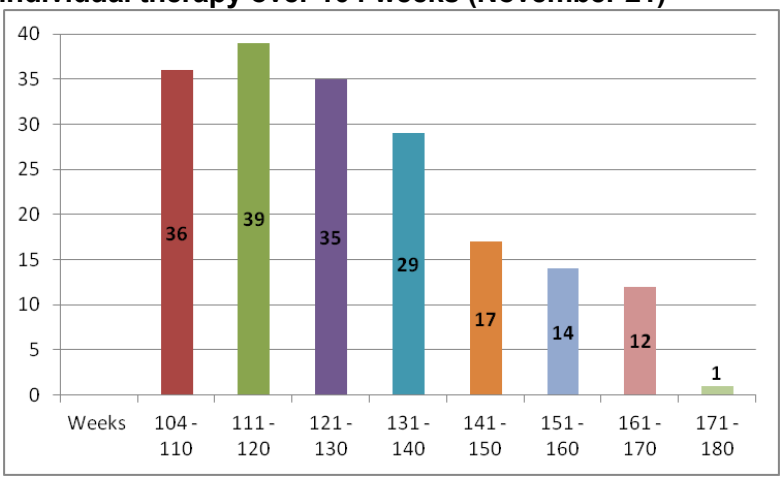


Figure 2. **Distribution of patients waiting for individual therapy over 104 weeks (November 21)**



The 245 people (Figure 1a) waiting over 104 weeks in October includes people waiting for groups (which were on hold due to the pandemic) plus some who in process of being discharged having not opted into therapy. The 183 people in Figure 2 are those waiting for individual therapy. This figure is a more realistic picture of genuine capacity issues within the service.

Contact and support for patients while on the waiting list

The longest waits (104+ weeks) are within both the Adult Mental Health (AMH) psychology service and the General Medical service within Clinical Health Psychology.

All patients within the AMH psychology service are seen by a clinician for assessment (face to face or via Near Me) prior to being placed on the therapy waiting list. This assessment provides patients with a psychological formulation of their difficulties, advice with management and, if appropriate, information on self help resources and other supports. The psychology service is

not a crisis mental health service and a significant number of patients will already be known to colleagues within the wider mental health service and as such in receipt of support from them, including having access to the duty worker.

Both the AMH and Clinical Health psychology service contact people on the waiting list after 6 months (and then every 3-6 months) with advice about resources and how to seek help if their situation has deteriorated. Patients are also contacted and offered any new service developments if this is clinically appropriate (e.g. new psychotherapy groups). The patients who are also open to staff within one of the Community Mental Health Teams have access to indirect input from Psychology including MDT discussion and case consultation, and can be re-assessed or expedited, if appropriate. Anyone on the waiting list for any clinical speciality in the psychology service, is reviewed at the request of their referrer and re-assessed or expedited if appropriate.

Plans to address the longest waits

In order to impact the longest waits, the service requires greater capacity. Efforts to increase capacity are focused upon recruitment and service development, with the latter focused on creating new therapeutic options which enhance efficiency.

As reported previously, recruitment is underway utilising funding from both Fife Health and Social Care Partnership and the Scottish Government. Having completed detailed demand-capacity modelling, supported by a data analyst from Public Health Scotland, the psychology service is clear as to the staff required to meet the needs of the longest waiting patients. Recruitment has been successful for a number of clinical/counselling psychology posts and more is underway. However, there is a national issue with workforce availability for clinical and counselling psychologists. The Head of the Psychology Service in Fife sits on the national Heads of Psychology committee who are working closely with colleagues from Scottish Government and NHS Education Scotland to try to address this issue. While national developments mean that there will be an increase in the overall PT workforce in 21/22, this increase will largely be staff trained to deliver less highly specialised PTs than those required by the longest waiting patients in Fife (and elsewhere).

The Psychology Service engages in continuous service development in response to changes in the clinical evidence base, quality improvement drivers and the demand-capacity gap. With respect to the current situation for longest waiting patients, new, more efficient, service delivery options (to meet complex needs) have been developed and piloted during 2021 and are now being mainstreamed. One example of this is the development of a new group programme for the delivery of schema therapy. Schema therapy is designed to address unhelpful beliefs and interpersonal patterns that are not responsive to first-line therapeutic approaches. It was initially developed as a treatment for ‘personality disorders’ and complex clinical problems. However, over the past 20 years, it has been further applied to an increasing range of clinical problems, and client groups. Group delivery of schema therapy is a new clinical development (supervision for the Fife staff leads was sourced from The Netherlands) and the work completed in the service will make a significant contribution to the clinical evidence base. While not suitable for all patients, the success of the group in terms of clinical outcomes and more efficient use of clinical resource, means that is has now become an element of core service provision in AMH psychology.

The AMH psychology service has also successfully trialled an approach to support clinicians to deliver episodes of care for complex patients. This involved the Consultant psychologist managers (of the clinical team with the highest referral rate) holding clinical case discussions focused on how to prioritise, with the patient, specific goals that are achievable within an agreed number of sessions (maximum 20). This approach is in line with the evidence base on therapeutic outcomes but it can be a challenge for less experienced clinicians when working

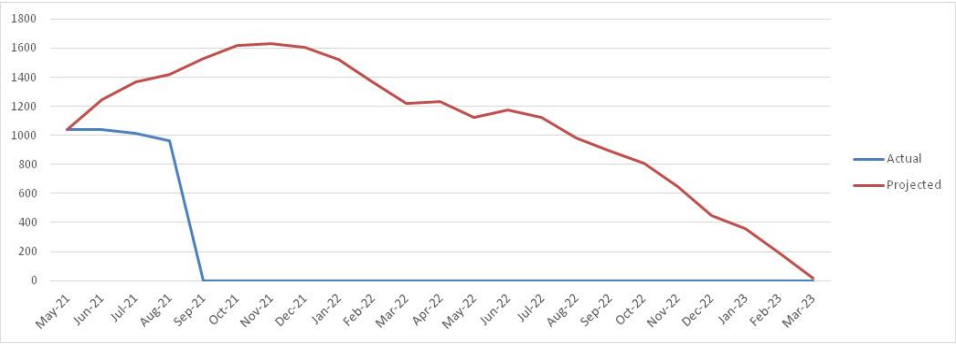
with people whose mental health issues are complex and often long-standing. The impact of this work in terms of it increasing the number of people being seen is being monitored but the indications, from the case management discussions which take place within quarterly line management supervision, are that it is having a positive impact on both clinical activity and staff morale.

The AMH psychology service is also introducing an in-house training programme to increase the skills of the clinical associate psychology workforce so that they can work with a wider range of presenting problems. This will free capacity amongst the clinical and counselling psychologists for work with the current longest waiting patients.

A review of the whole waiting list within Clinical Health psychology, highlighted that about 50% of people on the general medical service waiting list (i.e. around 140 people) had been referred with presenting difficulties associated with functional neurological disorder. Following successful recruitment to a senior post within the Clinical health psychology service, plans are underway to introduce new service delivery options to meet the needs of these patients. These are likely to include the development of a group to deliver psychoeducation about functional neurological disorder. Psychoeducation currently forms one component of individual therapy over a number of sessions and it is anticipated that group delivery (as part of a tiered suite of therapy options) will introduce increased efficiencies. The increased capacity will also support closer multidisciplinary team working to develop clinical pathways for this patient group.

Trajectory modelling for longest waits
The date set by the Scottish Government for achievement of the 18 week PTs referral to treatment target is 31 March 2023. Understanding the resource required to meet this target (and so inform our recruitment plans) has been the focus of the demand-capacity modelling to date. We have also plotted the trajectory for overall waiting list (Figure 3).

Figure 3. Waiting list trajectory for highly specialised psychological therapy



Further modelling is required to plot the trajectory for longest waiting patients and we plan to undertake this modelling in the New Year.

2.3.1 Quality/ Customer Care

Reducing waiting times and increasing access will improve quality and experience of individuals accessing Psychological Therapy services.

2.3.2 Workforce

There is a potential for increased staff stress in the short term due to demands of working through backlog while at the same time working in new ways in redesigned services and training other staff in PTs. The service is working to mitigate this.

There is acknowledgement from Scottish Government that the circumstances where all NHS Boards are recruiting at the same time, from the same potential workforce has brought challenges. Consideration is underway with NES to explore a national recruitment pathway to reduce unintended consequences of the targeted investment to inflate the workforce across all Boards at one time.

Longer term staff will benefit from working in services that are able to meet demand allowing them to focus more on early intervention and other aspects of service improvement in line with Government's transforming mental health agenda.

2.3.3 Financial

There are no additional financial implications arising from this report.

2.3.4 Risk/Legal/Management

Ongoing delay in maximising availability of PTs impacts the wider adult mental health services through increased demand and reduced efficiencies in the provision of multidisciplinary care.

2.3.5 Equality and Diversity, including Health Inequalities

Timely access to Psychological Therapies and delivery of the longer term ambition to increase the psychologically informed nature of integrated care throughout Fife will contribute to the mitigation of experienced health inequalities.

2.3.6 Other Impact

N/A

2.3.7 Communication, Involvement, Engagement and Consultation

There has been regular consultation with colleagues in the Scottish Government's Mental Health Division Performance and Improvement Team.

2.3.8 Route to the Meeting

- This report is an update produced in response to request by the Public Health and Wellbeing Committee, for further information relating to a previous report considered on 15 November 2021.

2.4 Recommendation

This report is for:

- **Assurance** members of the Public Health and Wellbeing Committee are asked to **note** the report.

3 List of Appendices –

N/A

Report Contact:
Dr Frances Baty
Head of Fife Psychology Service
E-Mail frances.baty@nhs.scot

NHS Fife

Meeting:	**Public Health & Wellbeing Committee**
Meeting date:	**10 January 2022**
Title:	**Developments of Draft Committee Workplan**
Responsible Executive:	**Joy Tomlinson, Director of Public Health**
Report Author:	**Joy Tomlinson, Director of Public Health**

1 Purpose

This is presented to the Public Health & Wellbeing Committee for:

- Assurance
- Discussion

This report relates to a:

- Local policy
- NHS Board/Integration Joint Board Strategy or Direction

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

- Effective

2 Report summary

2.1 Situation

As part of the formation of the Public Health and Wellbeing Committee there is a requirement to develop a workplan which will deliver the ambitions of the Committee. Proposed updates to the workplan are brought to Committee for further discussion and agreement.

2.2 Background

The Terms of Reference for the Public Health and Wellbeing Committee set out the purpose of supporting wider population health and wellbeing. This will be achieved through assurance across a range of services and Committee recognise that this will take time to become fully established. The Terms of Reference also set out the clear intention that through its work the Committee will strengthen collaboration and build momentum across all current partnerships.

This update considers the workplan for the committee and alignment with other Board Committees. It also considers areas for future inclusion in the workplan.

2.3 Assessment

The NHS Board ratified the Terms of Reference for the Public Health & Wellbeing Assurance Committee at their meeting on 30th November. Following this meeting, the Executive Leads for each of the Assurance Committees and Chairs met to consider alignment of work across the Committees.

It is recommended that all the areas included in the previously circulated draft workplan are included. These can now be removed from other Committee workplans. Timelines for all programmes of work can now progress to be finalised with leads across the workplan. It is anticipated this will be complete by the end of the calendar year.

The establishment of the Committee provides an opportunity to deliberately consider aspects of the healthcare system which can maximise benefit to the whole population. There is clear alignment between the universal health services across Primary and Community Care and the ambitions of the Committee to strengthen strategic support for these areas.

It is also of note that there are examples of other Public Health committees around Scotland which provides an opportunity to build on learning from other areas in the further development of this workplan.

The draft workplan is attached at Appendix 1.

2.3.1 Quality/ Patient Care

2.3.2 Workforce

There are no direct implications related to workforce through development of this workplan.

2.3.3 Financial

There are no direct financial implications related to this workplan

2.3.4 Risk Assessment/Management

No risk assessment has been completed related to this workplan.

2.3.5 Equality and Diversity, including health inequalities

Not directly applicable but the Committee will provide scrutiny and support of all strategies which it receives and will sustain a focus on reducing health inequalities and strengthening positive actions to support equality.

2.3.7 Communication, involvement, engagement and consultation

No external stakeholders have been involved in the writing of this report.

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.

2.4 Recommendation

Committee members are asked to agree the content of the draft workplan and to consider inclusion of strategic plans for Primary Care Services, Dental Services, Optometry and Community Pharmacy services in the next iteration of the draft workplan.

- **Decision** – Reaching a conclusion after the consideration of options.
- **Discussion** – Examine and consider the implications of a matter.

3 List of appendices

The following appendices are included with this report:

- Appendix 1, Draft Workplan

Report Contact
Joy Tomlinson
Director of Public Health
Email joy.tomlinson3@nhs.scot

Appendix 1

NHS FIFE PUBLIC HEALTH & WELLBEING COMMITTEE – DRAFT ANNUAL WORKPLAN, 2021/2022

	Lead	October	November	December	January	February	March
General							
Minutes of Previous Meeting	*Chair*		✓	✓	✓	✓	✓
Action List	*Chair*			✓	✓	✓	✓
Escalation of Items to Board	*Chair*		✓	✓	✓	✓	✓
Strategy and Planning							
Population Health and Wellbeing Strategy	DoF&S		✓	✓	✓	✓	✓
Anchor Institution Programme Board	DoPH			✓		✓	
Remobilisation / Annual Operational Plan	DoF&S/ADPP		✓		✓		✓
Mental Health Strategy Implementation	DoHSC				✓		
Primary Care Transformation Implementation	DoHSC				✓		
Corporate Objectives	DoF&S						✓
Quality and Performance							
Integrated Performance and Quality Report	DoF&S/ADPP		✓ **?**		✓		✓
Children In Fife	DoHSC						✓
Sexual Health and Blood Borne Virus Framework	DoHSC						
Healthy Weight	DoPH						
Smoking Cessation *(six monthly?)*	DoHSC						
Joint Health Protection Plan (*due June 2022*)	DoPH						
Health Promoting Health Service *(due August 2022)*	DoPH						
Person Centred Care, Participation and Engagement							
Equalities Outcome Report	DoN				✓		
Participation and Engagement Report	DoN				✓		
Governance and Assurance							
Board Assurance Framework – Public Health and Wellbeing	DoPH			**TBC**			
Covid Testing Programme	DoPH		✓		✓		✓
Flu Vaccine / Covid Vaccine (FVCV) Programme	DoPH/DoHSC		✓		✓		✓
Committee Self-Assessment Report	Board Secretary						✓
Corporate Calendar / Committee Dates	Board Secretary		✓				
Annual Committee Assurance Statement	Board Secretary						✓
Review of Annual Workplan	Board Secretary		✓				✓
Review of Draft Committee Workplan	DoPH			✓	✓	✓	✓

	Lead	October	November	December	January	February	March
Review of Terms of Reference	Board Secretary	✓					✓
Annual Reports							
Director of Public Health Report	DoPH						✓
Health Improvement Annual Report *(due May 2022)*	DoPH						
Integrated Screening Annual Report	DoPH						✓
Immunisation Annual Report (also goes to CGC – *due July 2022*)	DoPH						
Fife Child Protection Annual Report	DoN				✓		
Adult Support & Protection Annual Report (also goes to CGC)	DoN				✓		
Alcohol & Drugs Partnership Annual Report	DoHSC						
Other/ Ad Hoc							
Minutes of Fife Partnership Board	DoPH						
Minutes of Population Health & Wellbeing Portfolio Board	DoF&S						
Minutes of Public Health Assurance Committee	DoPH		✓		✓		✓

NHS Fife

Meeting:	**Public Health and Wellbeing Committee**
Meeting date:	**10 January 2022**
Title:	**NHS Fife Population Health and Wellbeing Strategy**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Authors:	**Susan Fraser, Associate Director of Planning and Performance** **Kirsty MacGregor, Head of Communications**

1 Purpose

This is presented to the Committee for:

- Assurance
- Discussion

This report relates to:

- Population Health and Wellbeing Strategy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The NHS Fife Board approved the launch of the NHS Fife population and staff survey on 30 November 2021. This will gauge individuals' attitudes to health and wellbeing, with the results of the survey being used to inform NHS Fife's Population Health and Wellbeing Strategy due for publication in March 2022.

2.2 Background

The Covid-19 pandemic has brought the most significant health challenge in the history of the NHS and this provides a unique opportunity for NHS Fife and the communities we serve to reflect and to make change for the better.

NHS Fife's ambition is to provide excellence in the delivery of healthcare and health services in the right place at the right time, for those who need it. But we are also looking to stretch beyond the place of fixing people when they are ill, toward a vision where we are an active participant in supporting our communities to address poverty, inequalities, and harm, and to improve their physical and mental wellbeing

NHS Fife serves a population of more than 370,000 people and we want as many people as possible to be enabled to take part in this survey-based conversation to help us establish current thoughts and attitudes towards our own health and wellbeing, now and into the future.

The Population Health and Wellbeing Strategy will replace the extant Clinical Strategy 2016-2021 and will focus on the needs and requirements of the population of Fife in terms of their overall health and wellbeing as well as delivery of clinical services.

The Board Development Session on 2 November 2021 explored the need for the strategy to address and target preventative and early interventions in specific areas and communities. The Board also discussed the need for plans to be put in place to identify localities where specialist services could be targeted to improve health and wellbeing outcomes for these communities. The survey will give the opportunity to provide the voices from these communities that will help shape future provision of heath and wellbeing services in Fife.

2.3 Assessment

As we review and develop our plans for the future, it is important to us that we capture the thoughts, views, and attitudes of local people and our staff.

NHS Fife has launched this conversation with individuals, community groups, partners, and stakeholders across the Kingdom, to get their views on how we can support their future health and wellbeing, learning lessons from the pandemic and recognising that Covid-19 has impacted certain groups more severely than others. This conversation is about understanding current attitudes and behaviours towards health and wellbeing as opposed to formal engagement or consultation in relation to service delivery and redesign.

Given the current covid restrictions, we wanted to create an accessible and safe forum to capture feedback from all our communities, partners, and service users.

The confidential survey developed by The Progressive Partnership Agency is open to anyone aged 16 or over who currently lives in Fife and takes around 10 minutes to complete, with responses completely anonymised. In parallel, an NHS Fife staff version of the survey "Colleague Conversation Survey" will also open to capture the thoughts of NHS Fife's 8,500 staff. We are also exploring options to hear the voices of our younger people.

The qualitative and quantitative results of the survey will be independently verified and used to create a foundation to inform further targeted conversations and a participation programme. The programme will ensure equitable and representative views and opinions from across all demographic and socio-economic groups in Fife potentially including a dedicated strand to engage with young people aged 15 and below.

Early planning indicates a range of stakeholders and groups where more targeted conversations may be useful including but not exclusively:

- Participation & Engagement Directory
- Peoples' Panel
- Primary Care (GPs / Dentists / Pharmacies)
- Equalities & Human Rights Strategy Group
- Gypsy Travellers Steering Group
- Accessible Communication Group
- BSL Group
- Transgender Experience of Health Group
- Transgender Participation and Engagement
- Health Improvement Scotland - Community Engagement
- Disabled Persons Housing Association
- HSCP contact for Carers networks
- HSCP for Localities

A small group was constituted including the Vice-chair of NHS Fife, the Director of Nursing and the Director of Finance and Strategy to shape the questionnaire design. This group worked closely with the agency to ensure the questionnaire met the requirements of NHS Fife.

The ‘Community Conversation Survey’ launched online at 10am on Monday 6 December 2021 and will enable Fife residents to give us their feedback on local health services, both now and into the future. The online survey will be open for 14 days and will close at midnight Sunday 12 December 2021, with the deadline of returning paper copies extended to Wednesday 15 December 2021.

To support the conversation a dedicated web page went live on Wednesday 1 December 2021 – this includes a link to the online version of the survey as well as the option to download and print a copy. Paper copies or translated versions of the survey are also available by emailing or phoning NHS Fife Communications, with paper copies and replied paid envelopes available for the public to collect from our main hospital receptions, vaccination venues and public libraries.

The web page URL will be: **www.nhsfife.org/conversation**
With a social media hash tag **#communityconversation**

2.3.1 Quality/ Patient Care

Quality of patient care and safety are at the heart of the Population Health and Wellbeing Strategy and the outcome from this community conversation will inform future quality and safety plans.

2.3.2 Workforce

Workforce is at the heart of the Population Health and Wellbeing Strategy and the outcome from this community and colleague conversation will inform future strategic workforce plans.

2.3.3 Financial

The Population Health and Wellbeing Strategy and the outcome from this community and colleague conversation will inform NHS Fife's future financial planning.

2.3.4 Risk Assessment/Management

The Population Health and Wellbeing Strategy will contain a robust risk assessment that will be monitored throughout the development and implementation of the Strategy.

2.3.5 Equality and Diversity, including health inequalities

An Equality Impact Assessment stage 1 has been completed and the EQIA stage 2 will be informed by the output from this community conversation.

2.3.6 Other impact

n/a

2.3.7 Communication, involvement, engagement, and consultation

The approach adopted is not a formal engagement framework more of a conversation involving as many individuals as possible as a sounding board and to use local knowledge and experiences to help shape future engagement with service users, carers, community groups and individuals across Fife and working for NHS Fife.

To create awareness of the survey with our staff and external stakeholders a comprehensive communications plan has been developed to encourage participation.

2.3.8 Route to the Meeting

The NHS Fife Board approved the launch of the community and colleague conversation on 30 November 2021.

2.4 Recommendation

The Committee is asked to take the paper for Assurance.

- The results of the survey will be used to create a foundation to inform further targeted conversations and a participation programme. The Committee is asked to discuss the potential range of groups noted in the paper where those more targeted conversations would be useful.

- Specifically, the Committee may wish to discuss how we involve our younger citizens in this work given the age restriction on the survey.

3 List of appendices

The following appendices are included with this report:

- EQIA Stage 1 Report

Report Contact
Kirsty MacGregor
Head of Communications
Email: kirsty.macgregor@nhs.scot

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

Appendix 1

Equality Impact Assessment
Brief Impact Assessment
(Form 1)

This is a legal document as set out in the Equality Act (2010) and the Equality Act 2010 (Specific Duties)(Scotland) regulations 2012 and may be used as evidence for cases referred for further investigation for compliance issues.

Completing this form helps you to decide whether or not to complete to a full EQIA

Consideration of the impacts using evidence / public or patient feedback etc is necessary

Title: Population, Health and Wellbeing Strategy (PHWS)

Question 1: Lead Assessor's contact details

Name	Margo McGurk	**Tel. No**	
Job Title:	Director of Finance and Strategy	**Ext:**	28139
Department	Finance	**Email**	margo.mcgurk@nhs.scot

Question 2: Which Service, Dept, Group or Committee is responsible for carrying out the Standard Impact Assessment?

Name : PH&WS Core Team	

Question 3: What is the scope for this EQIA? (Please x)

NHS	✓	**NHS Fife** **Acute**		**NHS Fife Corporate**	
HSCP		**Service specific**		**Discipline specific**	

Question 4:

Describe the aim and purpose of the policy, policy review, existing or new service, redesign, new build, new project or program.

Aim	To develop a Population Health and Wellbeing Strategy for NHS Fife to supersede the Clinical Strategy 2016-2021.
Purpose	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

Question 5:

Identifying the Impacts in brief

Consider any potential Impacts whether positive and/or negative including **social and economic impacts** and human rights. Please note, in brief, what these may be, if any.

Relevant Protected Characteristics	Impacts negative and positive Social / Economic Human Rights
Age - children and young people, adults, older age	The strategy will impact on the population of Fife with the expectations that the impact will be positive. Changes cannot be defined at this time. Appropriate Groups will be engaged with including older people's group and CYP groups
Disability - mental health, neurological, physical, deaf, hard of hearing	Through the engagement process, the strategy will consider the needs of those with disabilities. Groups to be engaged with will be identified through the public partner volunteer form. There should be a positive impact for those with mental health as this is one of the delivery areas.
Race - black and ethnic people including Gypsy Travellers, racism by cast	BAME communities will be engaged with for the new strategy as a result of disproportionate effects

	on health from COVID and poorer access to services for some groups
Sex - women and men	Men and women require specific services at times, this will be recognised in the strategy. Specific targeting of men's groups as they tend not to come forward to services as readily as women
Sexual Orientation - lesbian, gay, transgender or bisexual	An awareness of the needs of LGBT groups will be considered in the strategy and subsequent delivery of the actions. Groups will be engaged with.
Religion and Belief or Spiritual Care	Spiritual care improves health and wellbeing and as such will be explored as part of the design of the strategy.
Gender Reassignment – transitioning pre and post transition regardless of Gender Recognition Certificate	A consultation on GRA has concluded nationally with local services possibly being more responsible for local Transgender care, this must be explored in terms of what is required locally and therefore from the strategy. Staff require support at delivery stage to improve patient care and outcome.
Pregnancy and Maternity – including breastfeeding	Local groups will be engaged with. (As above)
Marriage and Civil Partnership	The strategy will not address this area but the strategy will be based on a equality of access regardless.

Question 6:

If necessary- please include in brief evidence or relevant information, local or national, that have influenced the decisions being made (this could include demographic profiles, audits, research, published evidence, and health needs assessment, work based on national guidance or legislative requirements, complaints etc). Any evidence /data that supports your assessment can be inserted into the box below.

Please enter evidence/data links:

Scottish Government Protecting Scotland, Renewing Scotland

Scottish Government Remobilise, Recover, Redesign: The Framework for NHS Scotland

Independent Review of Adult Social Care in Scotland (Feeley Report)

Scotland Programme For Government

4 National Care Programmes

National health and wellbeing outcomes

2020 Vision Scotland

Equality Outcome plan 2021-2025

Public Health Scotland Priorities

NHS Fife COVID Remobilisation Plan 3 (and RMP4 due for submission by Sept 2021)

Fife Clinical Strategy 2016-2021

Fife Population Health Assessment 2021

IJB Strategic Plan

Plan4Fife

Learning from Canterbury – Opportunity from Adversity

Learning from Carnegie – Creating an Enabling State

Learning from HIS – Transforming Health and Wellbeing Outcomes

Question 7:

Have you consulted with staff, public, service users, children and young people and others to help assess for Impacts?

(Please tick)

Yes		**No**	x

If yes, **who** was involved and **how** were they involved?

If not, why not, was this necessary? Do you have feedback, comments/complaints etc that you are using to learn from, what are these and what do they tell you?

Who did you ask? When and how? Did you refer to feedback, comment or complaints etc?

We will have a staged approach to the design and development of the strategy which includes:

Engaging patients and public via use of the participation and engagement networks

Engaging patients and public through the EQIA process at stage 2

Analysing patient feedback and learning from complaints and comments

Listening to the experiences of staff and volunteers who are keen observers of service delivery

Engaging patients and public through the participation and engagement networks on the draft strategy

Question 8:

Meeting the Public Sector Duty as part of the Equality Impact Assessment

Please provide a rationale to support the results of the Brief Impact Assessment, in that due consideration has been given to the following: you can add in the positive outcomes and the negative ones

- **Eliminate unlawful discrimination, harassment and victimisation**

- **Advance equality of opportunity between different groups; and**
- **Foster good relations between different groups**

What we must do	Provide a description or summary of how this work does contribute to or achieve
Eliminate discrimination Advance equality of opportunity Foster good relations	The PH&W strategy will ensure that we meet the needs of all the people who access our services. It will be created in partnership with staff and public. Their experiences and opinions will be listened to ensuring the strategy is representative of them. We will work to eliminate discrimination by identifying inequalities within service delivery and act to ensure we address these via the plan We will further equality by exploring data and health needs of certain populations in order to focus our plans on reducing inequality for the certain groups And we will foster good relations by working with our staff and public by including them in the design and delivery of the plans and further work across services involving staff and patients.

Question 9:

If you believe your service is doing something that 'stands out' as an example of good practice - for instance you are routinely collecting patient data on sexual orientation, race, religion and belief etc. - please use the box below to describe the activity and the benefits this has brought to the service. This information will help others consider opportunities for developments in their own services.

- The Strategy will be available in a range of languages and it will be developed in conjunction with the Head of Person-Centred Care and the Equality and Human Rights
- Pride badges and pledge showing support of LGBT plus Community

Question 10:

Has your brief assessment been able to demonstrate the following and why?

Option 1: No major change (where no impact or potential for improvement is found, no action is required)

Option 2: Adjust (where a potential or actual negative impact or potential for a more positive impact is found, make changes to mitigate risks or make improvements)

Option 3: Continue (where a potential or actual negative impact or potential for a more positive impact is found but a decision not to make a change can be objectively justified, continue without making changes)

Option 4: Stop and remove (where a serious risk of negative impact is found, the plans, policies etc. being assessed should be halted until these issues can be addressed)

Explain decision

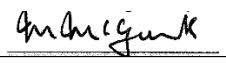
Option 1 No action Option 1: No major change (where no impact or potential for improvement is found, no action is required)
Option 2 Adjust Option 2: Adjust (where a potential or actual negative impact or potential for a more positive impact is found, make changes to mitigate risks or make improvements)
Option 3 Option 3: Continue (where a potential or actual negative impact or potential for a more positive impact is found but a decision not to make a change can be objectively justified, continue without making changes)
Option 4 Stop and remove (where a serious risk of negative impact is found, the plans, policies etc. being assessed should be halted until these issues can be addressed) **All large scale developments, change, planning, policy, building, etc must have an EQIA**
The strategy will be a review of the existing strategy and the strategic direction for the next 5 years. Although there is no major change as a result of the strategy, there may be major change as a result of the implementation of the strategy.

If you have identified that a full EQIA is required then you will need to ensure that you have in place, a working group/ steering group/ oversight group and a means to reasonably address the results of the Impact Assessment and any potential adverse outcomes at your meetings.

For example you can conduct stage 2 and then embed actions into task logs, action plans of sub groups etc and identify lead people to take these as actions.

Stage 2 require public involvement and participation.

You should make contact with patient relations dept to request community and public representation, and then contact the Scottish Health Council to discuss further support for participation and engagement.

To be completed by Lead Assessor	
Name	**Margo McGurk**
Email	Margo.mcgurk@nhs.scot
Telephone (ext)	**28139**
Signature	

Date	**30/7/21**

Return to Equality and Human Rights Lead Officer at

Fife.EqualityandHumanRights@nhs.scot

To be completed by Equality and Human Rights Lead officer – for quality control purposes	
Name	
Email	
Telephone (ext)	
Signature	
Date	

NHS Fife

Meeting:	**Public Health & Wellbeing Committee**
Meeting date:	**10 January 2022**
Title:	**NHS Fife Population Health and Wellbeing Strategy Update: Public Health Intelligence and Overview**
Responsible Executive:	**Joy Tomlinson, Director of Public Health**
Report Author:	**Catherine Jeffery Chudleigh, Consultant in Public Health**

1 Purpose

This is presented to the Public Health & Wellbeing Committee for:

- Assurance

This report relates to a:

- Local policy
- NHS Board/Integration Joint Board Strategy or Direction
- National Health & Well-Being Outcomes

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

- Effective
- Person Centred

2 Report summary

2.1 Situation

This paper summarises recent work by the public health department, in contributing to the development of the Health and Wellbeing Strategy. In particular questions, raised at the Board Development Session on 2nd November 2021, are responded to.

2.2 Background

The focus of public health work in supporting the health and wellbeing review strategy is in supporting the developing strategy to be driven by data and evidence-based. This has been delivered through:

- Conducting a Health and Wellbeing review for Fife which identifies areas of priority for health and wellbeing; and
- Advocating for, and providing advice in relation to, the opportunities for integrating prevention into NHS services based on recent evidence.

In November, and moving into December, the focus of Public Health support in relation to this strategy is on:

- Developing a recommendations paper on prevention, based on findings from the Health and Wellbeing review for the EDG for 16th December meeting
- Updating the Health and Wellbeing review for EDG 16th December on the basis of:
    - Emerging data on demographics and distribution of disease
    - The HSCP locality profiles have been received this week so these are being integrated into the health and wellbeing report
    - Feedback from the board development session
- Gathering feedback to develop and finalise the draft infographic summarising the health and wellbeing review
- Developing a response to the queries raised at the Board Development Session for the Health and Wellbeing Board Assurance Committee members.

2.3 Assessment

For the purpose of providing an update, responses to the queries raised at the Board Development Session presented here are succinct. Some more detailed reflections are offered in Appendix 1.

1. What is the potential gain from preventive activities?

Preventive activities contribute to improved quality of life, reduced risk factors for poor health, decreased disease burden and symptoms, extended healthy life expectancy and increased economic and social engagement, as well as reducing long term costs associated with health services.

Generally, evidence based preventive measures are considered to be highly cost effective (being below objective thresholds for cost-effectiveness). Some emerging but recommended preventive activities are less well evaluated. Some examples describing how preventive work embedded in routine service can influence change are described in Appendix 1.

2. Request for greater segmentation of data below Fife level, perhaps focusing on a few key indicators such as life expectancy

Locality profiles for the 7 H&SCP Localities in Fife have been produced and these will be integrated into the Health and Wellbeing review. They provide data on selected indicators at a locality level, including life expectancy.

Data is also disaggregated for many outcomes according to the standard index of multiple deprivation (SIMD) which helps us to understand variations in health outcomes between populations living in the 20% least deprived areas of Fife and populations living in the 20% most deprived areas, which tend to be associated with poorer health outcomes, and where we recommend services should be delivered with proportionate universalism[1].

[1] Proportionate universalism is **the resourcing and delivering of universal services at a scale and intensity proportionate to the degree of need**.

3. Data on addiction in our communities and intergenerational challenges

The Health and Wellbeing review captures data on substance misuse in Fife and its distribution in Fife, with some of this disaggregated by level of deprivation (SIMD).

The mechanisms by which poverty and disadvantage interact with child, and subsequently adult, health and wellbeing outcomes is complex and interconnected but higher rates of reported child protection issues and parental drug use are associated with higher levels of deprivation.

There is a growing body of research which demonstrates that adverse childhood experiences (ACEs – including experience of drug misuse) increases the likelihood of adversity and health consequences in adults.

4. Description of existing preventive activities, so what existing preventive activities are being delivered by NHS Fife (including what outreach improvement work is underway?)

Preventive activities in Fife are delivered across a continuum from modifying the social determinants of health through to reducing complications of established disease.

The major areas of preventive work the Public Health department and the Health Promotion Service are currently contributing to are described in appendix 1, with discrete projects and partnerships within each workstream.

In terms of outreach work, most preventive work is targeted towards improving the health and wellbeing of people living in the most deprived areas of Fife who experience the greatest level of health inequality and need. The health promotion team also work extensively with educational settings, third sector and often excluded groups to target services and training. Preventive activities include outreach in response to identified needs at particular times and often excluded populations, for example with migrant and ethnic minority communities and people experiencing homelessness.

Considerable preventive work is undertaken in primary and secondary care, as well as partner organisations, and some services have worked directly with public health to integrate more preventive activities in their services, for example maternity services.

Conclusions

Work is ongoing to ensure that the new Population Health and Wellbeing strategy is fully supported with a strong evidence base. The information provided will include information at locality level.

Preventive activities are one specific element which will be included in the Strategy and while the evidence base varies, there are many examples of cost-effective interventions which can prevent or mitigate ill-health.

Committee members can be assured that the Health and Wellbeing Review will provide a robust platform for the emerging Population Health and Wellbeing Strategy.

2.3.1 Quality/ Patient Care

The Health and Wellbeing review will support development of the new Population Health and Wellbeing strategy.

2.3.2 Workforce

There are no direct implications as a result of this work.

2.3.3 Financial

There are no direct implications at this time. Overall, preventive activities provide positive benefit to individuals and communities and are beneficial to minimise both financial and human costs from ill-health.

2.3.4 Risk Assessment/Management

No risk assessment has been completed as a result of this work.

2.3.5 Equality and Diversity, including health inequalities

No impact assessment has been completed but the work will contribute to ensuring that population groups who may be disadvantaged are fully considered within the developing strategy.

2.3.7 Communication, involvement, engagement and consultation

This update paper has been produced to assure Committee members of the work taken forward following the Board development session.

2.3.8 Route to the Meeting

This paper has been shared with EDG colleagues by email in advance of the meeting.

2.4 Recommendation

Committee members are asked to discuss the content and note the key findings for assurance.

- **Assurance** – For Members' information only.

3 List of appendices

The following appendices are included with this report:

- Appendix No1: Summary Evidence Review

Report Contact
Catherine Jeffery Chudleigh
Consultant in Public Health
Email: catherine.jefferychudleigh@nhs.scot

Appendix 1

Reflection on questions raised at Board Development Session

1. What is the potential gain from preventive activities?

Preventive activities contribute to improved quality of life, reduced disease burden and symptoms, extended healthy life expectancy and increased economic and social engagement as well as reducing long term costs to the health services.

Generally evidence based preventive measures are considered to be highly cost effective, particularly when the alternative cost of current and future healthcare, social and economic costs are taken into consideration[2]. Some emerging areas of implementing preventive work are less well evaluated as they are novel and/or little or poor quality research has been undertaken upon which to draw conclusions. For example social prescribing and link workers for embedding preventive care into routine health services, although they are recommended based on expert opinion and available evidence. Generally, the more complex and multi-agency an intervention is the weaker the evidence base is, mostly due difficulties ascertaining cause and effect between components of the intervention.

In terms of a few examples of how preventive work embedded in routine service can influence change:

- A Systematic Review of alcohol brief interventions showed both approaches significantly reduced consumption compared to controls.
- An NIHR-funded systematic review found that exercise referral schemes increased physical activity in people who have no or little physical activity to begin with compared with usual care or advice. These are cost-effective for people who have existing health conditions or other health risk factors and are sedentary or inactive.
- An evidence review by NHS GGC concluded that financial inclusion interventions result in benefits from advice in terms of improved mental health, reduced stress or anxiety and better quality of life which theoretically contribute to improved health and wellbeing in the longer term[3].
- Locally in Fife, the 'improving the cancer journey' project reports that between 2018 and September 2021, 336 people have been referred via ICJ to Citizen's Advice Rights Fife and have been helped to access financial support amounting to £600k, addressing a core social determinant of health.
- A recent evaluation by Healthcare Improvement Hub Scotland (NHS Health Scotland), of an NHS Fife and Shelter Scotland project at Victoria Hospital, focusing on supporting homeless people at the point of discharge from hospital found it was potentially cost-effective, on average saving £2,422 per patient supported. This has the potential to significantly reduce both the proportion of people experiencing future hospital stays, and length of stay and indicates that the intervention can address housing needs and reduce the number of people with no fixed abode and/or are street homeless[4].

In practice, even where there is strong evidence, lack of time and low confidence about discussing health risk factors and social determinants of health with patients can deter routine early enquiries and interventions in relation to health risk factors and social determinants of

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[2] For further information on health interventions that are considered to be 'best-buys' by Public Health Scotland (that is are cost-effective, likely to reduce inequalities and prevent future cost to the NHS) see this report by Public Health Scotland.

[3] https://www.nhsggc.org.uk/your-health/public-health/maternal-and-child-public-health/healthier-wealthier-children/health-benefits-of-financial-inclusion/#

[4] https://ihub.scot/media/8194/supporting-homeless-patients-attending-hospital-health-economics-report.pdf

health from being implemented systematically in routine healthcare. In terms of more costly or far reaching prevention activities, a challenge can be that resources to invest in prevention activity are needed but are often committed to the treatment for preventable diseases, despite the opportunity cost of not investing in prevention. To maximise the prevention opportunities in Fife, we would need to think creatively about how this can be achieved systematically, there are many examples of how this might be done, available to appraise.

2. Request for greater segmentation of data below Fife level, perhaps focusing on a few key indicators such as life expectancy

Locality profiles for the 7 HSCP Localities in Fife have been produced and these will be integrated into the health and wellbeing review. They provide data on selected indicators at a locality level. In terms of life expectancy, male life expectancy ranges from 74.6 in Levenmouth to 79.7 in North East Fife Locality and Female life expectancy from 78.5 in Cowdenbeath (78.6 in Levenmouth) to 83.3 in North East Fife Locality. Not all indicators can be disaggregated to this level due to small numbers.

Data is also disaggregated for many outcomes according to the Scottish index of multiple deprivation (SIMD) which helps us to understand variations in health outcomes between populations living in the 20% least deprived areas of Fife and people living in the 20% most deprived areas, which tend to be associated with poorer health outcomes, and where we recommend services should be delivered with proportionate universalism[5]. This data shows us for example that in the most deprived 20% of Fife:

- There are 44% more early deaths from cancer than the overall average
- There are 74% more early deaths from ischaemic heart disease than the overall average
- Smoking rates are 4 times higher than in the least deprived areas

This disaggregated data should help understand need and support the development of NHS services and preventive work aligned with localities and proportionate to need.

3. Data on addiction in our communities and intergenerational challenges

The Health and Wellbeing review captures data on substance misuse in Fife and its distribution in Fife. There is no safe level of smoking and drinking and the majority of harm from substance misuse relates to smoking and also to alcohol consumption at a moderate level.

In terms of addiction, we know that more than 1 in 5 adults in Fife are known to drink to a harmful or hazardous level, similar to the proportion in Scotland. Alcohol related admissions, an indicator of significant alcohol related harm, are nearly double in the most deprived parts of Fife compared to the least. Population prevalence of drug misuse was estimated in 2012/13 to be 1.2%, lower than in Scotland, however drug related hospital admissions are higher in Fife, although this could reflect genuine (and effective) differences in care pathways. In Fife, as in Scotland, a sharp increase in drug related deaths has been observed in the previous decade[6].

The mental, physical and social health of individuals is influenced by multiple environmental factors which accumulate over the life course from as early as the pre-conception phase. The mechanisms by which poverty and disadvantage interact with child, and subsequently adult, health and wellbeing outcomes, is complex and interconnected. The effect of poverty can contribute to mental health, financial problems and substance misuse in parents which can affect parenting and in some

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[5] Proportionate universalism is **the resourcing and delivering of universal services at a scale and intensity proportionate to the degree of need**.

[6] Fife Alcohol and Drug Partnership (2019) Drug related death report, available at: https://www.fifeadp.org.uk/__data/assets/pdf_file/0025/228715/Fife-ADP-Drug-Related-Deaths-Report-2019.pdf (accessed 28/09/2021)

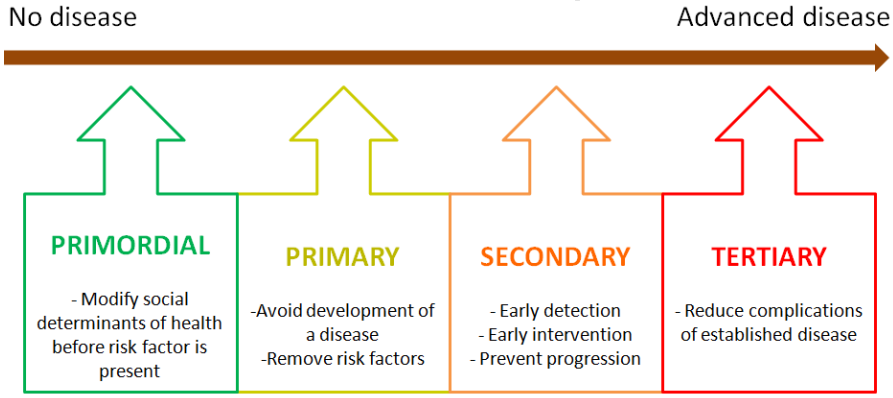
cases contribute to abuse, neglect or major adversity which affect children's health and wellbeing in the immediate and longer term. Cases of child protection with parental drug misuse, is higher in Fife than in Scotland.

There is a growing body of research which demonstrates that adverse childhood experiences (ACEs – including experience of drug misuse) increases the likelihood of adversity and health consequences in adults. It is estimated that around 7% of adults in Fife have experienced four or more ACEs. This highlights the importance of preventing and mitigating these ACEs in Fife and tackling child poverty as part of child protection prevention, as well as to achieve broader health and wellbeing outcomes for children.

In Fife, we have some good examples of positive interventions in relation to addressing the effect of child poverty and adversity on health and wellbeing outcomes. There are opportunities to strengthen existing interventions further, particularly in the areas highlighted above through for example interventions to address child poverty; the family nurse partnership; preventing and mitigating the impact of adverse childhood experiences; trauma informed services; promoting income maximisation and whole family approaches to substance misuse.

4. Description of existing preventive activities, so what existing preventive activities are being delivered by NHS Fife (including what outreach improvement work is underway?)

Preventive activities occur across a continuum from modifying the social determinants of health through to reducing complications of established disease.



The major areas of preventive work the Public Health department and the Health Promotion Service are currently contributing to are described in the table below, with discrete projects and partnerships within each workstream including partnership working with agencies who directly influence the social determinants of health.

In terms of outreach work, much of preventive work is targeted towards improving the health and wellbeing of people living in the most deprived areas of Fife who experience the greatest level of health inequality and need. This extends from working with partners to influence the social determinants of health to supporting services focused in the most deprived populations (e.g. Fife community food project) and delivering services with explicit targets for uptake in the most deprived populations (e.g. smoking cessation). The health promotion team also work extensively with educational settings, third sector and often excluded groups to target services and training. Preventive activities are also implemented in response to an identified need at particular times and for often excluded groups, for example providing health screening to new migrants in Fife; working with religious communities during the COVID-19 outbreak to support awareness raising and test uptake; and supporting work in relation to homelessness and health. Previously dieticians have delivered adult weight management programmes within the local mosque. Beyond

public health, NHS Fife services are fundamental to tertiary prevention and also contribute to primary and secondary prevention through for example: primary care, Addiction services, Family Nurse Partnership, Adult Weight Management and Child healthy weight Services, Health Visiting pathway, Child protection services and Mental health services. Some services have worked directly with public health through health promoting health services and other interventions to integrate more preventive activities in their services, for example midwifery, however this is variable. A more detailed stocktake of specific preventive interventions delivered by and within NHS Fife services would help understand the potential opportunity for change and areas to target prevention activities. A broader network of agencies also contributed to prevention including Environmental Health and regulatory services, educational settings, community development, Fife HSCP, other Fife Council partners and third sector and community organisations.

Health Promotion Team (HSCP) - Food and health including food insecurity - Mental health improvement and suicide prevention - Welfare reform and anti-poverty - Children and young people - Training on health promotion, prevention and social determinants of health - Tobacco prevention and protection including smoking cessation services - Health promoting health services - Supporting health improvement at a local level through localities - Workplace health	**Healthcare Public Health Team** - Delivery of national Screening Programmes - Dental Public Health - Vaccination Programmes - Prevention and harm reduction for substance misuse, including alcohol (including drug related deaths) - Health and housing and homelessness - Collaboration in east of Scotland type 2 diabetes prevention partnership
Population Health Team with NHS Fife and partners - Influencing prioritisation of income, housing, education and employment programmes as part of the Plan 4 Fife - Housing, homelessness and health - Migrant health including health screening for new refugees in Scotland - Supporting work towards establishing NHS Fife as an Anchor Institution - Working in partnership to reduce child poverty - Supporting the development of place based approaches in Fife and economic regeneration of Levenmouth	**Health Protection team** - Contribute to the NHS Fife Cancer and Health and Wellbeing Strategy - Enhanced COVID response and Test and Protect programme with full contact tracing and community testing functions - Health Protection preventing and responding to communicable disease cases and outbreaks and environmental hazards, (including out of hours health protection) - Partnership working on Climate change and health - Resilience function

The Health and Wellbeing review is developing recommendations as to how NHS Fife can strengthen its preventive activities to further promote health and wellbeing for the Fife population, with a focus on extending beyond our traditional sphere of preventive activity (predominantly treatment services), based on the best available evidence.

NHS Fife

Meeting:	**Public Health and Wellbeing Committee**
Meeting date:	**10 January 2022**
Title:	**Anchor Institution Programme Board**
Responsible Executive:	**Dr Joy Tomlinson, Director of Public Health**
Report Author:	**Jo-Anne Valentine, Public Health Manager (Health Improvement)**

1 Purpose

This is presented to Public Health and Wellbeing Committee for:

- Assurance
- Discussion

This report relates to a:

- Annual Operational Plan
- Emerging issue
- Local policy
- NHS Board/Integration Joint Board Strategy or Direction

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

As an Anchor Institution NHS Fife can have a direct impact on reducing health inequalities locally. Key areas in which this can be achieved are employability, procurement and spend, estates, property and land and finances.

In April 2021, NHS Fife established an Anchor Institution Programme Board, chaired by the Chief Executive, with the aim of providing strategic leadership to the development of NHS

Fife as a recognised Anchor Institution in order to support NHS Fife's key objective to continue to work to reduce poverty and inequality.

The Public Health and Wellbeing Assurance Committee is asked to note the progress in the development of NHS Fife as an anchor institution.

2.2 Background

Anchor institutions have been described by The Health Foundation as organisations that have an important presence in a place, usually through a combination of being large scale employers, the largest purchasers of goods and services in the locality, controlling large areas of land and/or having relatively fixed assets[1]. In addition anchor institutions are tied to a particular place by their mission, histories, physical assets and local relationships.

The Health Foundation 2019 report, "Building healthier communities: the role of the NHS as an anchor institution" highlighted how decision makers across the health care system can maximise the contribution the NHS makes to the social, economic and environmental conditions that shape good health[2].

Meanwhile, the impacts of covid-19 have contributed to worsening the conditions that shape good health. Along with the direct impacts of Covid-19 and other health related harms, the societal and economic impacts have also been recognized. The pandemic will impact differently on different groups of people and some of these impacts will continue for many years, potentially widening existing health inequalities. By working as an anchor institution we can have an impact on reducing health inequalities.

As a community planning partner one of our key objectives is to continue to work to address poverty and inequality through ensuring the prioritisation of income, housing, education and employment programmes as part of the Plan 4 Fife.

A recommendation from the Fairer Fife Commission report of 2015, Fairness Matters was that NHS Fife should contribute to a reduction in inequalities over and above the obvious provision of public health services and the integration agenda eg. as an employer, a procurer of goods and services and as a strong partner[3].

The January 2021 Fife Council commissioned, Centre for Local Economic Strategies (CLES) report Community Wealth Building in Fife includes a set of recommendations closely aligned to those areas which Anchor Institutions can influence – progressive procurement of goods and services; making financial power work for local places; socially productive use of land and assets; fair employment and just labour markets; and plural ownership of the economy[5].

As part of the Plan 4 Fife, Fife Partnership has agreed its new priorities as being community wealth building, economic recovery, tackling poverty and climate change[4].

NHS Fife's Strategic Planning and Resource Allocation 2021/22-2023/24 Health Inequalities Programme included a key objective of continuing to work to address poverty and inequality, including developing as an Anchor Institution.

The NHS Fife Anchor Programme Board has convened on three occasions and a process of self-assessment is underway.

2.3 Assessment

Some aspects of developing as an anchor institution are already been adopted by NHS Fife or are works in progress eg. living wage accreditation, apprenticeship scheme, partnering with employability programmes.

Kickstarter and No-one Left Behind are examples of programmes where by reviewing our employability processes we are widening access to quality work and offering career opportunities to local people from deprived or excluded communities (such as care leavers). Our Director of Workforce and a Consultant in Public Health are both members of Opportunities Fife, our local employability community planning partnership.

Although much of our procurement is conducted through nationally agreed contracts, we are exploring the proportion of spend and which areas of spend from procurement can go into the local economy. Our procurement team are having conversations with National Procurement about how we can make progress with this. Linking our procurement principles to the community wealth building principle that wealth should not automatically be extracted from the local economy will help to build the local economy. By purchasing more locally and for social benefit and we can direct more spend towards local businesses and contribute to create social value.

In terms of estates and buildings, anchor institution characteristics include operating as an asset for local communities as well as being providers of health care. This may include offering space for local schools or community groups to use, linking up with local suppliers including farmers markets and local producers to use space within buildings and across the estate. Within Estates and Facilities work is beginning to review usage of land and buildings to support local communities and further considering how to reduce any negative impact from our estate on the environment.

An additional area of operating as an anchor institution is to consider the impact of our finances locally. This could include approaching the Trustees of Fife health Charity for their view on how to support local initiatives and to review the level of our investments in to 'green' or ethical companies and into positive health benefits.

Some of the concepts of being part of an Anchor Institution will be new to many members of staff particularly within support departments who may see their role solely as being to support health care delivery. In order to make progress in each of the four areas identified we need clear and consistent leadership to support development of actions. We may also need training and development for key members of staff. Support from Public Health Scotland may also be available to help us progress this work.

2.3.1 Quality/ Patient Care

The quality of some of our support services may be improved by being more directly linked to local businesses and organizations. No direct impacts on quality or patient care have been identified.

2.3.2 Workforce

Widening access to employment will have a positive impact on reducing health inequalities of the local population. Staff health and wellbeing may be improved by having more direct links into for example the local food economy, and by improving our impact on the environment.

2.3.3 Financial

No additional financial costs have been identified.

2.3.4 Risk Assessment/Management

The development of an action plan to progress aspects of being an Anchor Institution can include identification and management of risks.

2.3.5 Equality and Diversity, including health inequalities

Operating as an Anchor Institution and contributing to community wealth building will impact positively on reducing health inequalities. An EQiA will be completed once identified areas of action have been agreed.

2.3.6 Other impact

The core of recognizing ourselves as an Anchor Institution is impacting in a positive way on our local economy and environment.

2.3.7 Communication, involvement, engagement and consultation

Our Anchors Institution work has been discussed at a Board Development meeting, and at a meeting of EDG in March 2021. It has also been discussed at Fife Partnership Board. An introductory presentation has been given at the Area Clinical Forum. The Anchor Institution Programme Board recognises the importance of engagement and consultation particularly with our own staff groups, and this will form part of the programme's action plan.

2.3.8 Route to the Meeting

This paper was requested by the Public Health and Wellbeing Committee. An earlier version of this paper was presented to EDG on 11th March 2021.

2.4 Recommendation

- **Assurance –** Committee members are receiving this paper as assurance of the background and progress in establishing NHS Fife as an Anchor Institution.
- **Discussion** – Public Health and Wellbeing Assurance Committee is asked to consider and discuss the contents of this paper and those areas of business included in development as an Anchor Institution.

3 List of Appendices

The following appendices are included with this report: None attached, but links included as references below:

References

1. Health Foundation

   https://www.health.org.uk/news-and-comment/charts-and-infographics/the-nhs-as-an-anchor-institution

2. Health Foundation: Building healthier communities: the role of the NHS as an anchor institution

   https://www.health.org.uk/publications/reports/building-healthier-communities-role-of-nhs-as-anchor-institution

3. Fairer Fife Commission: Fairness Matters 2015

   https://publications.fifedirect.org.uk/c64_Fairness_Matters_Report_2015.pdf

4. Fife Partnership Papers February 2021 page 7

   https://online.fifedirect.org.uk/news/index.cfm?fuseaction=committee.event&evntid=1F709A56-155D-C00E-F193181A17F055E4

5. CLES: Community Wealth Building in Fife within Fife Partnership Papers February 2021 page 53

   https://online.fifedirect.org.uk/news/index.cfm?fuseaction=committee.event&evntid=1F709A56-155D-C00E-F193181A17F055E4

Report Contact
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NHS Fife

Meeting:	**Public Health & Wellbeing Committee**
Meeting date:	**10 January 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 Public Health & Wellbeing Committee for:

- Discussion

This report relates to the:

- Joint Fife Remobilisation Plan for 2021/22 (RMP4)

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

- Safe
- Effective
- Person Centred

2 Report Summary

2.1 Situation

The Population, Health & Wellbeing Committee is a new body set up to monitor progress in this area of the NHS Fife services. This report informs the 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 October 2021.

2.2 Background

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

The report is presented at the 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 December report comprises a full update to the performance data, Exec Summary and drill-down Improvement actions, along with a summary of remobilisation activity. Suggested measures for scrutiny of PH&W Committee are:

- Antenatal Access
- Smoking Cessation
- Alcohol Brief Interventions
- Drugs & Alcohol Waiting Times
- Dementia
- Detect Cancer Early

Pressure in the Emergency Department has continued to be extremely challenging, and performance against the 4-Hour Standard was the lowest recorded since being monitored in the IPQR. Un planned attendance fell in October, compared to September, but was still 5% higher than in the corresponding month of 2020.

Within Acute Services, performance against the National Standards for New Outpatients and TTG fell in October, but there was a modest improvement in Diagnostics. The latter remained significantly lower than at this time last year.

Comparing October 2021 with October 2020, the Waiting Lists in all areas were higher by over 30% for Outpatients and TTG, and had more than doubled for Diagnostics.

Activity in all areas in the first month of RMP4 was lower than forecast.

In Cancer Services, there were no breaches against the 31-Day DTT measure, for the third time this FY, but the 62-Day RTT performance remained over 10% below the Standard. The number of patients starting treatment within 62 days of referral was 20% higher than forecast in RMP4, but was about 15% lower than forecast in relation to the 31-day measure.

Within Mental Health, the % of clients starting treatment within 18 weeks of referral, both in CAMHS and for Psychological Therapies, fell in October, but was similar to (CAMHS) or significantly higher (Psychological Therapies) than a year ago. Waiting Lists were trending upwards, while activity in the first month of RMP4 was lower than forecast.

2.3.1 Quality/ Patient Care

Not applicable.

2.3.2 Workforce

Not applicable.

2.3.3 Financial

Financial aspects are covered by the specific sections of the IPQR.

2.3.4 Risk Assessment/Management

Not applicable.

2.3.5 Equality and Diversity, including health inequalities

Not applicable.

2.3.6 Other impact

None.

2.3.7 Communication, involvement, engagement and consultation

The NHS Fife Board Members and existing Standing Committees are aware of the approach to the production of the IPQR and the performance framework in which it resides. The December IPQR will be available for discussion at the round of January 2022 Standing Committee meetings.

2.3.8 Route to the Meeting

The IPQR was drafted by the PPT, ratified by the Associate Director of Planning & Performance and approved for release by the Director of Finance & Strategy.

2.4 Recommendation

The PH&W Committee is requested to:

- **Discussion** – Examine and consider the NHS Fife performance as summarised in the IPQR, with respect to its frequency of presentation and enhancement of its content to suit the goals of the committee

3 List of appendices

None

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Fife Integrated Performance & Quality Report

Produced in December 2021

Introduction

The purpose of the Integrated Performance and Quality Report (IPQR) is to provide assurance on NHS Fife's performance relating to National LDP Standards and local Key Performance Indicators (KPI).

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

The IPQR comprises of the following sections:

I. Executive Summary

a. LDP Standards & Local Key Performance Indicators (KPI)

b. National Benchmarking

c. Indicatory Summary

d. Remobilisation Summary

e. Assessment

II. Performance Assessment Reports

a. Clinical Governance

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

c. Staff Governance

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

I. Executive Summary

At each meeting, the Standing Committees of the NHS Fife Board consider targets and Standards specific to their area of remit. This section of the IPQR provides a summary of performance against LDP Standards and local Key Performance Indicators (KPI). These indicators are listed within the Indicator Summary, which shows current, previous and (where appropriate) 'Year Previous' performance as well as benchmarking against other mainland NHS Boards.

Health Boards are planning the recovery of services following the first and second waves of the COVID-19 Pandemic. NHS Fife 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 6 (21%) classified as **GREEN**, 4 (13%) **AMBER** and 19 (66%) **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 October:

- Falls Rate at lowest level since June
- C Diff HAI/HCAI quarterly rate at lowest level since February
- Stage 1 Complaints quarterly rate at highest level since April

Additionally, it has now been 18 months since the Cancer-31 DTT performance fell below the 95% Standard.

b. National Benchmarking

National Benchmarking is based on whether NHS Fife performance is in the upper quartile of the 11 mainland Health Boards (●), lower quartile (●) or mid-range (●). The current benchmarking status of the 29 indicators within this report has 10 (34%) within upper quartile, 14 (49%) in mid-range and 5 (17%) in lower quartile.

There are indicators where national comparison is not available or not directly comparable.

c. Indicator Summary

Performance

- meets / exceeds the required Standard / on schedule to meet its annual Target
- behind (but within 5% of) the Standard / Delivery Trajectory
- more than 5% behind the Standard / Delivery Trajectory

Benchmarking

- Upper Quartile
- Mid Range
- Lower Quartile

Section	Measure	Target 2021/22	Reporting Period	Year Previous		Previous		Current			Trend	Reporting Period	Fife		Scotland
Clinical Governance	Major & Extreme Adverse Events	N/A	Month	Oct-20	17	Sep-21	26	Oct-21	29	↓		N/A			
	HSMR	N/A	Year Ending	Jun-20	1.00	Mar-21	1.01	Jun-21	1.03	↓		YE Jun-21	1.03	●	1.00
	Inpatient Falls	7.68	Month	Oct-20	7.94	Sep-21	7.93	Oct-21	7.12	↑		N/A			
	Inpatient Falls with Harm	1.65	Month	Oct-20	1.68	Sep-21	1.50	Oct-21	1.80	↓		N/A			
	Pressure Ulcers	0.42	Month	Oct-20	1.00	Sep-21	1.28	Oct-21	0.99	↑		N/A			
	Caesarean Section SSI	2.5%	Quarter Ending	Jun-20	2.2%	Mar-21	2.7%	Jun-21	3.6%	↓		QE Dec-19	2.3%	●	0.9%
	SAB - HAI/HCAI	18.8	Quarter Ending	Oct-20	15.7	Sep-21	16.6	Oct-21	16.2	↑		QE Jun-21	6.3	●	18.7
	SAB - Community	N/A	Quarter Ending	Oct-20	10.6	Sep-21	9.6	Oct-21	11.7	↓		QE Jun-21	8.6	●	10.9
	C Diff - HAI/HCAI	6.5	Quarter Ending	Oct-20	9.2	Sep-21	9.5	Oct-21	7.0	↑		QE Jun-21	10.0	●	14.6
	C Diff - Community	N/A	Quarter Ending	Oct-20	3.2	Sep-21	4.2	Oct-21	2.1	↑		QE Jun-21	4.3	●	5.4
	ECB - HAI/HCAI	33.0	Quarter Ending	Oct-20	39.3	Sep-21	55.6	Oct-21	51.1	↑		QE Jun-21	37.6	●	38.2
	ECB - Community	N/A	Quarter Ending	Oct-20	33.9	Sep-21	40.5	Oct-21	39.5	↑		QE Jun-21	32.2	●	41.9
	Complaints (Stage 1 Closure Rate)	80%	Quarter Ending	Oct-20	80.5%	Sep-21	72.0%	Oct-21	78.4%	↑		2020/21	80.2%	●	79.5%
	Complaints (Stage 2 Closure Rate)	65%	Quarter Ending	Oct-20	37.3%	Sep-21	27.0%	Oct-21	18.0%	↓		2020/21	32.8%	●	57.8%
Operational Performance	IVF Treatment Waiting Times	90%	Month	Oct-20	100.0%	Sep-21	100.0%	Oct-21	100.0%	↔		N/A			
	4-Hour Emergency Access	95%	Month	Oct-20	94.1%	Sep-21	80.1%	Oct-21	76.3%	↓		Oct-21	76.3%	●	73.5%
	Patient TTG (% of Total Waits <= 12 Weeks)	100.0%	Month	Oct-20	54.9%	Sep-21	68.2%	Oct-21	64.9%	↓		Sep-21	69.3%	●	37.5%
	New Outpatients (% of Total Waits <= 12 Weeks)	95%	Month	Oct-20	59.3%	Sep-21	58.3%	Oct-21	56.5%	↓		Sep-21	58.0%	●	48.1%
	Diagnostics (% of Total Waits <= 6 Weeks)	100%	Month	Oct-20	94.3%	Sep-21	75.7%	Oct-21	78.7%	↑		Sep-21	75.8%	●	57.8%
	18 Weeks RTT	90%	Month	Oct-20	65.1%	Sep-21	69.7%	Oct-21	71.1%	↑		QE Sep-21	71.4%	●	75.1%
	Cancer 31-Day DTT	95%	Month	Oct-20	100.0%	Sep-21	98.3%	Oct-21	100.0%	↑		QE Jun-21	99.0%	●	98.1%
	Cancer 62-Day RTT	95%	Month	Oct-20	85.0%	Sep-21	82.9%	Oct-21	83.3%	↑		QE Jun-21	80.3%	●	84.1%
	Detect Cancer Early	29%	Year Ending	Mar-20	24.5%	Dec-20	19.4%	Mar-21	19.6%	↑		2019, 2020	22.5%	●	24.1%
	Freedom of Information Requests	85%	Quarter Ending	Oct-20	85.7%	Sep-21	71.8%	Oct-21	77.8%	↑		N/A			
	Delayed Discharge (% Bed Days Lost)	5%	Month	Oct-20	5.2%	Sep-21	10.9%	Oct-21	10.4%	↑		QE Jun-21	9.2%	●	5.0%
	Delayed Discharge (# Standard Delays)	N/A	Month	Oct-20	35	Sep-21	83	Oct-21	93	↓		Oct-21	30.78	●	26.92
	Antenatal Access	80%	Month	Aug-20	83.3%	Jul-21	87.2%	Aug-21	89.6%	↑		FY 2020/21	89.3%	●	88.5%
	Smoking Cessation	473	YTD	Aug-20	45.7%	Jul-21	59.5%	Aug-21	52.8%	↓		FY 2020/21	53.3%	●	84.9%
	CAMHS Waiting Times	90%	Month	Oct-20	76.5%	Sep-21	82.1%	Oct-21	76.0%	↓		QE Sep-21	83.8%	●	78.6%
	Psychological Therapies Waiting Times	90%	Month	Oct-20	64.7%	Sep-21	84.5%	Oct-21	82.3%	↓		QE Sep-21	86.3%	●	87.2%
	Alcohol Brief Interventions (Priority Settings)	80%	YTD	Mar-19	60.2%	Dec-19	75.7%	Mar-20	79.2%	↑		FY 2019/20	79.2%	●	83.2%
	Drugs & Alcohol Treatment Waiting Times	90%	Month	May-20	86.8%	Apr-21	91.0%	May-21	87.1%	↓		QE Mar-21	94.5%	●	95.6%
	Dementia Post-Diagnostic Support	N/A	Annual	2018/19	93.4%	2019/20	93.2%	2020/21	96.1%	↑		2018/19	93.7%	●	75.1%
	Dementia Referrals	N/A	Annual	2018/19	61.0%	2019/20	58.5%	2020/21	50.5%	↓		2018/19	60.9%	●	43.4%
Finance	Revenue Expenditure	(£13.822m)	Month	Oct-20	N/A	Sep-21	(£8.958m)	Oct-21	(£10.228m)	↓		N/A			
	Capital Expenditure	£32.082m	Month	Oct-20	N/A	Sep-21	£6.812m	Oct-21	£7.821m	↑		N/A			
Staff Governance	Sickness Absence	3.89%	Month	Oct-20	4.93%	Sep-21	6.42%	Oct-21	6.34%	↑		YE Mar-21	4.77%	●	4.67%

d. NHS Fife Remobilisation Summary – Position at end of November 2021

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

		Quarter End	Quarter End	Month End			Quarter End	Quarter End
		Jun-21	Sep-21	Oct-21	Nov-21	Dec-21	Dec-21	Mar-22
TTG Inpatient/Daycase Activity (Definitions as per Waiting Times Datamart)	Projected	2,981	3,120	1,062	1,264	1,074	3,400	3,740
	Actual	3,260	2,953	841	1,124			
	Variance	279	-167	-221	-140			
New OP Activity (F2F, NearMe, Telephone, Virtual) (Definitions as per Waiting Times Datamart)	Projected	17,100	19,125	6,645	7,167	7,093	20,905	21,861
	Actual	19,488	20,161	5,976	7,596			
	Variance	2,388	1,036	-669	429			
Elective Scope Activity (Definitions as per Diagnostic Monthly Management Information)	Projected	1,801	1,833	613	613	614	1,840	1,840
	Actual	1,406	1,509	441	578			
	Variance	-395	-324	-172	-35			
Elective Imaging Activity (Definitions as per Diagnostic Monthly Management Information)	Projected	10,850	11,250	4,655	4,556	4,431	13,642	13,692
	Actual	12,971	12,629	3,973	4,046			
	Variance	2,121	1,379	-682	-510			
A&E Attendance (Definitions as per Scottish Government Unscheduled Care Datamart)	Projected	17,110	19,110	7,030	6,700	6,890	20,620	20,340
	Actual	20,728	21,110	6,431	6,403			
	Variance	3,618	2,000	-599	-297			
A&E 4-Hour Performance (%) : ALL A&E and MIU (Definitions as per Core Sites, unplanned attendances only)	Projected			82.5%	84.0%	84.5%	80.0%	83.0%
	Actual			76.4%	79.7%			
	Variance			-6.1%	-4.3%			
Emergency Admissions (Definitions as per Scottish Government Unscheduled Care Datamart)	Projected	8,040	8,320	3,650	3,540	3,490	10,680	10,120
	Actual	10,085	10,042	3,328	3,359			
	Variance	2,045	1,722	-322	-181			
Total Emergency Admission Mean Length of Stay (Definitions as per Discovery indicator attached)	Projected	5.82	5.85				5.63	5.73
	Actual	5.54	6.16					
	Variance	-0.28	-0.28					
Urgent Suspicion of Cancer - Referrals Received (SG Management Information)	Projected	2,450	2,610	870	870	870	2,610	2,610
	Actual	2,885	3,047	899	1004			
	Variance	**435**	**437**	**29**	**134**			
31 Day Cancer – Decision to treat to first treatment (Definitions as per published statistics)	Projected	415	435	128	128	128	384	384
	Actual	305	337	109				
	Variance	-110	-98	-19				
62 Day Cancer - Referral to First treatment (Definitions as per published statistics)	Projected			65	70	65	200	210
	Actual			78				
	Variance			13				
CAMHS - First Treatment Appointments (patients treated within 52 weeks of referral)(Definitions as per published statistics)	Projected			146	140	119	405	393
	Actual			118	127			
	Variance			-28	-13			
CAMHS - Backlog First Treatment Appointments (patients treated after waiting 52+ weeks, if applicable) (Definitions as per published statistics)	Projected			8	40	20	68	30
	Actual			3	5			
	Variance			-5	-35			
CAMHS - Performance against the 18 week standard (%) (Definitions as per published statistics)	Projected			75.0%	65.0%	68.0%	69.3%	75.0%
	Actual			76.0%	71.2%			
	Variance			1.0%	6.2%			
Psychological Therapies - First Treatment Appointments (patients treated within 52 weeks of referral) (Definitions as per published statistics)	Projected			683	698	560	1,941	2,197
	Actual			525				
	Variance			-158				
Psychological Therapies - Backlog First Treatment Appointments (patients treated after waiting 52+ weeks, if applicable) (Definitions as per published statistics)	Projected			69	95	70	234	210
	Actual			38				
	Variance			-31				
Psychological Therapies - Performance against the 18 week standard (%) (Definitions as per published statistics)	Projected			73.4%	69.6%	77.4%	73.2%	67.9%
	Actual			82.3%				
	Variance			8.9%				

		Month End	Month End	Month End			Month End	Month End
		Jun-21	Sep-21	Oct-21	Nov-21	Dec-21	Dec-21	Mar-22
Delayed Discharges at Month End (Any Reason or Duration, per the Definition for Published Statistics) [1]	Projected	65	63	96	91	84	84	66
	Actual	128	112	121	107			
	Variance	63	49	25	16			
Code 9 Delayed Discharges at Month End (Any Duration, per the Definition for Published Statistics) [1]	Projected	28	27	28	25	23	23	20
	Actual	47	29	28	31			
	Variance	19	2	0	6			
Standard Delayed Discharges at Month End (Any Duration, per the Definition for Published Statistics) [1]	Projected	37	36	68	66	61	61	46
	Actual	81	83	93	76			
	Variance	44	47	25	10			

[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**	**1.03**

The HSMR for NHS Fife for the year ending June rose by 0.2 in comparison to the rate for the year ending March, and remained above the Scotland average and in the worst-performing Mainland Health Board quartile. The rate for VHK alone was also 1.03.

Inpatient Falls (with Harm)	*Reduce falls with harm rate by 10% in FY 2021/22 compared to rate in FY 2020/21*	**1.65**	**1.80**

We continue to maintain a focus on falls prevention work despite workforce and environmental challenges. Changes in ward configurations and patient pathways remain dynamic with supplementary staff supporting care delivery. Support continues to focus on areas where falls with harm have increased noting a slight increase in some areas. The workplan has been reviewed to support a delay in some of the actions, with progress continuing albeit at a slower timescale.

Pressure Ulcers	*50% reduction by December 2020, continued for FY 2021/22*	**0.42**	**0.99**

Acute: In October, Hospital Acquired Pressure Ulcers (HAPU) remained above the median with no special cause flags. There was a slight reduction in grade 2, grade 3 and suspected deep tissue injury and no incidence of multiple. There have been no grade 4 reported since November 2018.

HSCP: The rate of hospital acquired pressure ulcers has increased from the last quarter. Monitoring is undertaken weekly using a patient safety dashboard, reporting on all inpatient wards within the partnership. The dashboard enables timely action, highlighting areas for further improvement activity. In addition, all HAPU graded major or extreme undergo robust review with key learning to inform improvement activity.

Caesarean Section SSI	*We will reduce the % of post-operation surgical site infections to 2.5%*	**2.5%**	**3.6%**

Mandatory SSI surveillance remains paused (as per the start of the Covid-19 pandemic) until further instruction from the Scottish Government. However, Maternity Services continue to monitor their Caesarean Section SSI cases and, where necessary (in the case of deep or organ space SSIs) carry out Clinical Reviews. Note that the performance data provided is non-validated and does not follow the NHS Fife Methodology, and that no national comparison data has been published since Q4 2019.

SAB (MRSA/MSSA)	*We will reduce the rate of HAI/HCAI by 10% between March 2019 and March 2022*	**18.8**	**16.2**

NHS Fife continues to be on target to achieve a 10% infection rate reduction by March 2022. There was one Renal haemodialysis line SAB in October, but there have been no PVC SABs since August.

C Diff	*We will reduce the rate of HAI/HCAI by 10% between March 2019 and March 2022*	**6.5**	**7.0**

At the end of October, NHS Fife is in line to achieve the local improvement trajectory for a 10% reduction of HCAI CDI by March 2022. There was just one health care associated CDI in October. 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 since August.

ECB	*We will reduce the rate of HAI/HCAI by 25% between March 2019 and March 2022*	**33.0**	**51.1**

The target for NHS Fife is to achieve a 25% reduction of HCAI ECBs by March 2022. At the end of October, NHS Fife was above the trajectory to achieve this target. There were 24 ECBs in total for October with 3 of these due to a CAUTI and 1 CAUTI was associated with trauma. Reducing CAUTI incidence remains the quality improvement focus to achieve the reduction target of HCAI ECBs.

Complaints – Stage 2	*At least 65% of Stage 2 complaints are completed within 20 working days (50% by October 2021)*	**65%**	**18.0%**

There continues to be an ongoing challenge to investigate and respond to Stage 2 complaints within the national timescales due to the ongoing response to COVID-19 and current service pressures. There is an increase in the complexity and number of complaints received and numbers received continue to be high. PRD continues to respond to concerns and Stage 1 complaints relating to COVID-19 vaccination appointments as the programme team has started delivering third vaccines.

e. Assessment (cont.) – Operational Performance

		Target	Current
4-Hour Emergency Access	*95% of patients to wait less than 4 hours from arrival to admission, discharge or transfer*	**95%**	**76.3%**

The high attendance trend has continued which has impacted on the 4-hour access target, a theme across mainland health boards. Access pathways through the Flow and Navigation hub is being increased further for managing GP admissions for early redirection where possible. Embedding of the Assessment pathways in AU1 continues, but is challenged by high occupancy and demand for bed capacity. The Emergency Department has successfully remodelled the Resus area, providing increased capacity accommodating both red and amber pathways.

Patient TTG (Waiting)	*All patients should be treated (inpatient or day case setting) within 12 weeks of decision to treat*	**100%**	**64.9%**

Performance in October deteriorated with 64.9% waiting less than 12 weeks compared to stable performance of 68% since June 2021. This was as a result of a reduction in activity in October which was less than projected and less than previous months partly due to elective surgery being restricted to urgent patients only in response to significant pressures in unscheduled care. The waiting list continues to rise with 3,691 patients on list in October, 12% greater than in October 2019 pre-covid. There is a continued focus on clinical priorities whilst reviewing long waiting patients. NHS Fife remains one of the best performing Board in Scotland for TTG. A recovery plan is being implemented and additional resources have been agreed with the Scottish Government to deliver the plan, however, 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%**	**56.5%**

		Target	Current

Performance in October continues to deteriorate with 56.5% waiting less than 12 weeks. Referrals to outpatients and the waiting list remains high and with 21,721 on the outpatient waiting list is 44% higher than in October 2019 pre-covid. Particular attention continues to be focused on urgent and urgent suspicion of cancer referrals along with those who have been waiting more than 52 weeks, with the number waiting over 52 weeks in October reduced by a quarter since March. We had anticipated that the need for social distancing and enhanced infection control procedures would be reduced by October and this was reflected in the projected activity levels. Due to the ongoing need for these measures to be in place, our outpatient capacity and therefore activity continues to be restricted. A recovery plan is being implemented and additional resources have been agreed with the Scottish Government to deliver the plan but the recovery will be slower than anticipated due to the continued capacity restrictions.

Diagnostics	*100% of patients to wait no longer than 6 weeks from referral to key diagnostic test*	**100%**	**78.7%**

Performance continues to be under significant pressure, decreasing to 78.7 % of patients in October waiting less than 6 weeks. There were 52.7 % of patients waiting less than 6 weeks for endoscopy and 82.3% for radiology waiting less than 6 weeks. The waiting list for diagnostics has increased to 5741 in October after a period of being stable at around 4800 and this increase is mainly within radiology where the demand for urgent and inpatient test in particular for CT and Ultrasound remains high. There continues to be significant pressures from unscheduled care activity resulting in increased routine waits for these modalities. Particular attention continues to be focused on urgent and urgent suspicion of cancer referrals along with those routine patients who have been experiencing long waits. Activity continues to be restricted in Endoscopy due to the need for social distancing and enhanced infection control procedures. A recovery plan is being implemented and additional resources have been agreed with the Scottish Government to deliver the plan but the recovery is likely to be slower than anticipated because of the continued restrictions in activity and increases in unscheduled and urgent demand.

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%**	**83.3%**

October 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 routine staging and investigations, while Oncology capacity remains an issue. The majority of breaches continue to be seen in prostate due to the challenging, lengthy pathway. The range of breaches were 1 to 59 days (average 22 days).

FOI Requests	*At least 85% of Freedom of Information Requests are completed within 20 working days*	**85%**	**77.8%**

There were 48 FOI requests closed in October, 9 of which were late, a monthly closure performance of 81.3%. The performance figure above reflects the performance for the 3-month period ending October, and is the highest since June. Provisional figures for November show a continuing improvement towards the target.

Due to staff turnover in the FOI Role, the Information Governance and Security Advisors are overseeing the administration of FOI requests.

Delayed Discharges	*The % of Bed Days 'lost' due to Patients in Delay is to reduce*	**5%**	**10.4%**

The number of bed days lost due to patients in delay continues to rise and has remained above the target 5%. Increased hospital activity over the recent months has resulted in more people requiring social care; this demand has been unable to be met due to social care services experiencing significant workforce pressures. H&SCP have surged 62 downstream beds over the last 4 months to mitigate against the lack of home care, but this has resulted in the increase in the % of bed days lost. H&SC continue to recruit for care at home and are commissioning additional interim beds. As of the 1st December 41% of the official delays are code 100 and code 51X.

Smoking Cessation	*Sustain and embed successful smoking quits at 12 weeks post quit, in the 40% most deprived SIMD areas*	**473**	**104**

Service provision has continued to be delivered remotely by phone, Near Me appointments and use of translation service. New staff are going through a competency framework for quality assurance purposes with the aim of having a competent, confident workforce. This has taken an extended period of time due to the pandemic and remote working restrictions. Main service access is self-referral by phone. We are accepting all referrals due to the pandemic conditions, acknowledging that not all clients contribute to

		Target	Current
	the SIMD target, and are therefore currently unable to assess SIMD status. There is a current downturn in clients numbers.		
CAMHS Waiting Times	*90% of young people to commence treatment for specialist CAMH services within 18 weeks of referral*	**90%**	**76.0%**
	Referral to Treatment (RTT) performance has dropped to 76% which reflects an increased activity against the longest waits due to new recruitment and psychology staff working from the back of the waiting list. As work on the longest waits progresses, RTT% will show a continuing drop until longest waits are reduced to 18 weeks. This is projected to be achieved by Dec 2022. Demand remains high for priority and urgent appointments with the majority of the CAMHS workforce addressing this need. 7 of the 8 new posts to address the demand have been recruited with 6 of these now in situ. Recruitment process is ongoing to address the Phase 1 funding from the Scottish Government Recovery & Renewal fund and a proposal for Phase 2 spend has been submitted to HSCP SLT for approval. The Recovery & Renewal funds will address national priorities such as achieving the CAMHS National service specification, Urgent Response, Intensive Home treatment as well as building internal capacity to provide specialist, evidence-based interventions.		
Psychological Therapies	*90% of patients to commence Psychological Therapy based treatment within 18 weeks of referral*	**90%**	**82.3%**
	The overall waiting list continues on a downward trend, and there has been a further reduction in numbers waiting over 52 weeks. The overall trend in referrals remains upward. The reduction in the RTT target % can be attributed to a larger number of the longest waiting patients starting therapy in September and October compared to the previous two months. This is an anticipated consequence of services addressing the waiting list backlog.		

e. Assessment (cont.) – Finance

		Target	Current
Revenue Expenditure	*Work within the revenue resource limits set by the SG Health & Social Care Directorates*	**(£13.822m)**	**(£10.228m)**

At the end of October the board's reported financial position is an overspend against budget of £13.232m comprising of an adverse variance for Acute Services Division of £13.557m and £3.049m for External Health Care Providers, offset by favourable variances across Corporate Functions. Included in the Acute Services overspend is an adverse variance for Set Aside budgets of £4.0m 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) are reporting an underspend of £3.007m for the 7 months to October.

Capital Expenditure	*Work within the capital resource limits set by the SG Health & Social Care Directorates*	**£32.082m**	**£7.821**

The overall anticipated capital budget for 2021/22 is £32.082m. The capital position for the period to October records spend of £7.821m. Therefore, 24.38% of the anticipated total capital allocation has been spent to month 7.

e. Assessment (cont.) – Staff Governance

		Target	Current
Sickness Absence	*To achieve a sickness absence rate of 4% or less*	**3.89%**	**6.34%**

The sickness absence rate in October was 6.34%, a decrease of 0.08% from the rate in September. The average rate for COVID-19 related special leave, as a percentage of available contracted hours for the financial year to date was 1.28%.

II. Performance Exception Reports

Clinical Governance

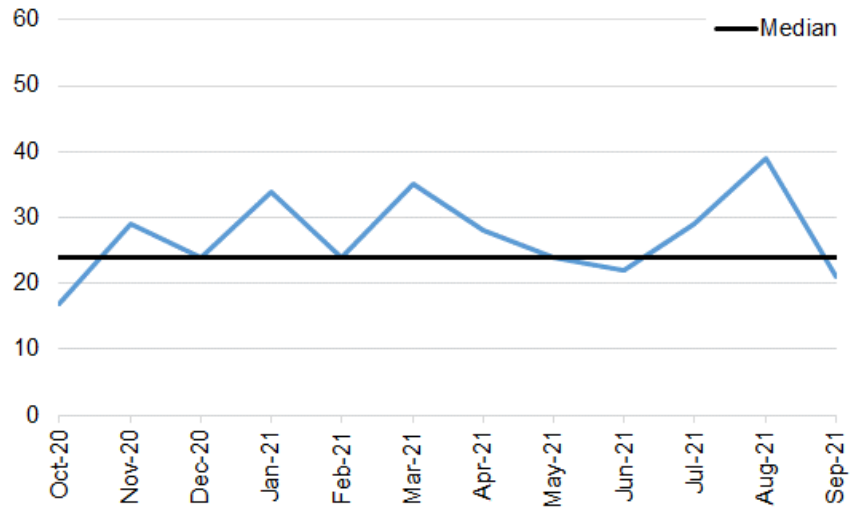
Finance, Performance & Resources: Operational Performance

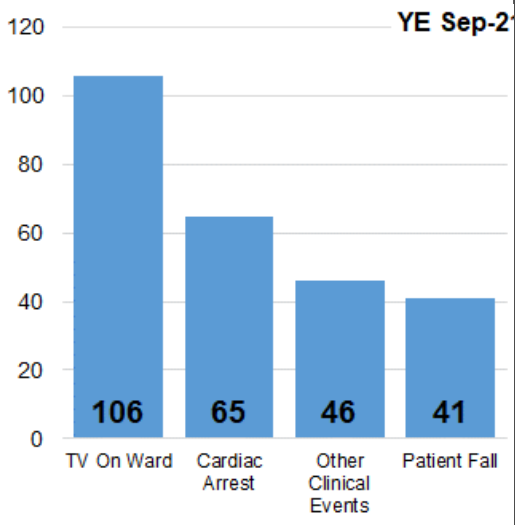
Finance, Performance & Resources: Finance

Staff Governance

Adverse Events

Major and Extreme Adverse Events





All Adverse Events

	Month	2020/21							2021/22				
		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
ALL	NHS Fife	1340	1307	1251	1288	1210	1365	1358	1371	1348	1417	1447	1367
	Acute Services	558	640	603	573	531	630	594	647	605	626	615	592
	HSCP	748	635	621	694	653	708	725	682	694	741	795	735
	Corporate	34	32	27	21	26	27	39	42	49	50	37	40
CLINICAL	NHS Fife	903	955	930	904	855	954	937	1010	934	1007	951	943
	Acute Services	509	596	560	534	495	588	547	598	547	566	548	523
	HSCP	378	341	360	359	346	353	372	388	365	412	383	394
	Corporate	16	18	10	11	14	13	18	24	22	29	20	26

Commentary

There has been a marginal reduction in the overall number of incidents reported in September and October. There was an increase in reporting in the following categories:

- Infrastructure (Accommodation / Availability / Staffing)
- Specimen Management
- Healthcare Associated Infection

There has been a slight reduction in the number of falls in September and October, with October seeing 208 falls reported, this being the lowest number reported in 4 months.

Cardiac arrests in October have increased to 7 Incidents in comparison to 4 in each of the previous 2 months. Collaborative work with the Scottish Patient Safety Programme on 3 Acute Adult work streams is underway in relation to the deteriorating patient.

A new lead for Adverse Events is now in post and is providing dedicated leadership in the drive forward of the review of adverse events policy and process.

The following 3 key short term goals have been identified for completion by the end of January:

1. Communication and engagement of staff, with particular focus on the SAER process
2. Improvements to patient involvement
3. Review of the mapping of the current Adverse Events process to identify and action improvements required within the Adverse Events Team

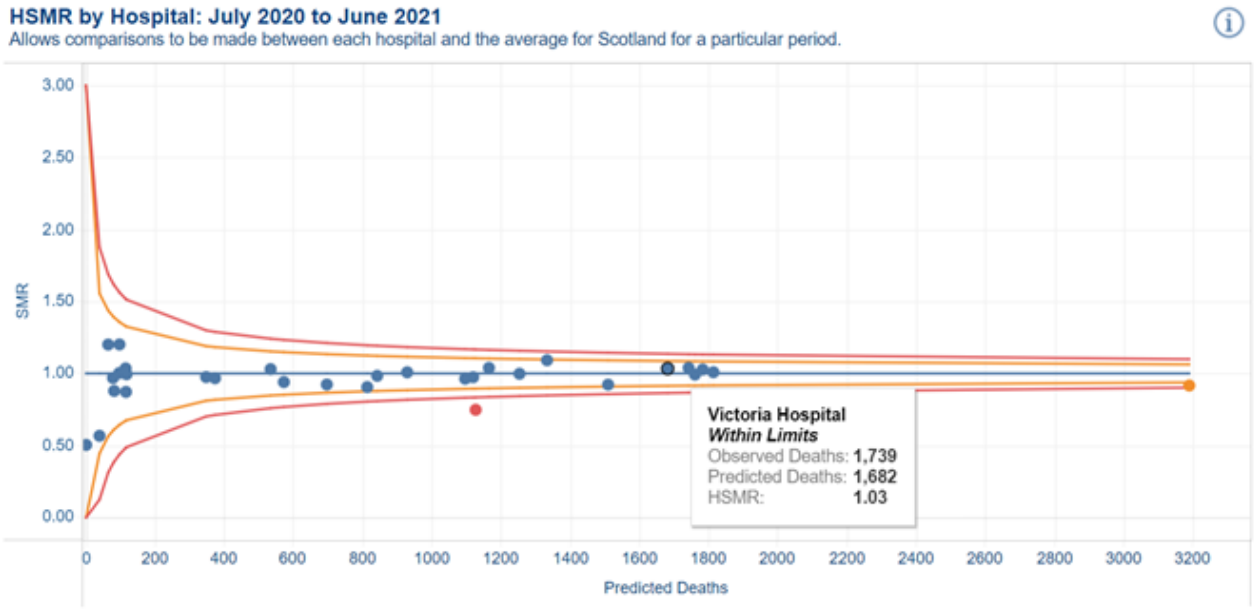
HSMR

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; July 2020 to June 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.



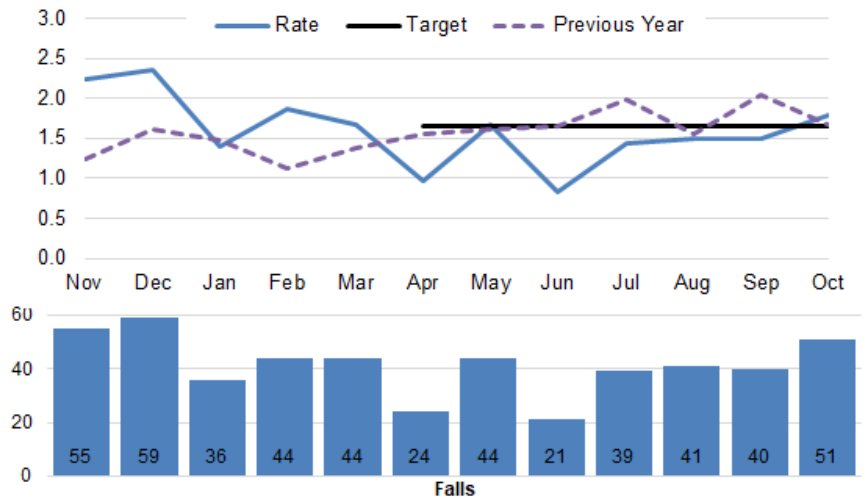
Commentary

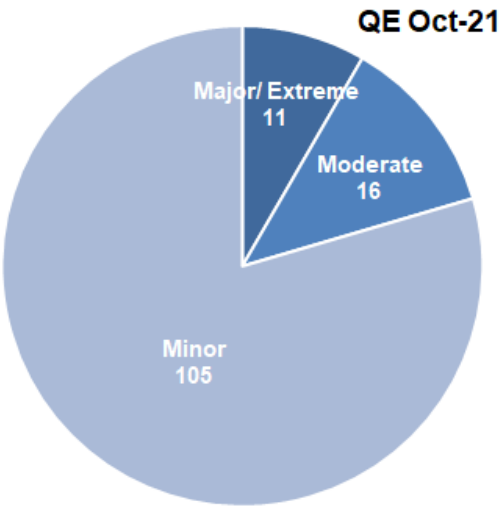
The HSMR for NHS Fife has remained above the 1.00 mean for all periods since the measure was changed two years ago. This should be seen as normal variation, but we will continue to monitor this closely. The difference between actual and predicted number of deaths in the year ending June produced a ratio of 1.03, with VHK itself also being 1.03.

Inpatient Falls with Harm

Reduce Inpatient Falls with Harm rate per 1,000 Occupied Bed Days (OBD)
Target Rate (by end March 2022) = 1.65 per 1,000 OBD

Local Performance





Performance by Service Area

	2020/21					2021/22						
	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
NHS Fife	2.24	2.35	1.39	1.87	1.68	0.98	1.68	0.82	1.45	1.50	1.50	1.80
Acute Services	1.54	1.67	1.24	1.18	0.98	0.35	0.88	0.33	0.79	1.26	0.81	1.67
HSCP	2.88	2.96	1.53	2.47	2.29	1.54	2.40	1.27	2.03	1.72	2.11	1.91
Target						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

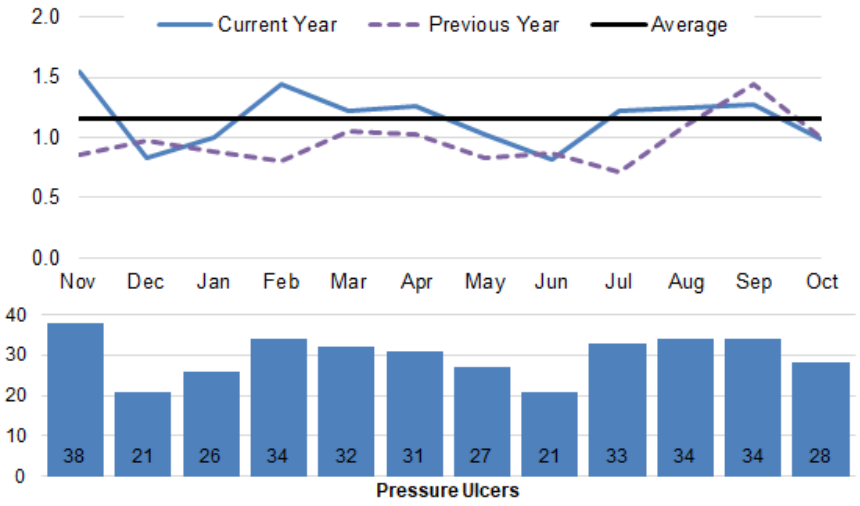
IMPROVEMENT ACTIONS

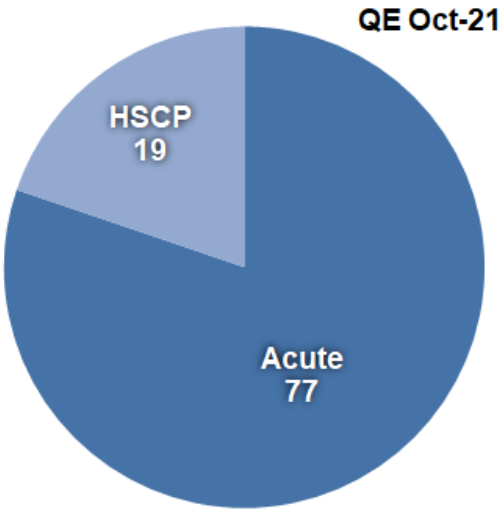
20.3 Falls Audit	***By Feb-22***
A new national driver diagram and measurement package have still to be finalised and as already reported have been tested in four boards across Scotland in May and June. As previously noted, due to current challenges NHS Fife documentation will be reviewed early in 2022, with an audit then to follow.	
20.5 Improve effectiveness of Falls Champion Network	***By Jan-22***
This work has been significantly delayed and opportunities to refresh are further hampered with workforce challenges. This will continue to be an area of focus for the group and meetings with local Heads of Nursing are planned in order to support progress.	
21.2 Falls Reduction Initiative	***Complete Nov-21***
The falls reduction initiative over a 6-month period demonstrated positive improvements and sustained reduction in falls within the 3 Mental Health wards that took part. However due to workforce pressures and Covid 19, there has been a reduction in the Quality Improvement initiatives being tried and tested. This project is now complete, however quality data continues to be collated and this will continue to be monitored.	
21.3 Integrated Improvement Collaborative	***By Jan-22***
The Community Hospital collaborative has been slowed due to workforce pressures and Covid 19. However, process measures and data continue to be collected and a number of small tests of change have been tried out within the wards. Data is collated and available weekly, shared with the Nursing Directorate and Heads of Service by the Clinical Governance Team. This data also presents as triangulated data including falls, tissue viability, and medication errors to inform decisions and strategy.	

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						
		Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
Grade 2 to 4	NHS Fife	1.55	0.83	1.00	1.44	1.22	1.26	1.03	0.82	1.22	1.25	1.28	0.99
	Acute Services	2.39	1.17	2.06	2.18	2.12	2.42	1.68	1.58	2.05	2.36	2.27	1.44
	HSCP	0.78	0.53	0.07	0.80	0.43	0.23	0.44	0.15	0.49	0.27	0.42	0.59

KEY CHALLENGE(S) IN 2021/22

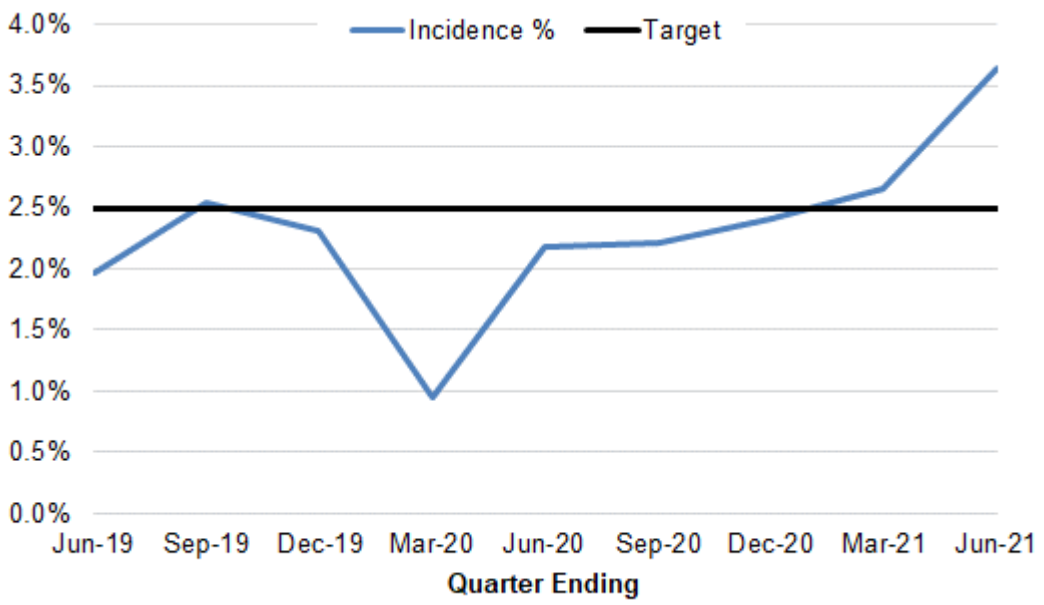
Analysing impact of COVID-19 on clinical pathway for handling Pressure Ulcers, and taking appropriate action to improve performance – this continues to require an agile response

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	**By Jan-22**
Community inpatients wards are undertaking self-assessment against the Prevention and 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. Wards continue to measure compliance with skin assessment, review and intervention, using weekly data to identify areas for improvement.	
22.2 Community Nursing QI Work	**By Mar-22**
One of the community nursing teams has implemented a focused piece of improvement work, complemented by adopting a "back to basics" approach, to ensure that all relevant skin and risk assessments are completed. This is having a positive impact on patient outcomes. We are investigating expanding the speciality list within Datix to allow for more robust data analysis, enabling targeted support, education and improvement opportunities. However, teams have been required to support the delivery of COVID and Flu vaccines in the community, and the target completion date has slipped accordingly. Adverse event reviews are increasing providing wider learning for other services such, and including care homes.	
22.3 ASD Pressure Ulcer Improvement Programme	**By Mar-22**
The commencement of third cohort of the Pressure Ulcer Improvement Programme (PUIP) has been paused due to the current staffing pressures. However QI support has been offered to individual areas on a bespoke basis. Teams involved in cohort 1 and 2 continue to collect process measures data and are encouraged to continue to identify and test change ideas until sustained improvement is achieved.	
22.4 Implementation of Focused Improvement Activities	**By Mar-22**
There are a number of focused improvement activities taking place in a variety of settings. ICU have two projects underway, one aiming to improve the management of moisture related skin damage and a second aiming to improve pressure area care for patients nursed prone. Ward 31 and ED are also carrying out improvement projects.	

Caesarean Section SSI

Sustain C-Section SSI incidence for inpatients and post discharge surveillance (day 10) below 2.5% during FY 2021/22

Local Performance



National Benchmarking

Quarter 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	**By Mar-22**

The SSI Implementation Group de-mobilised in August 2020 as there were no outstanding actions, infection rates had improved and there was a robust system in place for reviewing (LAER/SAER) any Deep or Organ Space SSI cases. The group will re-establish if any future concerns develop.

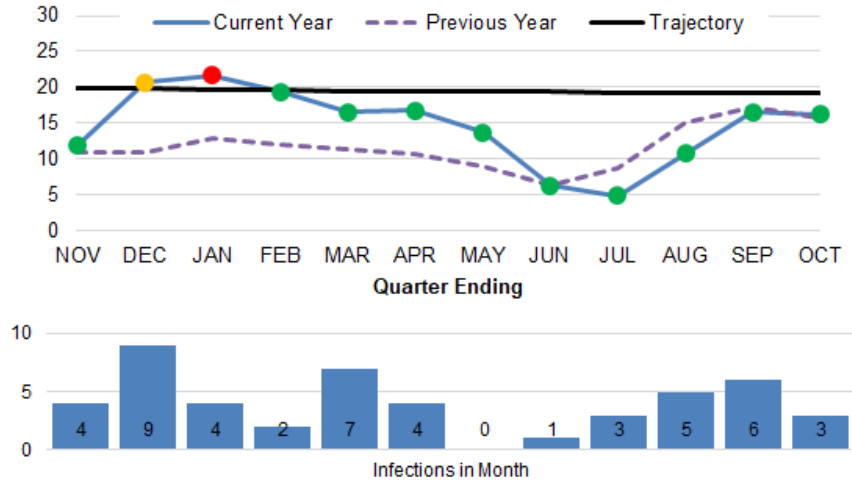
Due to the ongoing Covid-19 pandemic, there is currently no date (set by ARHAI) for resumption of SSI surveillance.

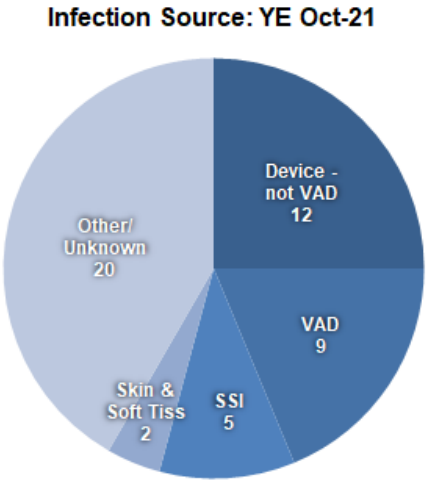
On resumption of the C-section SSI surveillance programme, the IPCT will review the surveillance methodology to capture any practice/patient pathway changes due to the pandemic response and/or any alterations to the case definition. This will ensure that the surveillance methodology remains the most effective means of capturing SSI cases.

SAB (HAI/HCAI)

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

Local Performance





National Benchmarking

Quarter Ending	2019/20		2020/21				2021/22
	Dec	Mar	Jun	Sep	Dec	Mar	Jun
NHS Fife	10.9	12.5	6.3	18.7	20.6	17.8	6.3
Scotland	15.2	16.3	20.3	17.3	18.9	18.4	18.7

KEY CHALLENGE(S) IN 2021/22

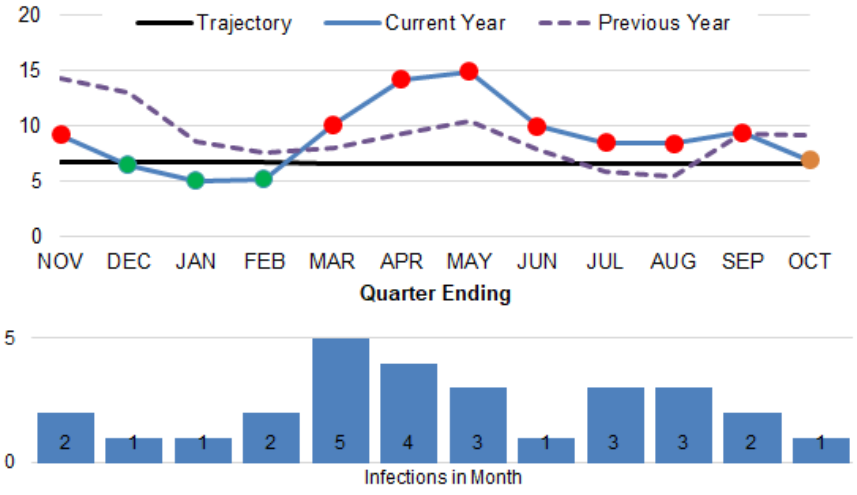
Vascular access devices and medical devices such as urinary catheters are risk factors identified for SAB, and infections in these areas need to be minimised in order to achieve the 10% reduction by March 2022

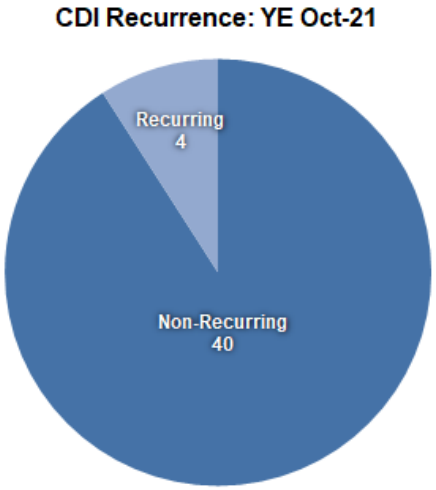
IMPROVEMENT ACTIONS	
20.1 Reduce the number of SAB in PWIDs	***By Mar-22***
The incidence of SABs in PWIDs has continued to reduce, with only 4 cases identified in 2021 to date (compared to 5 in 2020 and 14 in 2019). The PGD for Antibiotic prescribing is now in progress by Addiction Services and IPCT continue to support AS with SAB improvements, albeit a planned November meeting had to be cancelled. A voiced over educational video by IPCT on SAB definitions, signs, symptoms and interventions has been completed for AS staff training.	
20.2 Ongoing surveillance of all VAD-related infections	***By Mar-22***
Monthly charts distributed to clinical teams to inform of incidence of VAD SABs - these demonstrate progress and promote quality improvement as well as raising triggers and areas of concern	
20.3 Ongoing surveillance of all CAUTI	***By Mar-22***
Bi-monthly meetings (last one in November) 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 Driver Diagram for the UCIG is currently being reviewed and updated.	
20.4 Optimise comms with all clinical teams in ASD & the HSCP	***By Mar-22***
Monthly SAB reports distributed with Microbiology comments, to gain better understanding of disease process and those most at risk. This allows local resources to be focused on high-risk groups/areas and improve patient outcomes. The Ward Dashboard utilised by clinical staff to access and display 'days since last SAB' in each ward for public assurance is currently inaccessible, so wards are currently being updated by the IPC surveillance team.	
22.1 Use Electronic insertion and maintenance bundles for PVC, CVC, urinary catheters	***By Mar-22***
Electronic insertion and maintenance bundles for PVCs are completed on Patientrack to support best practice. Compliance is reported weekly to ward Senior Charge Nurses if the ward failed to achieve 90% of all PVC being removed prior to the 72hr breach. There are Quality Improvement (QI) projects to support areas which are not achieving best practice. Similar electronic insertion and maintenance bundles are planned for in-dwelling urinary catheters and CVCs to promote and support best practice, reduce avoidable harm and improve quality of care.	

C Diff (HAI/HCAI)

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

Local Performance





National Benchmarking

Quarter Ending	2019/20		2020/21				2021/22
	Dec	Mar	Jun	Sep	Dec	Mar	Jun
NHS Fife	13.1	8.0	7.9	9.3	7.7	14.0	10.0
Scotland	15.1	13.6	15.4	17.4	16.4	15.8	14.6

KEY CHALLENGE(S) IN 2021/22

Sustain and further reduce healthcare-associated CDI and recurrent CDI in order to achieve the 10% reduction target by March 2022

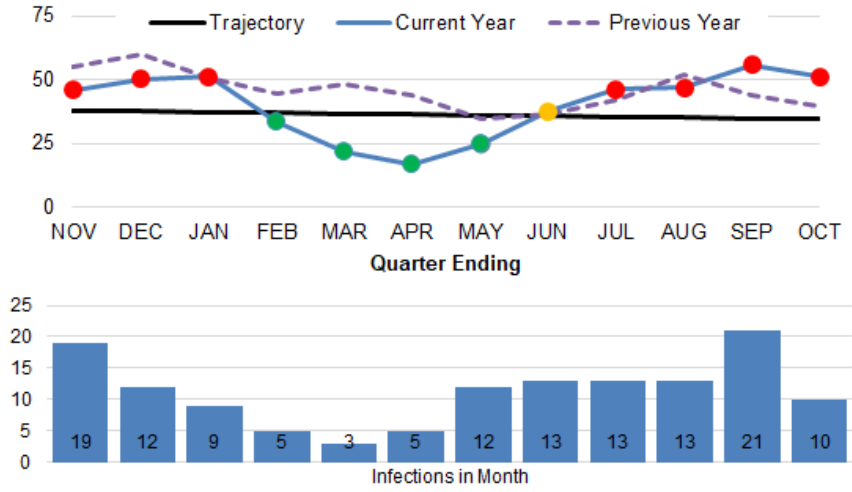
IMPROVEMENT ACTIONS

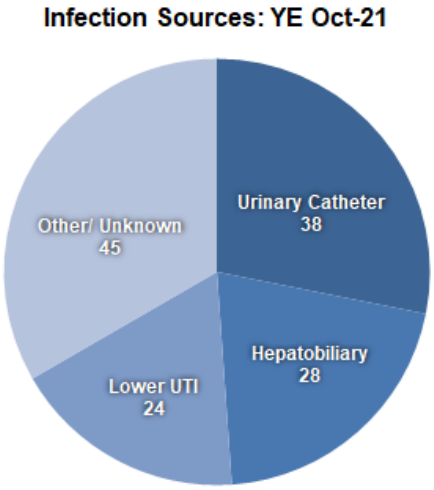
20.1 Reducing recurrence of CDI	***By Mar-22***
Each CDI occurrence is reviewed by a consultant microbiologist. The patient's clinician is then advised regarding patient treatment and management to optimize recovery and prevent recurrence of infection. To reduce recurrence of CDI Infection for patients at high risk of recurrent infection, two treatments are utilised in Fife, Fidaxomicin and Bezlotoxumab. The latter is can be prescribed whilst faecal microbiota transplantation is unavailable during the COVID-19 pandemic.	
20.2 Reduce overall prescribing of antibiotics	***By Mar-22***
NHS Fife utilises National antimicrobial prescribing targets by NHS Fife microbiologists, working continuously alongside Pharmacists and GPs to improve antibiotic usage. Empirical antibiotic guidance and the revised Microguide app has been circulated to all GP practices.	
20.3 Optimise communications with all clinical teams in ASD & the HSCP	***By Mar-22***
Monthly CDI reports are distributed, to enable staff to gain a clearer understanding of the disease process, recurrences and rates. IPCN ward visits reinforce SICPs and transmission-based precautions, provide education to staff to promote optimum CDI management and daily Medical Management form completion. The Ward Dashboard utilised by clinical staff to access and display 'days since last CDI' in each ward for public assurance is currently inaccessible, so wards are currently being updated by the IPC surveillance team.	

ECB (HAI/HCAI)

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

Local Performance





National Benchmarking

Quarter Ending	2019/20		2020/21				2021/22
	Dec	Mar	Jun	Sep	Dec	Mar	Jun
NHS Fife	60.0	47.9	36.4	45.3	50.3	21.6	37.6
Scotland	40.8	36.4	39.7	42.0	40.9	34.7	38.2

KEY CHALLENGE(S) IN 2021/22

Lower Urinary tract Infections (UTIs) and Catheter associated UTIs (CAUTI) remain the prevalent source of ECBs and are therefore the areas to address to reduce the healthcare-associated inflection ECB rate

IMPROVEMENT ACTIONS

20.1 Optimise communications with all clinical teams in ASD & the HSCP	***By Mar-22***

Monthly reports and charts are distributed to key clinical staff across the HSCP and ASD. Each CAUTI associated ECB undergoes IPC surveillance to establish a history. All CAUTI ECBs associated with traumatic insertion, removal or self removal are submitted for DATIX to assist understanding and learning. From December, as part of the strategy to reduce E.coli Bacteraemia (ECB), a DATIX will be submitted for ALL catheter associated ECBs (including those without trauma) to result in a LAERs by the patients clinical team. NHS Fife are collaborating with NHS Shetland & Grampian to pioneer an enhanced ECB CAUTI surveillance tool, and next meet in December.

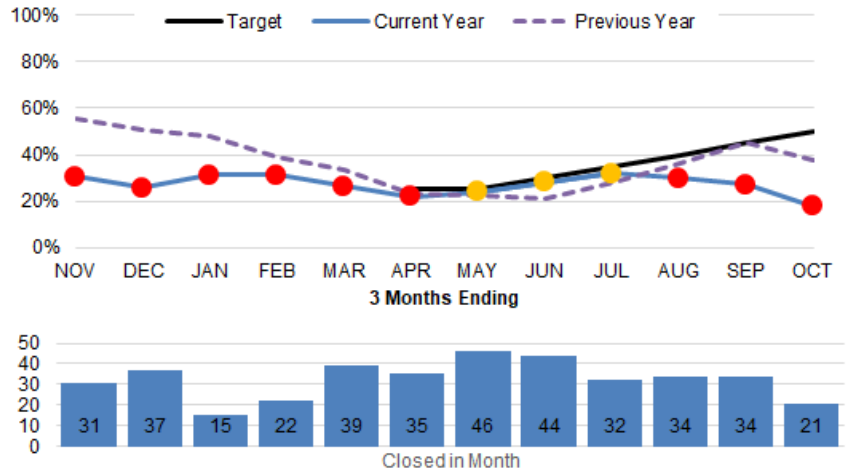
20.3 Ongoing work of Urinary Catheter Improvement Group (UCIG)	***By Mar-22***

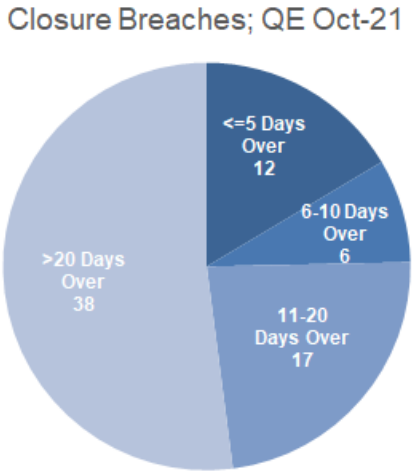
The UCIG meeting last met in November. Initiatives to promote hydration and provide optimum urinary catheter care (including continence care) across Fife continue. They cover analysis and update of process, training/education/promotion and quality improvement work. Work involves the district nursing service and staff in both private and NHS care homes as well as a QI CAUTI programme at Kelty GP Practice.

Complaints | Stage 2

At least 65% of Stage 2 complaints are completed within 20 working days (50% by October 2021)

Local Performance





Performance by Service Area

3-Month Ending	2020/21					2021/22						
	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
NHS Fife	30.5%	25.8%	31.3%	31.1%	26.3%	21.9%	24.2%	28.0%	32.0%	30.0%	27.0%	18.0%
Ack <= 3 Days (Monthly)	100.0%	100.0%	93.3%	95.5%	94.9%	100.0%	93.5%	100.0%	96.9%	100.0%	100.0%	100.0%
ASD	34.0%	30.5%	36.5%	35.3%	19.3%	15.9%	15.7%	22.5%	23.5%	25.7%	27.3%	20.7%
HSCP	15.4%	13.9%	20.0%	18.2%	50.0%	38.1%	48.3%	31.4%	38.7%	23.3%	20.8%	13.0%

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 Mar-22**

Patient Relations are completing in-house QA checks on draft final responses, impacted due to current pressures within the department.
A review of the current complaint handling process by Clinical Governance and Patient Relations has started, but is on hold due to the ongoing response to COVID-19 and current capacity issues.

22.2 Improve education of complaint handling	**By Mar-22**

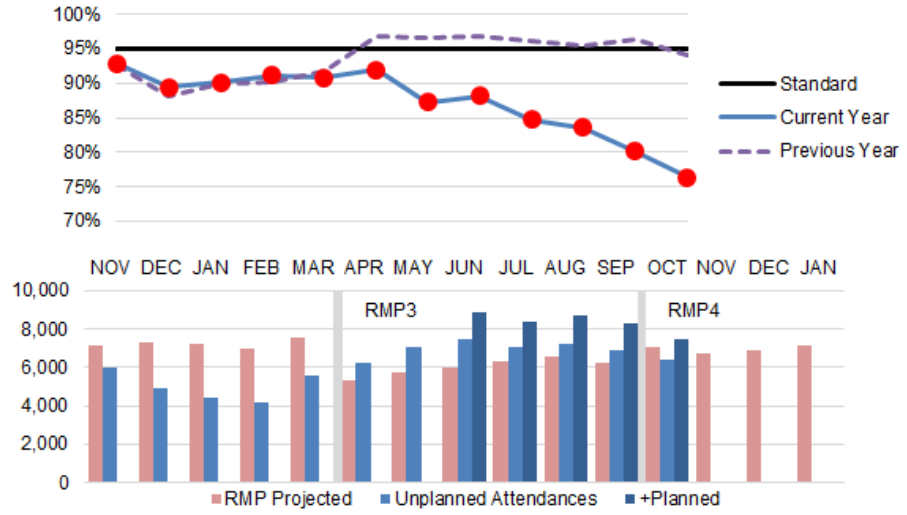
This action aims to improve overall quality by delivering education programmes at induction and bespoke training sessions across the Clinical Services. While some training sessions have been delivered virtually, this is on hold due to the ongoing response to COVID-19 and current capacity issues.

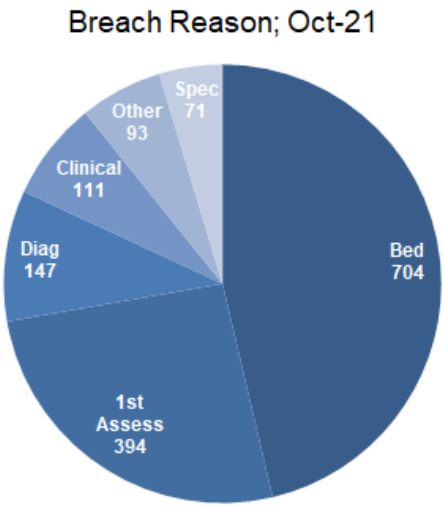
Bespoke training sessions with Fife Wide & Fife East took place in May and June, and the aim was that these would restart during the remainder of 2021, however, there has not been the capacity to do so.

4-Hour Emergency Access

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

Local Performance





National Benchmarking

Month	2020/21					2021/22						
	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT
NHS Fife	92.9%	89.4%	90.1%	91.1%	90.8%	91.9%	87.2%	88.2%	84.7%	83.6%	80.1%	76.3%
Scotland	89.8%	86.4%	86.0%	86.2%	88.5%	88.7%	87.2%	85.0%	81.5%	77.8%	76.1%	73.5%

KEY CHALLENGE(S) IN 2021/22

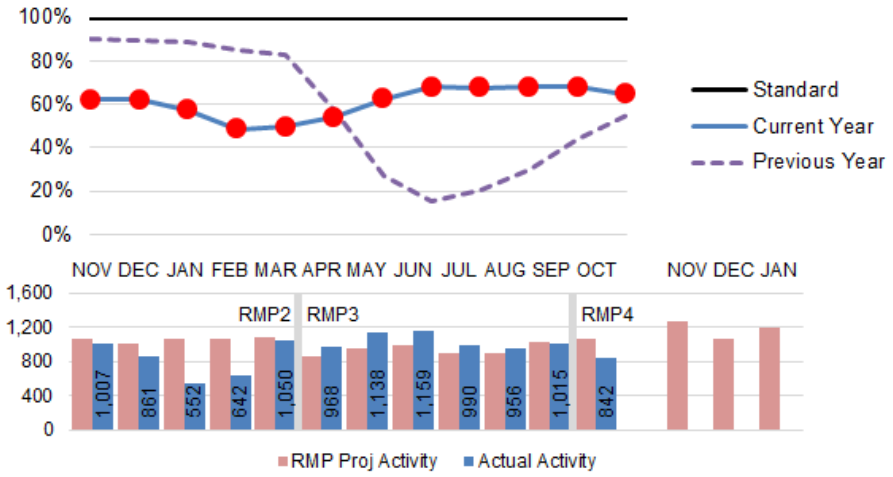
- Achievement of 4-hour access Standard
- Delivery of an integrated Flow and Navigation HUB
- Increased patient demand for urgent care

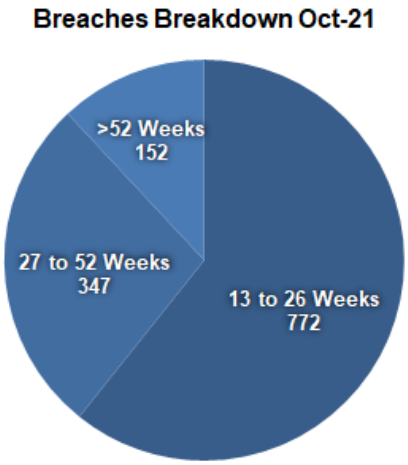
IMPROVEMENT ACTIONS	
21.2 Integration of the Redesign of Urgent Care model and the Flow & Navigation Hub	**By Mar-22**
Virtual Flow and Navigation appointments to ED are now in place and the Hub has expanded to handle GP calls previously taken by ANPs into AU1. Early indication shows decreased number of referrals with a re-direction rate of 26%. Expansion for 24/7 handling is in planning.	
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	**By Dec-21**
Bed waits continue to be the principal reason for breaches. There has been an increase in 8-hour breaches due to capacity challenges across the site. All directorates are focussed on improvement actions which can improve flow into downstream wards and effectively manage admission demand from front door. Principle actions are focussed on: reducing duplication with handovers, in reach model from wards to AU1 achieving earlier transfers, reducing number of patients in delay, earlier discharge planning and improving team(s)communication.	
22.3 Develop re-direction policy for ED	**By Dec-21**
SLWG and joint HSCP/ASD reference group established to embed principles from National Re-direction Guidance into ED pathways and re-direct patients who can be supported in alternative clinical settings or through self care	

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						
	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT
NHS Fife	62.3%	62.3%	57.4%	48.6%	49.7%	54.1%	62.7%	67.9%	67.6%	68.2%	68.2%	64.9
Scotland	37.4%	37.0%	35.9%	33.5%	34.7%	35.5%	37.2%	38.6%	36.7%	36.5%	34.0%	

KEY CHALLENGE(S) IN 2021/22

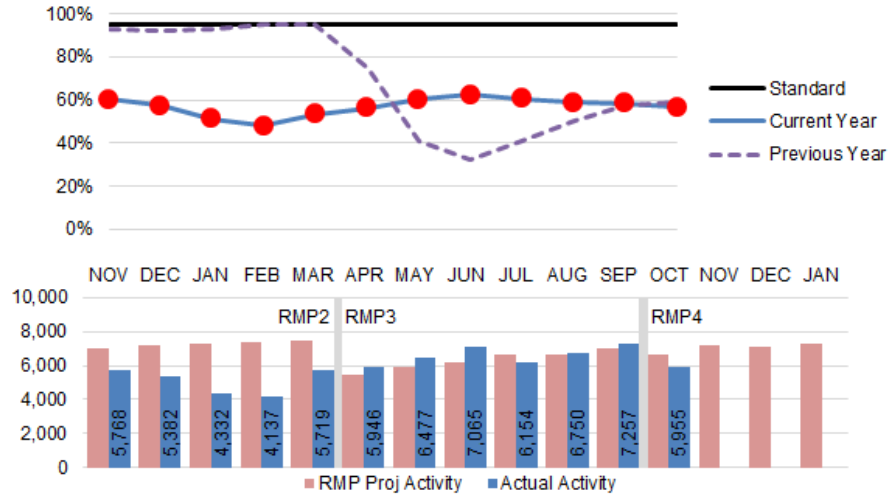
- Reduced Theatre Capacity due to current infection control and social distancing measures
- Clinical Prioritisation leading to long waits for lower priority patients
- Increased demand as a result of backlog in outpatients and change in case mix
- Increased unscheduled workload
- Staff vacancies, absence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

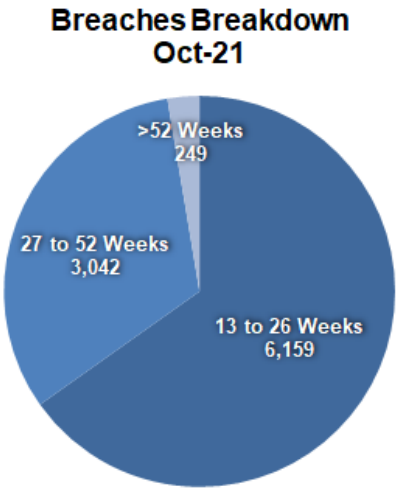
IMPROVEMENT ACTIONS	
22.1 Monitor and review DCAQ against waiting times improvement plan, secure additional funding from SG and amend plan prior to formal review in September	**Complete Sep-21**
22.2 Redesign Pre-assessment to increase capacity and flexibility around theatre scheduling	**By Mar-22**
Business case near completion for submission mid December	
22.3 Undertake waiting list validation against agreed criteria	**By Mar-22**
Clinical teams continue to review lists and prioritise patients, Clinical Prioritisation Group meets regularly. This work will continue as clinical prioritisation remains 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	**By Mar-22**
First meeting of Integrated Planned Care Programme Board planned for 8th December	

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						
	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT
NHS Fife	60.3%	57.5%	51.2%	48.0%	53.4%	56.4%	60.3%	62.4%	60.7%	58.6%	58.3%	56.5%
Scotland		47.8%	44.5%	43.9%	48.3%	50.5%	52.3%	53.4%	51.6%	49.7%	48.1%	

KEY CHALLENGE(S) IN 2021/22

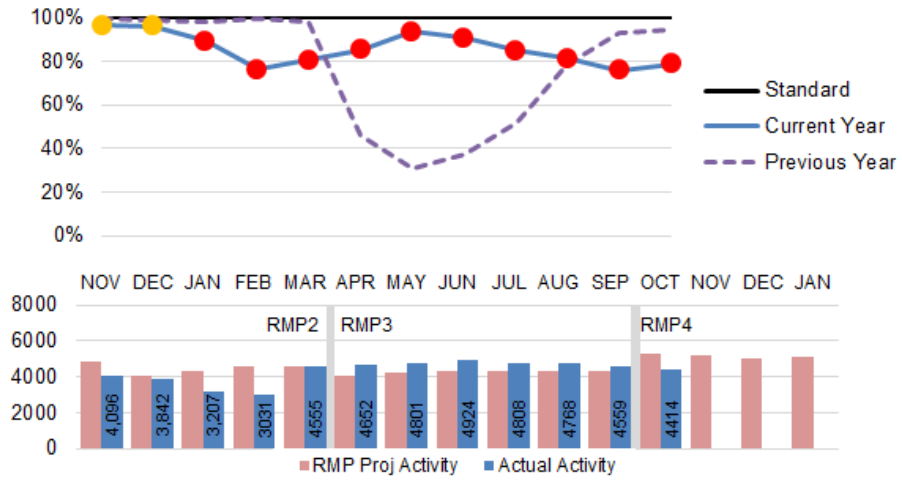
- Reduced Clinic capacity due to current infection control and social distancing measures
- Clinical Prioritisation leading to long waits for lower priority patients
- Increased demand as a result of unmet need and change in case mix of referrals
- Increased unscheduled workload
- Staff vacancies, absence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

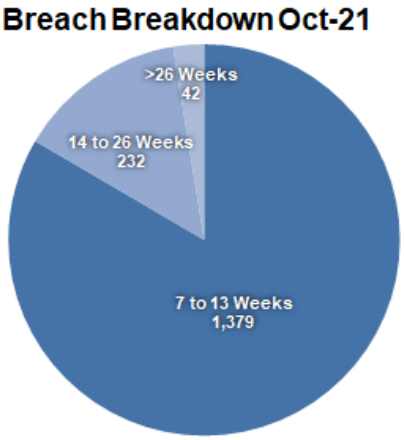
IMPROVEMENT ACTIONS	
22.1 Monitor and review DCAQ against waiting times improvement plan, secure additional funding from SG and amend plan prior to formal review in September	**Complete Sep-21**
22.2 Deliver appropriate elements of Modernising outpatients and unscheduled care redesign to reduce and manage demand and sustain capacity	**By Mar-22**
First meeting of Integrated Planned Care Programme Board planned for 8th December	
22.3 Actively promote and support staff wellbeing initiatives within the acute division	**By Mar-22**
Directorates promoting and supporting initiatives	
22.4 Understand impact of potential changes to guidance on social distancing and actions needed to implement	**By Dec-21**
Revised guidance issued and following advice from Infection Control local team unable to reduce social distancing to 1m in outpatients in VHK or QMH apart from Paediatrics at VHK. Further information on risk assessment from neighbouring board sought.	

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						
	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT
NHS Fife	96.5%	95.9%	89.2%	76.2%	80.6%	85.3%	93.5%	90.6%	84.9%	81.2%	75.7%	78.7%
Scotland	57.2%	55.9%	52.0%	57.8%	61.4%	61.8%	64.1%	62.6%	57.2%	56.5%	57.8%	

KEY CHALLENGE(S) IN 2021/22

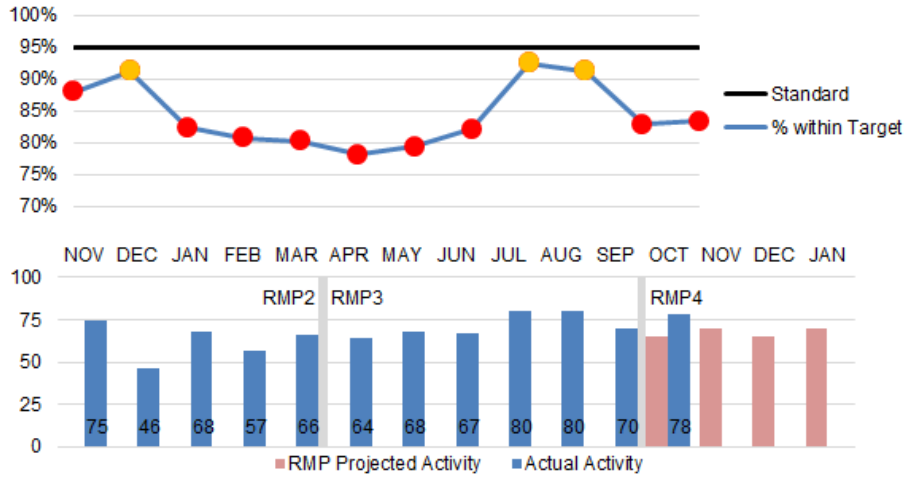
- Reduced diagnostic capacity due to current infection control and social distancing measures
- Clinical Prioritisation leading to long waits for lower priority patients
- Increased demand as a result of unmet need, backlog in outpatients and change in case mix of referrals
- Staff vacancies, absence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

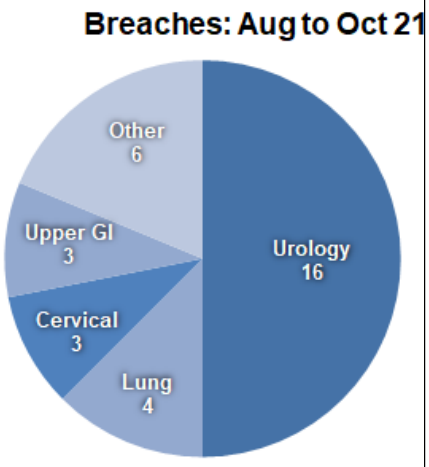
IMPROVEMENT ACTIONS	
22.1 Monitor and review DCAQ against waiting times improvement plan, secure additional funding from SG and amend plan prior to formal review in September	**Complete Sep-21**
22.2 Explore implementation of point of care testing in endoscopy	**By Mar-22**
Testing platform chosen, governance processes to support implementation underway	
22.3 Actively promote and support staff wellbeing initiatives within the acute division	**By Mar-22**
Directorates promoting and supporting initiatives	
22.4 Actively seek alternative sources of additional CT capacity to manage increasing waiting times for routine patients	**By Mar-22**
Alternative sources being explored, along with engagement with National Radiology Access Team for additional funding	

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						
	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT
NHS Fife	88.0%	91.3%	82.4%	80.7%	80.3%	78.1%	79.4%	82.1%	92.5%	91.3%	82.9%	83.3%
Scotland	84.8%	85.3%	81.6%	81.9%	83.0%	84.5%	83.0%	83.6%	82.8%	83.5%	83.1%	78.8%

KEY CHALLENGE(S) IN 2021/22

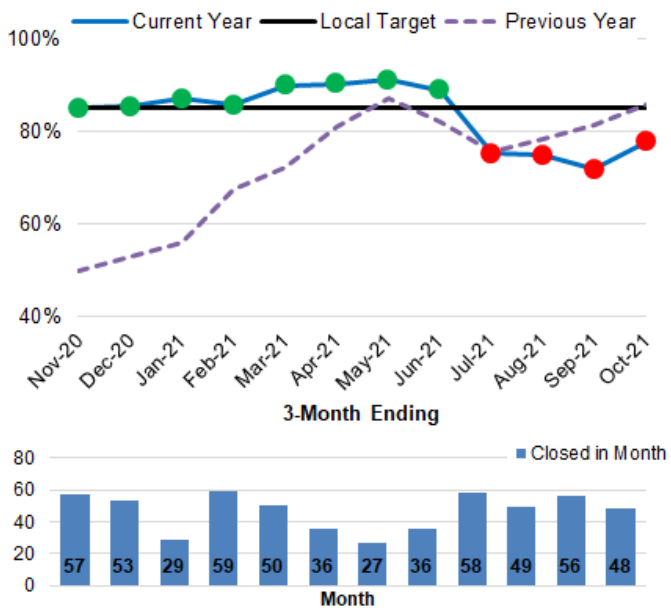
- Prostate cancer pathway (remains the most challenged pathway in NHS Fife)
- Increased number of referrals into the breast service, converting to cancers
- Catch up with the paused screening services (which will increase the number of patients requiring to be seen)
- Introduction of the robot may impact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

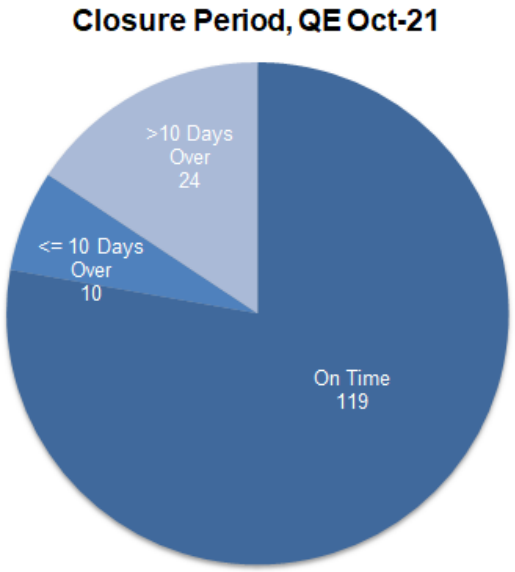
IMPROVEMENT ACTIONS	
20.3 Robust review of timed cancer pathways to ensure up to date and with clear escalation points	**By Mar-22**
This will be addressed as part of the overall recovery work and in line with priorities set within the Cancer Recovery Plan and by the leadership team. Priority will be given to the most challenging pathways.	
20.4 Prostate Improvement Group to continue to review prostate pathway	**By Mar-22**
This is ongoing work related to Action 20.3, with the specific aim being to improve the delays within the whole pathway. A national review of the prostate pathway will be undertaken as part of the Recovery Plan.	
21.2 Cancer Strategy Group to take forward the National Cancer Recovery Plan	**By Mar-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 in currently being drafted.	
22.1 Effective Cancer Management Review	**By Mar-22**
The Scottish Government Effective Cancer Management Framework review to improve cancer waiting times performance is underway. The recommendations from the review will be addressed as part of the improvement process. The Scottish Government will be visiting NHS Fife to introduce the reviewed Framework.	

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						
	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
Health Board	87.5%	93.5%	92.3%	83.6%	93.5%	93.5%	79.2%	88.6%	58.0%	83.3%	74.5%	78.0%
IJB	88.9%	14.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	42.9%	77.8%	100.0%

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	**By Dec-21**

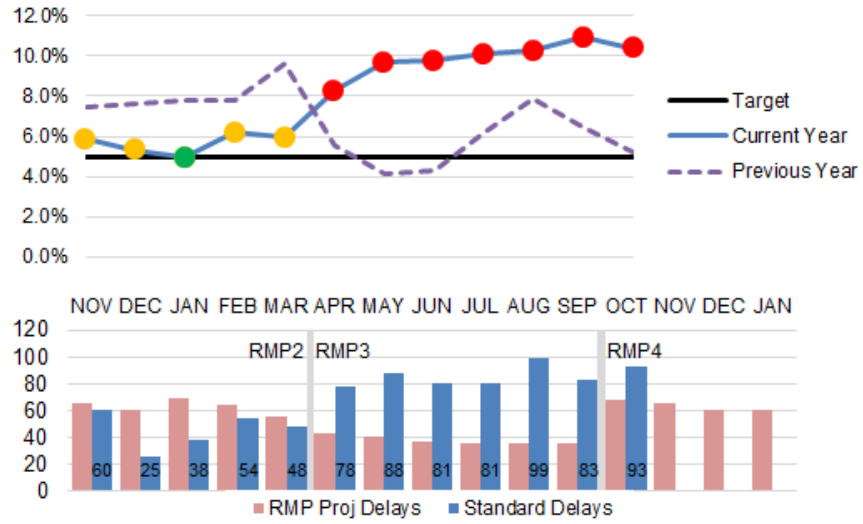
The first EDG Paper (1.0 - Process) passed through EDG in February. The Scottish Information Commissioner's Office has commended the work NHS Fife has undertaken so far to remedy the Board's previous low level of FOISA compliance.

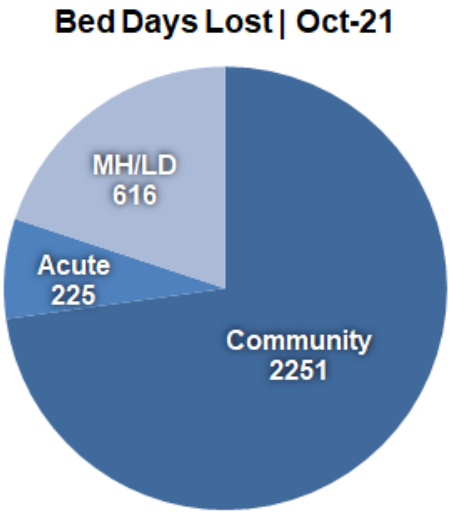
This action will be left open for the rest of 2021, while resourcing issues remain to be resolved.

Delayed Discharges (Bed Days Lost)

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

Local Performance





National Benchmarking

Quarter Ending	2019/20				2020/21				2021/22
	Jun	Sep	Dec	Mar	Jun	Sep	Dec	Mar	Jun
NHS Fife	7.6%	8.0%	7.2%	8.3%	4.6%	6.8%	5.4%	5.7%	9.2%
Scotland	6.8%	7.2%	7.1%	7.3%	3.8%	5.1%	4.8%	4.6%	5.0%

KEY CHALLENGE(S) IN 2021/22

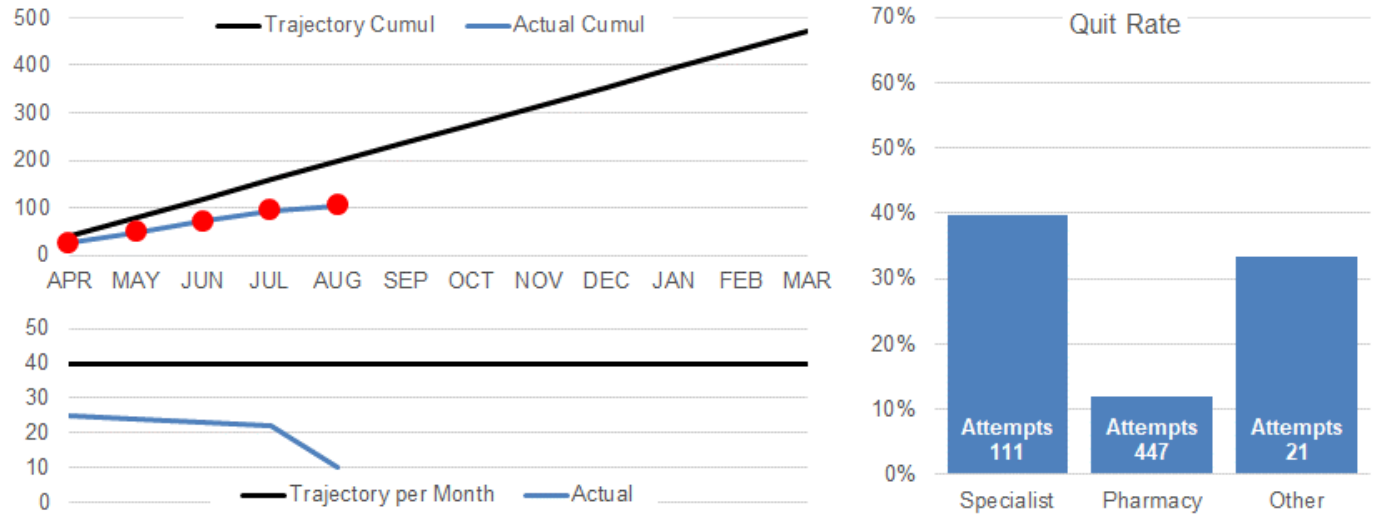
- Capacity in the community – demand for complex packages of care has increased significantly
- Information sharing – H&SC workforce having access to a shared IT, for example Trak, Clinical Portal
- Workforce – Ensuring adequate and safe staffing levels to cover the additional demand to facilitate discharge 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 Mar-22**
The Oversight "Home First" group meeting with H&SC, NHS Fife, Fife Council and Scottish Care took place in April. Seven subgroups are taking forward the operational actions to bring together the "Home First" strategy for Fife. Regular monthly meetings take place, action plans/driver diagrams are now in place for the oversight and subgroups.	
22.1 Fully implement the "Moving On" Policy in Acute and Community Hospitals	**Complete Jul-21**
22.2 Test of Change – Trusted Assessor Model (or similar) to support more timely discharges to STAR/Assessment placements in the community	**By Mar-22**
An SBAR was submitted to the Senior leadership Team and the test of change started on 4th October, running for 6 months	

Smoking Cessation

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

Local Performance



National Benchmarking

		2021/22											
		APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
NHS Fife	Actual	25	24	23	22	10							
	Actual Cumul	25	49	72	94	104							
	Trajectory Cumul	40	79	118	158	197	236	276	315	354	394	434	47
	Achieved	62.5%	62.0%	61.0%	59.5%	52.8%							
Scotland	Achieved												

KEY CHALLENGE(S) IN 2021/22

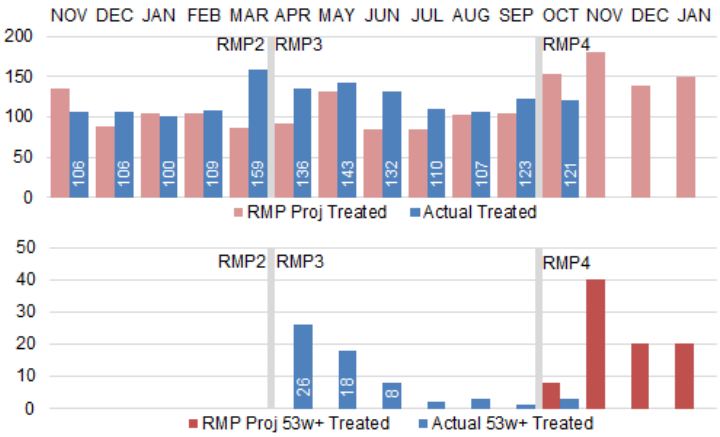
- Remobilising face to face delivery in a variety of settings due to venue availability and capacity
- Moving from remote delivery to face to face provision, patients having confidence in returning to a medical setting
- Potential for slower recovery for services as they may require to rebuild trust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

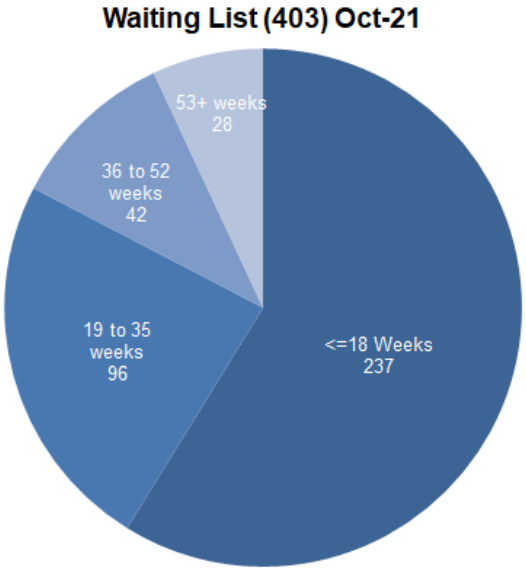
IMPROVEMENT ACTIONS	
20.2 Test Champix prescribing at point of contact within hospital respiratory clinic	**Complete Oct-21**
20.3 'Better Beginnings' class for pregnant women	**Complete Oct-21**
20.4 Enable staff access to medication whilst at work	**By TBD**
Action paused due to COVID-19	
21.1 Assess use of Near Me to train staff	**Complete Jul-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	**By Mar-22**
Assess and engage with two GP practices and one community venue to re-establish face to face provision in the most deprived communities. Risk assessments, PPE, equipment and patient flow to be considered and included in plans. Early discussions with 2 GP practices to restart in second week of January; remobilisation plan to go to remobilisation committee on 9th December.	

CAMHS 18 weeks RTT

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

Local Performance





National Benchmarking

Month	2020/21					2020/21						
	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT
NHS Fife	85.8%	85.8%	83.0%	88.1%	73.0%	68.4%	73.4%	79.5%	80.9%	88.8%	82.1%	76.0%
Scotland	72.9%	72.9%	67.5%	63.8%	67.5%	71.3%	71.8%	74.8%	75.9%	77.4%	82.1%	

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

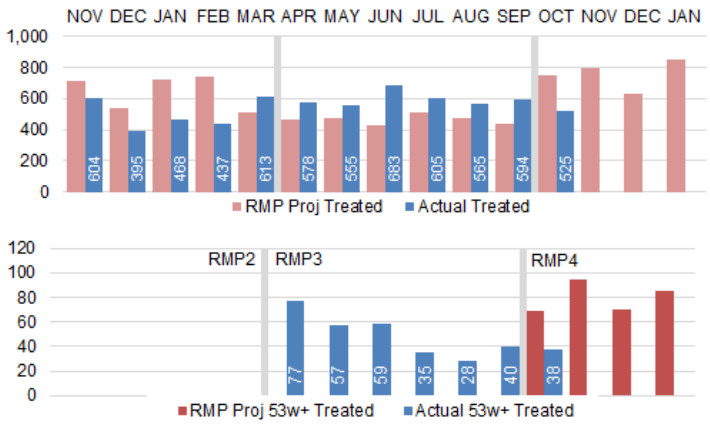
IMPROVEMENT ACTIONS

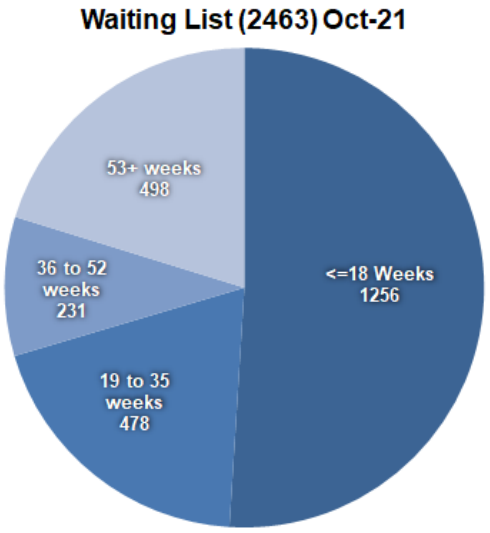
21.1 Re-design of Group Therapy Programme	**Complete Jul-21**
21.3 Build CAMHS Urgent Response Team (CURT)	**By Mar-22**
The CURT model is in place - full implementation will be delivered on the successful recruitment of an additional Senior Nurse and support worker. Responsiveness to A&E and Paediatric inpatient unit has been extended with same day assessments available if young people are considered fit for assessment. Activity has been significantly higher than anticipated with 60% increase in presentations to Emergency department due to self harm/suicidal ideation. This has resulted in all of the available capacity being required to respond to this urgent need with limited capacity available to extend the short term intervention model that was initially proposed. Review of activity and effectiveness of the model is ongoing with a full review of the original proposed model once staffing is at optimum level.	
22.1 Recruitment of Additional Workforce	**By Mar-22**
Recruitment is ongoing. To address immediate capacity issues, 7 of the 8 allocated posts have been appointed with 6 of these staff now in position and 2 temporary staff due to take up post in February to work on longest waits. Vacant posts continue to be advertised and review of banding is underway. All staff recruited have no CAMHS experience therefore induction/training period will be extended before active clinical caseloads can be allocated. SG funds have been allocated in order to achieve the CAMHS National Service specification. Phase 1 recruitment is underway and proposal for Phase 2 recruitment is with HSCP SLT for approval. Additional workspace and re-design of East and West CAMHS geographical boundaries has started.	
22.2 Workforce Development	**By Mar-22**
A revised development and training programme will start in. Three Programmes have been developed, to suit different levels of CAMHS experience. A Training needs analysis will be completed once all recruitment is 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						
	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT
NHS Fife	76.3%	80.8%	77.1%	84.0%	84.3%	78.2%	80.0%	82.6%	86.9%	87.4%	84.5%	82.3%
Scotland	78.1%	83.2%	79.3%	80.9%	80.9%	81.3%	82.5%	84.3%	88.5%	87.0%	86.1%	

KEY CHALLENGE(S) IN 2021/22

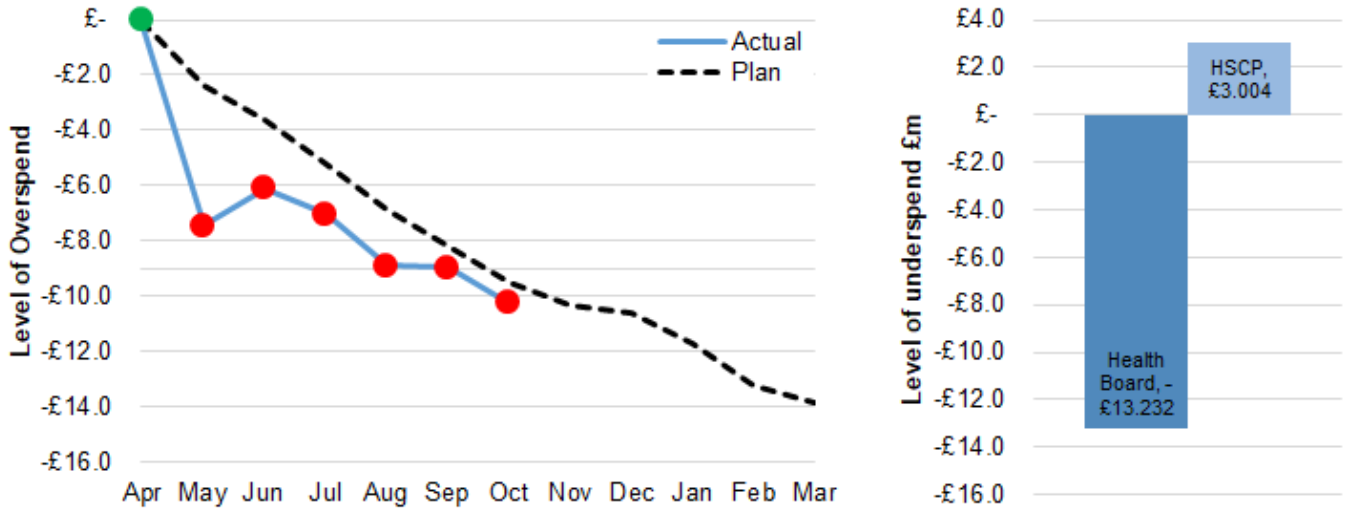
- Meeting waiting times and waiting list trajectories in line with timescales set out for allocation of new resource
- Recruitment of staff required to achieve the above at a time of national workforce pressures
- Progressing vision for PTs within the timeframe required to sustain improved performance

IMPROVEMENT ACTIONS	
20.5 Trial of new group-based PT options	**Complete Sep-21**
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 in Clinical Health Psychology service	**By Mar-22**
A change in establishment in the two Clinical Health specialities (General Medical and Pain Management) that are not meeting the RTT has allowed an expansion in capacity for brief/low intensity psychological interventions and the introduction of a tiered service model of 1:1 psychological therapies. The impact of these changes has been evaluated and have shown positive clinical outcomes. They have also had a positive impact on waiting times within the Pain Management service. It has not yet been possible however, to evaluate the impact on waiting times within the general medical service due to staff changes and vacancy. This will be completed into next year.	
22.3 Recruit new staff as per Psychological Therapies Recovery Plan	**By Mar-22**
Recruitment is on-going for staff trained to provide specialist and highly specialist PTs (as per Scottish Government definitions). Increased capacity in this tier of service is required to meet the needs of the longest waiting patients (those with the most complex difficulties) and to support services to meet the RTT in a sustainable fashion. A national issue with workforce availability has impacted anticipated timelines around recruitment. The psychology service has therefore progressed recruitment of other grades of staff who can 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 Director of Psychology is also participating in work with NHS Education for Scotland and Scottish Government colleagues to address the issues around workforce availability.	

Revenue Expenditure

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

Local Performance



1. Executive Summary

At the end of October the board's reported financial position is an overspend against budget of £13.232m comprising of an adverse variance for Acute Services Division of £13.557m and £3.049m for External Health Care Providers, offset by favourable variances across Corporate Functions. Included in the Acute Services overspend is an adverse variance for Set Aside budgets of £4.0m 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) are reporting an underspend of £3.007m for the 7 months to October.

Revenue Financial Position as at 31st October 2021

Budget Area	Annual Budget £'000	YTD Budget £'000	YTD Spend £'000	YTD Variance £'000
NHS Services (incl Set Aside)				
Clinical Services				
Acute Services Division	226,797	135,383	148,940	-13,557
IJB Non-Delegated	9,360	5,449	5,307	141
Non-Fife & Other Healthcare Providers	90,611	52,884	55,933	-3,049
Non Clinical Services				
Estates & Facilities	77,236	44,585	43,913	672
Board Admin & Other Services	88,775	55,961	54,846	1,115
Other				
Financial Flexibility & Allocations	24,649	1,409	0	1,409
HB retained offsets	60			0
Income	-38,228	-25,330	-25,367	37
SUB TOTAL	**479,260**	**270,341**	**283,572**	**-13,232**
Health & Social Care Partnership				
Fife H & SCP	378,083	216,656	213,652	3,004
SUB TOTAL	**378,083**	**216,656**	**213,652**	**3,004**
TOTAL	**857,343**	**486,997**	**497,224**	**-10,228**

1.2 Included in the board's reported overspend are Health Board retained unachieved legacy savings targets totalling £7.966m (annual £13.656m).

1.3 The Scottish Government has confirmed non repayable funding support to enable the board to break even at the end of the financial year and have identified a number of actions they require the board to undertake to minimise the level of funding support required.. These actions include the board conducting a robust review of savings plans and develop savings plans which will reflect 50% of the 2022-23 funding gap by the end of quarter 3 of this financial year. It is likely plans of approximately £10m will required to be identified. In light of the financial support to be provided, the Scottish Government have plans to monitor NHS Fife going forward on a monthly basis to review the development of savings plans and delivery with the first monthly additional reporting requirement commencing in November. The steps taken by NHS Fife to take forward the actions requested by Scottish Government include commencement of the 2022/23 Strategic Planning Resource Allocation Process, enhancement of the capacity within the PMO team and the establishment of a Financial Improvement/Sustainability programme reporting to the boards Population Health and Wellbeing Portfolio Board. This programme will develop and agree productive opportunities and savings targets for 2022/23 and a clear pipeline of plans for the more medium term.

1.4 Cost pressures within Acute Services continue to increase reflecting the exceptional demand on unscheduled care capacity. The many actions being taken to manage demand pressures have increased the requirement for temporary staffing. Additionally, increasing expenditure across medicines budgets continues to add to the significant cost pressures within clinical directorates particularly with Haematology/Oncology drugs budgets. Robotic assisted surgery is operational for the third month and the costs of surgical instruments are currently unfunded with a sustainable funding solution required.

1.5 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.

1.6 Funding allocations confirmed in month included our second tranche of Covid funding of £13.838m; and New Medicine Funding of £3.341m. Anticipated allocations total £4.485m. Allocation details are contained within Appendix 2.

1.7 Savings plans to the end of October identify £6.042m has been delivered with a balance of £2.139m remaining of the in-year commitment of £8.1m to be delivered by March 2022. Appendix 3 sets out the savings achieved including an analysis of recurring and non-recurring sources.

1.8 Redesign of Urgent Care (RUC) will be fully funded this year through a combination of Scottish Government funding £0.681m and earmarked H&SCP reserves of £0.935m brought forward from 2020/21. The expenditure against the Navigation Flow Hub will be monitored on a fortnightly basis alongside the other workstreams that are focusing on RUC.

1.9 The overall anticipated capital budget for 2021/22 is £32.082m. The capital position for the period to October records spend of £7.821m. Therefore, 24.38% of the anticipated total capital allocation has been spent to month 7.

2. Health Board Retained Services

Clinical Services financial performance at October 2021

Budget Area	Annual Budget £'000	YTD Budget £'000	YTD Spend £'000	YTD Variance £'000
Acute Services Division	226,797	135,383	148,940	-13,557
IJB Non-Delegated	9,360	5,449	5,307	141
Non-Fife & Other Healthcare Providers	90,611	52,884	55,933	-3,049
Income	-38,228	-25,330	-25,367	37
SUB TOTAL	**288,540**	**168,386**	**184,813**	**-16,428**

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.

2.2 The Acute Services Division reports an **overspend of £13.557m.** Acute Services are experiencing particularly challenging capacity pressures and a number of measures are underway to ease the pressure which may require an increase in temporary staffing levels, including over recruitment to unregistered nursing posts. However, included in the financial position to October are unachieved legacy savings targets that account for £7.443m of the reported overspend. The remainder of the reported overspend is largely due to overspends across Nursing, Senior and Junior Medical Pay budgets and significant non-pay pressures within Haematology/Oncology medicines budgets.

Nursing overspend continues to be prominent across Care of the Elderly, Obstetrics and Gynaecology, and Colorectal due to unfunded cost pressures, incremental progression, and safer staffing requirements. Junior medical and dental staff continue to receive banding supplements in Emergency Care, with unfunded clinical fellows also contributing to the cost pressure. Junior medical and dental staff in WCCS will also require banding supplements dating back to February 2021, with the value yet to be confirmed. Elderly medicine, Acute and A&E consultant overspends are partially offset by GI and Neurology vacancies in Emergency Care, and WCCS have cost pressures against both Obstetrics & Gynaecology, and Paediatric consultants. Recruitment is in progress to recruit to some consultant posts currently being covered by locums, with some not expected to be in post before March 2022.

Non pay cost pressures total £2.594m, with Acute medicines overspend of £2.506m. The expenditure on drugs in 2021/22 has increased by 17% compared to the same period last year. Haematology / oncology drugs make up a significant proportion of this increase, with SMC approvals for further indications having an impact. As a continuation from 20/21: Dermatology; GI; Neurology; and Respiratory all present increased costs due to the volume of patients being treated and new drugs that are being made available via the homecare service.

2.3 The IJB Non-Delegated budget reports an **underspend of £0.141m.** 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 £3.049m** per Appendix 4. As reported previously, the main driver is the increase in the expected annual value of the service agreement with NHS Lothian. Savings yet to be delivered in this area amount to £0.875m and discussions continue with NHS Tayside.

Corporate Functions and Other Financial performance at October 2021

Budget Area	Annual Budget £'000	YTD Budget £'000	YTD Spend £'000	YTD Variance £'000
Non Clinical Services				
Estates & Facilities	77,236	44,585	43,913	672
Board Admin & Other Services	88,775	55,961	54,846	1,115
Other				
Financial Flexibility & Allocations	24,649	1,409	0	1,409
HB retained offsets	60			0
SUB TOTAL	**190,720**	**101,955**	**98,759**	**3,196**

2.5 The Estates and Facilities budgets report an **underspend of £0.672m.** This comprises an underspend in pay of £0.375m across several departments including estates services, catering and laundry; and non pay underspend of £0.527m on PPP and £0.460m on rates due to receipt of disabled rate relief for Lynebank. This benefit is partially offset by overspends on property maintenance £0.265m and equipment £0.157m.

2.6 Within the Board's corporate services there is **an underspend of £1.115m**. The main driver for this underspend is the level of vacancies across Finance (£0.199m) and Nursing (£0.252m) directorates. An underspend within Digital and Information's budgets is largely attributable to a VAT rebate of £0.228m in July offset against various overspends.

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 £1.409m** has been released at month 7, with 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 £3.004m.**

Budget Area	Annual Budget £'000	YTD Budget £'000	YTD Spend £'000	YTD Variance £'000
Health & Social Care Partnership				
Fife H & SCP	378,083	216,656	213,652	3,004
SUB TOTAL	**378,083**	**216,656**	**213,652**	**3,004**

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 £4.0m overspend to month 7 per 1.1 above).

3.2 The underspend at October is consistent with the position reported in previous months and is a result of numerous vacancies across a number of teams due to significant challenges in availability of staffing.

3.3 Following the IJB financial planning process, the IJB CFO has indicated the underspend may be used to inform a non-recurring budget realignment this financial year. This proposal is being further analysed and validated prior to any realignment process taking place this year.

3.4 A review of the Integration Scheme has been agreed by the respective partners, NHS Fife Board and Fife Council in September 2021, and has been submitted for Ministerial Approval, after which final approval will be sought at the IJB Committee in January 2022.

3.5 The overspend on the set-aside services is currently held within the Acute Services Directorate Budget and not the IJB and is not included in the reported projected overspend for the IJB. If a different arrangement was in place between the IJB and the Health Board in relation to the management of costs in excess of the available budget, the IJB would face significant cost pressure as a result of the significant demand for hospital services.

Details of funds held within Delegated Health Earmarked Reserves are noted at Appendix 6.

4. Forecast

4.1 Our assessment (at month 7) of our forecast outturn to the year end has been updated to reflect a potential overspend of £16.448m for Health Board retained services. This includes the in-year deficit in our opening financial plan of £13.656m unachieved savings and a core potential additional overspend of £2.792m. This is an improvement of circa £0.4m on the previous forecast outturn overspend of £16.868m. The main pressures contributing to the £3m overspend are, cost pressure in respect of our Service Level Agreement with NHS Lothian; and Acute drugs cost pressures. Work is underway to identify every opportunity to reduce the level of support required from Scottish Government.

4.2 In addition, whilst some progress is being made, in that limited funding has been received, we remain c£5m-£8m away from NRAC funding parity across Scotland. This has a significant bearing on our financial planning arrangements and our qualitative and quantitative performance.

4.3 Whilst the Health delegated underspend position is forecast at £5.112m, the most recent H & SCP finance report identifies a **projected year end overspend position of £4.179m** (Source: November 2021 H&SCP Finance & Performance Committee). Five key areas of overspend that are contributing to the projected outturn overspend are Hospital & Long Term Care, Family Health Services, Older People Residential and Day Care, Homecare Services and Adult Placement. At the same Committee a recovery plan was tabled for consideration, with plans to be actioned which aim to reduce the projected overspend by £1.4m by the end of the financial year. Discussion and detailed review of the projected year end outturn and the mitigating actions required to improve the financial position will be taken forward with the Chief Finance Officer for the H&SCP.

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. However, similar to last year, it is likely that a cash transfer will be required from Health to Council to allow both organisations to report a balanced position; and work continues to quantify the value.

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 overspend of £13.232m for the 7 months to date;
- **Note** that workforce and capacity pressures across our system continue to drive increased costs in-year and present a financial challenge.
- **Note** the potential total overspend outturn position of £16.656m, with work continuing to reduce this position
- **Note** the confirmation of funding support by Scottish Government on the proviso a number of actions are taken forward

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	
Additional allocation	6,815	7,023		13,838	
H SCP ear marked reserve		2,639		2,639	
Anticipated allocation				0	
Total funding	**15,517**	**12,540**	**0**	**28,057**	**0**
Allocations made for April to October					
Planned Care & Surgery	563			563	
Emergency Care & Medicine	3,562			3,562	
Women, Children & Clinical Services	1,288			1,288	
Acute Nursing	0			0	
Estates & Facilities	593			593	
Board Admin & Other Services	1,139			1,139	
Public Health Scale Up	633			633	
Test and Protect	2,597			2,597	
Primary Care & Prevention Serv		525		525	
Community Care Services		876		876	
Complex & Critical Care Serv		177		177	
Professional/Business Enabling		116		116	
Covid Vaccine/Flu		7,334		7,334	
Social Care					
Total allocations made to M7	**10,375**	**9,028**	**0**	**19,403**	**0**
Balance In Reserves	**5,142**	**3,512**	**0**	**8,654**	**0**

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	
2-November 2021	Covid 19 PPE			258	258	Part of Covid Allocation based on Q1review
	Contribution to Pharmacy Global Sum			-340	-340	Annual Reduction
	Drug Tariff Reduction			-4,245	-4,245	Annual Reduction
	Child Healthy Weight			23	23	Specific Project
	Pregnancy Anaemia Management			28	28	Specific Project
	New Medicine Fund		3,344		3,344	Annual Allocation
	Pre-Operative Anaemia Project			46	46	Specific Project
	Long Acting Buprenorphine			273	273	As per funding letter
	Sexual Assault Referral Centres			3	3	Specific Project
	Workforce Wellbeing Primary Care & Social Care			136	136	Specific Allocation
	Workforce Wellbeing			129	129	Specific Allocation
	School Nurse Commitment Tranche 2		46		46	As per funding letter
	GDS Public Dental Service			2,090	2,090	Annual Allocation
	Winter Planning Funding			661	661	As per funding letter
	Discharge without delay pathfinder sites			340	340	As per SG announcement
	Remobilisation of NHS Dental Services			320	320	Specific Allocation
	Primary Medical Services - Telephony			37	37	Specific Allocation
	Urgent & Unscheduled Care Interface Care Programme			480	480	As per funding letter
	HNC Students			36	36	Backfill for student cohort
	Further General Covid Funding			2,434	2,434	Part of Covid Allocation based on Q1review
	Nurse Director Support for Care Homes			1,053	1,053	As per funding letter
	Test & protect			4,315	4,315	Part of Covid Allocation based on Q1review
	Covid & Extended Flu Vaccination			6,831	6,831	Part of Covid Allocation based on Q1review
					0	
					0	
					0	
					0	
	Total Core RRL Allocations	**721,804**	**75,858**	**43,465**	**841,127**	
Anticipated	Mental Health Bundle		1,363		1,363	
Anticipated	Distinction Awards		193		193	
Anticipated	Research & development		822		822	
Anticipated	Community Pharmacy Champions		20		20	
Anticipated	NSS Discovery		-39		-39	
Anticipated	NDC Contribution		-842		-842	
Anticipated	Community Pharmacy Pre-Reg Training		-159		-159	
Anticipated	PNP		120		120	
Anticipated	Golden Jubilee SLA		-24		-24	
Anticipated	PQIF		682		682	
Anticipated	ADP: seek & treat		1,159		1,159	
Anticipated	Waiting List		1,367		1,367	
Anticipated	Emergency Cancer Diagnostic Centre			291	291	
	Medical & Dental /AfC pay award	2,032			2,032	
Anticipated	NSD Adjustments		-2,130		-2,130	
		2,032	**2,532**	**291**	**4,855**	
Anticipated	IFRS			9,352	**9,352**	
Anticipated	Donated Asset Depreciation			174	**174**	
Anticipated	Impairment			1,333	**1,333**	
Anticipated	AME Provisions			500	**500**	
	Total Anticipated Non-Core RRL Allocations	**0**	**0**	**11,359**	**11,359**	
	Grand Total	**723,836**	**78,390**	**55,115**	**857,341**	

Appendix 3: Savings Position at October 2021

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 October £'000	Unachieved to March £'000
Health Board	21,837	8,181	13,656	4,247	1,795	6,042	2,139
					0		0
Total Savings	21,837	8,181	13,656	4,247	1,795	6,042	2,139

NHS Fife Potential Savings Summary	£000's	Risk level		Identified CY	Outstanding Balance		Identified FY	Outstanding Balance
Workforce Capacity and Utilisation Review	1,000	High		-407	593		-41	959
Pay Vacancy Factor (1%)	3,015	Medium		-3,015	0		-3,015	0
Repatriation of Services	500	Low		0	500		0	500
External Commissioning Cost Review	1,000	Medium		0	1,000		0	1,000
Medicine Utilisation	500	Medium		-640	-140		-709	-209
Contracts	1,500	Low		-129	1,371		0	1,500
Procurement - Non pay	500	Medium		0	500		0	500
Other	166	Low		-1,851	-1,685		-482	-316
	8,181			**-6,042**	**2,139**		**-4,247**	**3,934**

Appendix 4: Service Agreements

	CY Budget £'000	YTD Budget £'000	YTD Actuals £'000	YTD Variance £'000
Health Board				
Ayrshire & Arran	99	58	57	1
Borders	45	27	33	-6
Dumfries & Galloway	25	15	33	-18
Forth Valley	3,227	1,883	2,237	-354
Grampian	365	212	165	47
Greater Glasgow & Clyde	1,680	980	977	3
Highland	137	80	119	-39
Lanarkshire	117	68	149	-81
Lothian	31,991	18,661	19,741	-1,080
Scottish Ambulance Service	103	60	59	1
Tayside	41,584	24,257	24,834	-577
Savings	-1,500	-875		-875
	77,873	**45,426**	**48,404**	**-2,978**
UNPACS				
Health Boards	10,801	6,301	6,445	-144
Private Sector	1,151	671	844	-173
	11,952	**6,972**	**7,289**	**-317**
OATS	721	421	175	246
Grants	65	65	65	0
Total	**90,611**	**52,884**	**55,933**	**-3,049**

Appendix 5: Financial Flexibility & Allocations

	£'000	Flexibility Released to Oct-21 £'000
Financial Plan		
Drugs	2,093	0
CHAS	408	0
Junior Doctor Travel	32	9
Discretionary Points	209	0
Consultant Increments	245	102
Cost Pressures	3,541	1,124
Developments	1,960	174
Sub Total Financial Plan	**8,488**	**1,409**
Allocations		
Waiting List	3,549	0
AME: Impairment		0
AME: Provisions	923	0
Community Pharmacy Champion	19	0
Pay Award:AfC	1,706	0
6 Essential Action	456	0
ICU	485	0
Test & Protect	4,378	0
Winter	661	0
Cervical Incident	4	0
Cancer Waiting Time	531	0
Distinction Award	57	0
Unscheduled Care Summer	180	0
Cardiac Physiologists	24	0
Support to build recruitment capacity	65	0
Building Capacity for international recruitment	68	0
Young Patients Family Fund	55	0
Best Start	101	0
Emergency Cancer Diagnostic Centre	196	0
Pregnancy Anaemia Management	28	0
Preoperative Anaemia	46	0
Workforce Wellbeing	129	0
HNC CAP	36	0
Discharge Without Delay Pathfinders	340	0
Interface Carev Programme	480	0
Nurse Director Support	883	0
Covid General	761	0
Sub Total Allocations	**16,161**	**0**
Total	**24,649**	**1,409**

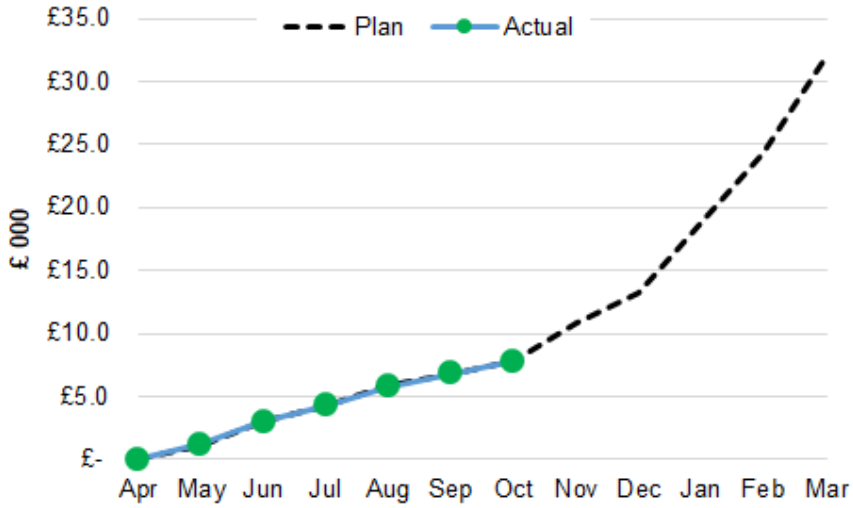
Appendix 6: Anticipated Funding from Health Delegated Earmarked Reserve

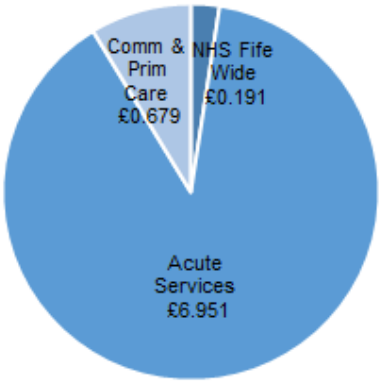
Health Delegated Earmarked Reserve		Included within Health		
	Total	To M7	Anticipated	Balance
	£000's	£000's	£000's	£000's
Vaccine	740	740		0
Care homes	526	82		444
Urgent Care Redesign	935	408		527
Flu	203	203	0	0
Primary Care Improvement Fund	2,524	1,011		1,513
Action 15	1,315			1,315
RT Funding	1,500			1,500
FSL	500	500		0
District Nurses	30			30
Fluenz	18			18
Core run rate	1,767	73	373	1,321
Core (covid offsets)	1,250	1,250		0
Total	**11,308**	**4,267**	**373**	**6,668**

Capital Expenditure

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

Local Performance





1. Annual Operational Plan

The capital plan for 2021/22 was approved by the FP&R Committee in July and was subsequently tabled at the NHS Fife Board. NHS Fife has assumed a programme of £32.082m. This comprises:

Capital Plan	£'000
Initial Capital Allocation	7,394
National Equipping Funding	1,537
Elective Orthopaedic Centre	15,907
HEMPA	1,100
Mental Health Review	76
Lochgelly Health Centre	517
Kincardine Health Centre	323
Energy Scheme Funding	1,800
Pre Capital Fund Grant	50
Covid Capital	1,878
QMH Theatre	1,000
CT Scanner	700
Repay PY overallocation	-200
Total	32,082

Due to the current climate there are significant potential risks associated with the capital programme this year and it is prudent to highlight them at this time. Nationally and locally there are critical risks regarding the availability of materials, price increases on materials, lead times and deliverability within the financial year end. NHS Fife is working to mitigate these risks wherever possible.

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

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 £7.821m, this equates to 24.38% 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	£1.889m
Equipment	£0.752m
Digital	£0.179m
Elective Orthopaedic Centre	£4.597m
Health Centres	£0.262m

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 31 October 2021 of £7.821m and the year-end spend of the total anticipated capital resource allocation of £32.082m.

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	225	119	225
Statutory Compliance	350	210	350
Capital Equipment	150	65	150
Condemned Equipment	24	22	24
Lochgelly Health Centre	0	0	0
Kincardine Health Centre	0	0	0
National Infrastructure Equipment Funding	8	0	8
Total Community & Primary Care	757	416	757
ACUTE SERVICES DIVISION			
Statutory Compliance	2,942	1,670	2,942
Capital Equipment	1,861	609	1,861
Clinical Prioritisation	181	19	181
Condemned Equipment	63	56	63
National Infrastructure Equipment Funding	1,529	0	1,529
Total Acute Services Division	6,576	2,354	6,576
NHS FIFE WIDE SCHEMES			
SG Payback Balance	200	0	200
Equipment Balance	92	0	92
Information Technology	1,000	179	1,000
Clinical Prioritisation	94	0	94
Statutory Compliance	77	0	77
Condemned Equipment	3	0	3
Fire Safety	60	10	60
Vehicles	72	0	72
Total NHS Fife Wide Schemes	1,598	189	1,598
TOTAL CAPITAL ALLOCATION FOR 2021/22	**8,931**	**2,959**	**8,931**

ANTICIPATED ALLOCATIONS 2021/22			
Elective Orthopaedic Centre	15,907	4,597	15,907
HEPMA	1,100	3	1,100
Kincardine Health Centre	323	105	323
Lochgelly Health Centre	517	157	517
Mental Health Review	76	0	76
Energy Funding Grant	1,800	0	1,800
Pre Capital Grant Funding	50	0	50
SG Payback	-200	0	-200
Covid Capital	1,878	0	1,878
QMH Theatre	1,000	0	1,000
CT Scanner	700	0	700
Anticipated Allocations for 2021/22	**23,151**	**4,863**	**23,151**

Total Anticipated Allocation for 2021/22	**32,082**	**7,821**	**32,082**

Appendix 2: Capital Plan - Changes to Planned Expenditure

Capital Expenditure Proposals 2021/22 Routine Expenditure	Pending Board Approval £'000	Cumulative Adjustment to September £'000	October Adjustment £'000	Total October £'000
Community & Primary Care				
Capital Equipment	0	135	15	150
Condemned Equipment	0	24	0	24
Clinical Prioritisation	0	171	54	225
Covid Equipment	0	0	0	0
Statutory Compliance	0	349	0	349
National Infrastructure Equipment Funding	0	0	8	8
Total Community & Primary Care	**0**	**679**	**77**	**756**
Acute Services Division				
Capital Equipment	0	1,816	45	1,861
Condemned Equipment	0	63	0	63
Clinical Prioritisation	0	165	16	181
Statutory Compliance	0	2,942	0	2,942
National Infrastructure Equipment Funding	0	0	1,529	1,529
	0	**4,986**	**1,590**	**6,576**
Fife Wide				
SG Payback Balance	200	0	0	200
Backlog Maintenance / Statutory Compliance	3,500	-3,411	-12	77
Fife Wide Equipment	1,805	-1,652	-60	93
Digital & Information	1,000	0	0	1,000
Clinical Prioritisation	500	-336	-70	94
Condemned Equipment	90	-87	0	3
Scheme Development	0	0	0	0
Fife Wide Asbestos Management	0	0	0	0
Fife Wide Fire Safety	0	60	0	60
General Reserve Equipment	94	-94	0	0
Pharmacy Equipment	205	-205	0	0
Fife Wide Vehicles	0	60	12	72
Total Fife Wide	**7,394**	**-5,665**	**-130**	**1,599**
Total Capital Resource 2021/22	**7,394**	**0**	**1,537**	**8,931**

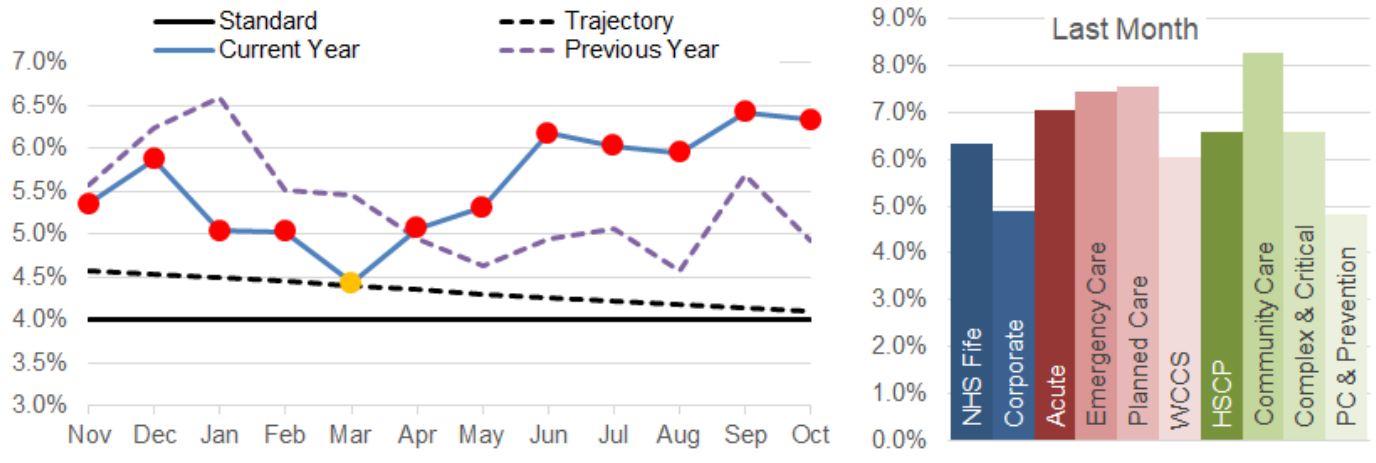
ANTICIPATED ALLOCATIONS 2021/22				
Elective Orthopaedic Centre	15,907	0	0	15,907
HEPMA	1,100	0	0	1,100
Kincardine Health Centre	323	0	0	323
Lochgelly Health Centre	517	0	0	517
Mental Health Review	76	0	0	76
Energy Funding Grant	1,800	0	0	1,800
Pre Capital Grant Funding	50	0	0	50
SG Payback	-200	0	0	-200
QMH Theatre	1,000	0	0	1,000
CT Scanner	700	0	0	700
Covid Capital	1,878	0	0	1,878
Anticipated Allocations for 2021/22	**23,151**	**0**	**0**	**23,151**

Total Planned Expenditure for 2021/22	**30,545**	**0**	**1,537**	**32,082**

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						
	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
NHS Fife	5.35%	5.87%	5.04%	5.03%	4.43%	5.07%	5.31%	6.17%	6.03%	5.95%	6.42%	6.34%
Scotland	4.96%	5.18%	4.82%	4.30%	4.56%	4.59%	5.04%	5.52%	5.62%	5.76%	6.12%	6.30%

KEY CHALLENGE(S) IN 2021/22

To secure an ongoing reduction in the current levels of sickness absence performance, as services remobilise, working towards the third-year trajectory for the Board of 3.89% in with NHS Circular PCS (AfC) 2019/2

IMPROVEMENT ACTIONS

22.1 Work towards improvement in long term sickness absence relating to mental health, using Occupational Health and other support services and interventions	**By Mar-22**
The additional Occupational Health Physician is taking forward specific support for staff affected by Mental Health and mental health training for managers. This is in addition to the individual case work being progressed by local managers and HR Officers and Advisors, with input from the specialist Occupational Health Mental Health Nurse. Additional staff support is being provided on a requested and targeted basis via the Staff Listening Service, Being Mindful of Your Wellbeing sessions, Peer Support, Care Space Mindfulness Drop-in sessions, outdoor sessions, access to Counselling, introduction of new eLearning Modules and access to the National PROMiS resources.	
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-22**
Promoting Attendance Review and Improvement Panels continue to meet regularly. This is alongside monthly and bespoke training sessions and the use of Tableau to identify and analyse “hot spots”/priority areas and trajectory setting/reporting. Feedback received following a programme to reinforce attendance management processes, undertaken between May and July will be discussed in partnership at the Attendance Management Workforce Review Group scheduled for December, with a series of actions being taken forward with key stakeholders thereafter.	
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**
Work has been undertaken with Digital & Information colleagues to provide initial COVID-19 specific absence reports and this will be refined to take account of systems developments. Weekly reports are being provided to EDG Gold.	

MARGO MCGURK
Director of Finance and Strategy
14th December 2021

Prepared by:
SUSAN FRASER
Associate Director of Planning & Performance

NHS Fife

Meeting:	**Public Health & Wellbeing Committee**
Meeting date:	**10 January 2022**
Title:	**Fife Child Protection Annual Report**
Responsible Executive:	**Janette Owen, NHS Fife Director of Nursing**
Report Author:	**Cicilie Rainey, Lead Nurse Child Protection**

1 Purpose

This is presented to the Public Health & Wellbeing Committee for:

- Assurance

This report relates to a:

- Emerging issue
- Government policy/directive

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

- Safe

2 Report summary

2.1 Situation

NHS Fife/H&SCP has a duty to safeguard and protect children and young people (C&YP). This is reflected in Fife's Children's Services Plan where child protection is one of the key priorities.

This annual report from Health's dedicated child protection team builds on the last 2 Clinical Governance Committee reports by continuing to interrogate Fife Child Protection (CP) CP team and Fife Child Protection Committee (CPC) data, as a means of exploring possible hidden harm due to the pandemic, as well as performance report, trends and the effectiveness/mitigation of safeguarding practice.

From a governance perspective the report briefly reflects on recent case reviews and our vision to move to a public protection model, which aligns well with the Promise, as well as an update on plans for implementation of the new CP guidance.

2.2 Background

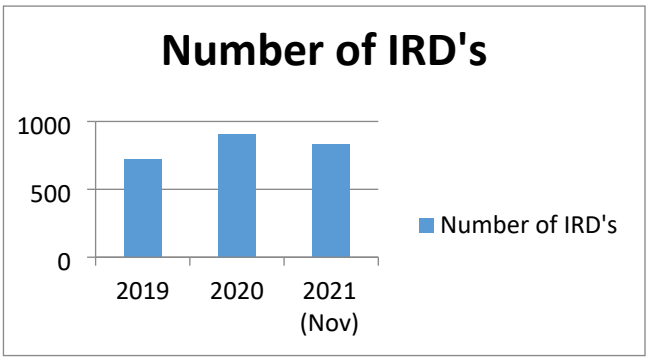
Concerns regarding possible hidden harm were raised due to an initial drop in IRDs and forensic medicals over late spring and early summer of 2020. However, by the end of December 2020 IRD trends were on a trajectory towards pre COVID levels and data presented in this report illustrates sustained levelling as per pre-COVID. The SOLACE reports from Scottish Government continued to offer assurance that on average 95% of the very vulnerable families known to services were being seen. Scottish Government analysis of the data also acknowledged need to interrogate data relating to the increasing number of children and young people with complex needs and risks, albeit not meeting the threshold of significant risk of harm, whose care is coordinated on a universal level. This is a dataset yet to be developed in Health to enable that scrutiny and analysis, but could provide insight into the more entrenched challenges relating to the

interface between wellbeing and protection, which is referred to in this report as a recurrent theme from case reviews.

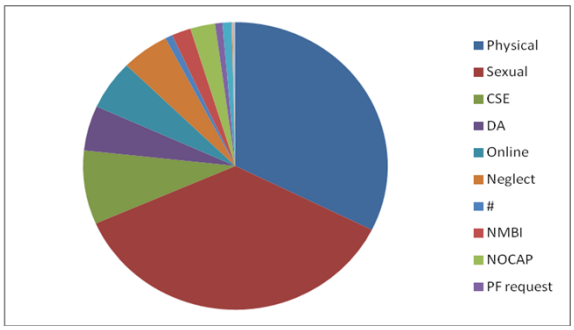
2.3 Assessment

2.3.i Inter-agency Referral Discussions(IRDs)

A total of **831** took place between Jan-Nov, 2021, which is in keeping with overall average.Physical and sexual harm remain the most common cause for an IRD, whilst 7% (including PF requests) were due to domestic abuse. The latter appears slightly lower compared to Child Protection Regiser categories, where domestic abuse remains ranked as 3rd highest reason for registration. There are signficant limitations to the data analysis however, including different QI use (CPC use academic breakdown, whilst CP team use financial year). Nevertheless, the data sets are helpful benchmarks, especially when the new CP guidance is implemented, which should ensure *all* child protection cases are managed consistently, rather than our current system which has a 2 way entry into child protection.



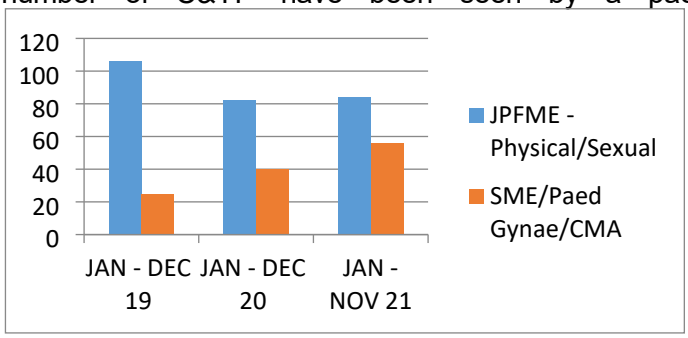
Nature of concern



(See App.1 for acronyms)

2.3.ii Forensic/specialist medicals

We noted that the number of children subject to joint paediatric forensic medical examination (JPFME) was lower in 2020, with a mean of 13.3%, compared to 20.7% in 2019. Conversion rate to forensic medicals this year is so far **10%.** This calculation remains a rough indicator only, as some physical and sexual IRDs result in a Specialist Medical Examination (SME) only, as no forensic evidence to warrant a JPFME. Hence a number of C&YP have been seen by a paediatrican nevertheless, just not been subject

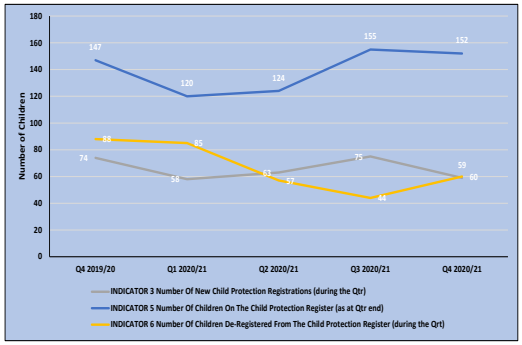


a JPFME. Due to an uplift of consultant paediatricians, including two with CP as their special interest, we have had more regular input from paediatricians in IRDs of cases where medicals may be required. This is likely to have strengthened decision making, including need for medicals, resulting in a more robust IRD contribution from Health

2.3.iii CPC data – Main concern recorded at registration

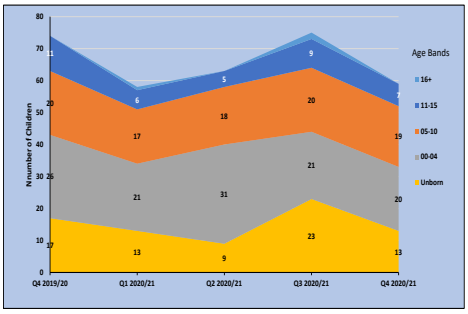
Further insight can be gained by reviewing thematic features of children placed on the Child Protection Register, as well as prevalence. Domestic abuse, emotional abuse and [parental] mental health were the most common concerns identified in Q2, which have remained the same over the past reporting year. During the last two quarters parental mental health is most frequent reason for registration, and although domestic abuse and parental drug abuse remain in the top 4, neglect continues to be second common reason for registration, which is a sustained rise over the last 5 quarters. Conversely, there is a relatively low number of neglect cases that are subject to IRDs (6%), again a likely illustration of our current 2-way entry into child protection

Concern	May-Jul Q4 2019/20	Aug-Oct Q1 2020/21	Nov-Jan Q2 2020/21	Feb-Apr Q3 2020/21	May-Jul Q4 2020/21	Reporting Period Ranked
Domestic Abuse	40	40	43	55	30	3
Alcohol Abuse	14	19	28	28	24	6
Drug Abuse	33	26	35	46	30	3
Non-engaging	29	24	32	37	23	7
Mental Health	49	39	39	55	39	1
Own Risk	6	17	14	21	14	11
Sexual Abuse	8	19	13	25	21	10
Child Exploitation	6	16	11	20	13	12
Physical Abuse	29	28	24	36	23	7
Emotional Abuse	45	38	42	41	29	5
Neglect	48	29	37	42	34	2
Other	20	22	21	33	22	9
Total Concerns	327	317	339	439	302	
Total Registrations	74	58	63	75	59	



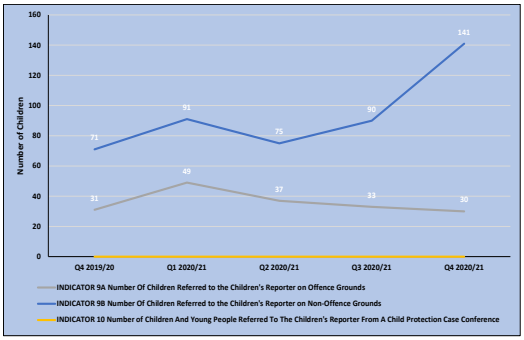
New registration of C&YP is on a downward trend (grey line). Given there have been less children subject to case conference and the conversion rate has gone down this is consistent with the number of newly registered decreasing also. The reason for this is currently being examined through a Multi-agency audits, focusing on de-registration and re- registration.

Age demographics – Child Protection Register Q4



The significant increase in Q3 (2021) for unborn has dropped back down to 13 which is more consistent with the previous quarters. As already noted, these datasets will be helpful benchmarks when implementation of the new CP guidance takes place, which will ensure all child protection concerns are raised as IRDs, including for unborn babies. Currently staff are expected to convene a child wellbeing meeting when there are emerging concerns, and the outcome is a case conference. This is an example of our current 2 way entry to child protection which may become more streamlined as the expectation going forward would be for an IRD to be raised, including for unborn.

2.3.iv Number of children referred to the Children's Reporter on non-offence grounds (blue)



	May-Jul Q4 2019/20	Aug-Oct Q1 2020/21	Nov-Jan Q2 2020/21	Feb-Apr Q3 2020/21	May-Jul Q4 2020/21
CPOs	21	15	10	16	10

Source: SCRA *Indicator 11*

C&YP can be referred to the Reporter when compulsory measures may be required to keep them safe, i.e. in foster care or at home.

165 individual children / young people referred to the Children's Reporter in Q4 – this increase in referrals was expected and has returned to a rate comparable with 18/19 figures. Lack of parental care remains the ground on which the majority of referrals relate (49% in Q4); close connection with a person who has carried out domestic abuse is again second (12% in Q4) jointly with the child being the victim of a schedule 1 offence (Physical or sexual abuse).

2.3.1 Quality/ Patient Care

Case Reviews/CPC risk register: response and mitigation.

CPC partners regularly review its risk register and a current high scoring risk the CGC should be aware of is the concern that the interface between wellbeing and welfare is not adequately understood. Getting it Right for Every Child (GIRFEC) principles are well embedded across the partnership, however the CPC has found that there continues to be differing interpretations about the roles of the named person service and the lead professional, which is undermining practitioners' confidence. This is resulting in a lack of a coordinated approach to meeting C&YP's needs, which can increase risk to C&YP who may be likely to be - or at risk of harm.

Work relating to strengthening GIRFEC practice (known as the Child Wellbeing Pathway in Fife) has been underway for some time, but currently on hold awaiting Scottish Government Practice Guidance. The most recent Initial Case Review (ICR 01.2021), mentioned in the previous report, is being taken forward as a Learning Review. It is likely that this review will shine a light on the interface issue, and findings from this review are awaited with interest. The Child Wellbeing Pathway has also featured in previous ICRs; hence the Learning Review findings are likely to have significant generalisable value. As referred to earlier in this report a minimum data set which captured GIRFEC activity and outcome to children is likely to strengthen governance in this area. This is being taken forward by the Child Health Management Team and Children's Services Partnership Group.

Reference was also made in the previous report regarding two ICRs regarding significant injuries in infants/very young children. Previous annual audit led by the Lead Consultant, concluded in December 2019 that there was very good compliance with the Managed Clinical Network's Under 2 Fracture Protocol and the Non Mobile Infant Bruising Guidance. Anecdotally this still appears to be the case. The annual audit is currently underway, hence findings as yet unavailable, but can be provided on request in 2022.

Previous CGC report also referred to the mitigation in place to strengthen governance within the Health Visiting (HV) service. Provision of supervision is recognised as a key component. The CP team is currently testing a new model of supervision which prioritises one-to-one case supervision rather than group sessions. This is as yet to be evaluated, but anecdotal feedback is encouraging. If confirmed when evaluated, the plan is to scale and spread this up to the whole HV service. This will however have an impact on CP team capacity, and a gap analysis report has been submitted to inform a paper to the Senior Leadership Group, which also includes resource implication due to the new CP guidance. In addition, four HV Team Leaders are about to complete a post graduate module in supervision. A further cohort of team leaders, including two child protection nurse advisors, commence in January 2022

Responding to signs of neglect: Neglect is another thematic feature of local case reviews. The Graded Care Profile 2, is an actuarial assessment tool designed for assessing and responding to indicators of neglect. This tool was acquired by Children's Services to support assessment. Implementation was delayed due to the HV/Family Nurses migrating to MORSE; however the planning phase is well under way, with a launch planned for May 2022

2.3.2 Workforce

2.3.2.i Learning and Development

To keep children and young people safe, staff need to be confident and competent in responding to indicators of harm. Since the pandemic, the CP team has adapted the training material to MS Teams. Since June CPC update report another 16 training sessions were offered to all NHS staff. A total of **168** staff attended training sessions within this 6 month period. Although only 50% return, over 99% of respondents have rated the training as very good or good with some themes emerging. Further detail is available on request.

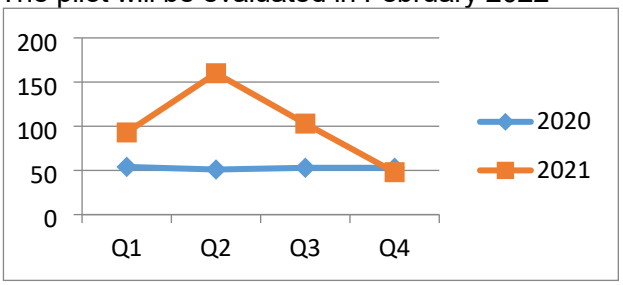
The CP Core training Framework has been refreshed and endorsed by Janette Owens, Nurse Director and Executive Lead for Child Protection. After a void due to the staffing implications of the pandemic, members Child Protection Health Steering Group are again committed to provide annual returns of staff uptake to CP training. The returns also invite a training needs analysis in order to identify any gaps in learning needs.

In addition, the team continuously review and update the training material to ensure it remains evidence based, and to factor in learning from case reviews.

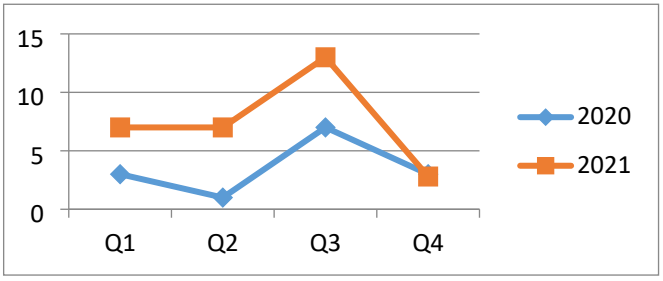
Unfortunately the CPC Learning and Development post has not been recruited to as yet, hence multi-agency training remains unavailable. That said, monthly CP peer review is available via Teams in collaboration with NHS Lothian, and the quarterly local peer review with police and social work colleagues has now recommenced. The CP team also contributed to a CP training event for GPs this

summer, facilitated by the east region MCN. This was positively evaluated and a number of GPs from Fife attended. The plan going forward is for 6 monthly pan-Fife/Lothian events for GPs, which the CP team will continue to contribute to.

2.3.2.ii CP supervision:
As discussed, the learning from case reviews and relatively low uptake by HVs, group supervision for HVs was paused in August and a test of change is under way with planned 1:1 supervision of all HVs. If successful, the model will be scaled up so that all HVs will receive at least two 1:1 supervision sessions/year with the CP team, in addition to the 6-8 weekly supervision delivered by the HV Team Leaders. Although paused, group supervision for HVs remains available on demand, as does 1:1 at any time. Group supervision has continued for other staff groups, including Family Nurse Partnership, specialist midwives and paediatric nurses, Addictions Services and a dedicated group for supervisors. The pilot will be evaluated in February 2022



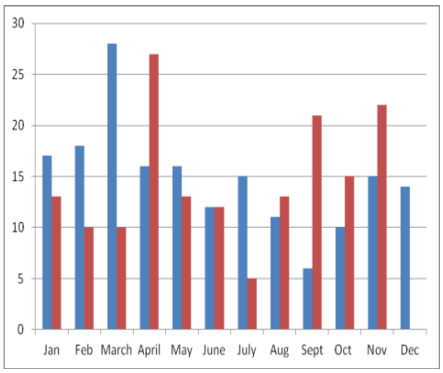
Number of staff attending group supervision



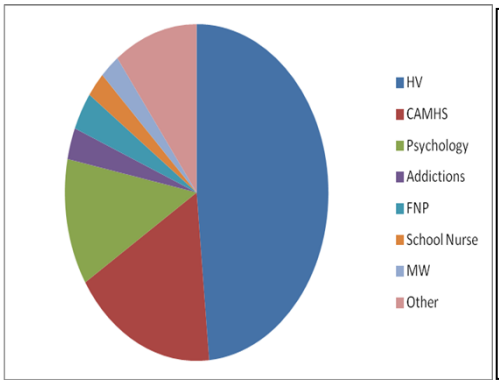
Number of one to one supervision sessions

2.3.2. iii Advice & support
There is often blurring between staff receiving supervision, and those seeking advice and support. Sometimes the only difference is the child protection nurse advisors do not have access to records, although many calls are also about adults (parents), often unnamed. It is therefore congruent to consider supervision and advice & support data together. The team receive calls from health professionals across both adult and children's services. Numbers are similar to 2020, with December 2021 stats outstanding. The calls received were in relation to an array of diverse CP issues. No overt specific patterns are identifiable however certain themes were evident and are listed below

Number of calls 2020/2021



Source



Emerging themes:

~Advice/reassurance re escalation of concerns and/or progression to Social Work notification of Child Concern (NOCC)
~Conflicts with differing professional thresholds- CWB v CP- potential for implementation of escalation policy
~Disclosure of historical sexual abuse
~Parental mental health
~Transient/ unseen children and young people/ non- engaging family
~Information sharing

Total No of calls 2020= 179
Total No of calls 2021= 161 (until Dec)

We continue to quality assure our calls, and feedback indicates high satisfaction rates, although feedback returns remains a challenge, this time 20%. Further detail will be available on request and forms part of performance reporting to the Child Protection Health Steering Group

2.3.2.iv Supervision and support within the CP team: Governance within the team itself is a priority, with particular focus on supervision. This take place in several ways:

- Restorative supervision: The nurses have access to monthly restorative supervision, lead by a Consultant psychologist from CAMHS. This continues to evaluate very well, and the attendance is 100%, other than due to annual leave/sickness. There is no doubt that as for many other services, the pandemic, working from home and continuous exposure to complex trauma cases has had impact on the team. The team therefore held a team development day which was externally facilitated, supported by the Consultant Psychologist. This had both emotional and practical benefits and energised the team.
- Team huddle: Following the IRD meeting there is an opportunity for a daily Huddle with CP Team members. The purpose is to reflect on IRDs and any cases brought to the team that warrants further discussion. It is rare for this not to occur, only not taking place if prioritising commitments to wider CP meeting/Restorative Supervision. Data has been collected since the end of Feb 2021 to capture the availability/ attendance of the Lead Nurse for Child Protection and/or medical staff involvement. The recent additional of 2 paediatric consultants with a specific CP remit has increased the availability of medical oversight within the Huddle. It is however recognised that SMEs/JPFMEs and clinical commitments frequently take priority, with the SCPNA/Lead Nurse having the opportunity to access medical opinion/ advice out-with the structured Huddle forum. Full data has not been captured but for Q3 Lead Nurse and/ or a paediatrician were present for approx 60-70% of huddles. It is noted that during Q2 and Q3 there have been a higher than normal number of days where no huddle has taken place; due to extensive time of meeting and/ or other priorities/ commitments. This has been particularly evident as Q3 has ended, noting that more IRDs are being received throughout the day with meeting participants re-convening for discussion. (Q4 outstanding)
- Supervision for Supervisors: The Lead Nurse for Child Protection facilitates a monthly supervision session for all CP supervisors, including the nurse advisors. Uptake by the CP nurses generally dependant on diary availability, but fosters cross-supervisors reflective learning and networking, as involves supervisors from Acute sector and specialists such as the Gender Based Nurse Advisor and Addictions Services, in addition to HV Team Leaders and others from Children's Services

2.3.3 Financial

No current financial commitment, although likely financial impact due to implementation of new child protection guidance

2.3.4 Risk Assessment/Management

Building capacity/CP service provision

The team is preparing for change, with vacancies in the team due to retirements and staff moving on to new posts. This is likely to impact on service delivery, at the very least for the first and second quarter of 2022. A contingency plan is being developed, whilst the training calendar has been stripped back and some group supervision sessions for wider staff groups are being paused. We see it as an opportunity to refresh and invigorate, and look forward to welcoming new members into the team.

Sadly we are still without our Lead Consultant Paediatrican; however robust and sustained mitigation is in place with the addition of Consultant Paediatricians with CP interest, and another Consultant due to start Spring 2022.

As described in the previous CGC report, a priority going forward is preparation for implementation of the new CP guidance. The Interim Children's Services Senior Service Manager is leading on the implementation of the new CP guidance. A gap analysis has been submitted by the CP Lead Nurse, in anticipation of likely uplift required within the CP service.

The team has already felt the impact of introducing a temporary quality assurance mechanism of IRDs, which is challenging and likely to be unsustainable by early next year due to staffing shortages within the CP (nursing) team. However, as this initiative was in direct response to an ICR, and is an integral part of the new guidance, solutions are currently being explored.

This is also a timely opportunity to review service provision through the lens of the Promise and the often cross cutting themes with Adult Support and Protection. There is a national move towards a Public Protection model in many Board areas, whilst in others it's already established, ie NHS Lothian, Lanarkshire and Dumfries & Galloway. A Public Protection governance framework is currently being drafted by the Lead Nurse for the consideration by the Interim Children Services Senior Service Manager.

2.3.5 Equality and Diversity, including health inequalities

This report reflects the standards of the three Quality Ambitions as set out in the Healthcare Quality Strategy for Scotland

This proposal meets the HB objectives to pursue quality improvement across health and social care integration in accordance with the National Health and Wellbeing Outcomes Indicators. This proposal supports attainment of outcomes 3, 4, 5, 7, 8 and 9

An impact assessment has not been completed because this is an update report relating to existing standards of practice. However a Children's' Right Wellbeing Impact Assessment will be undertaken by the Project Lead as part of the implementation of the new CP guidance

2.3.6 Other impact

Likely resource implications to resource capacity to implement systems changes and deliver the new standards of undertaking Inter-Agency Referral Discussions as directed by Scottish Government guidance

2.3.7 Communication, involvement, engagement and consultation

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.

- Child Protection Committee Self Evaluation and Improvement Subgroup (Source of Child Protection statistics)
- East Region Managed Clinical Network (CP team reporting of forensic medical statistics)
- Community Children's Services Interim Senior Service Manager
- Interim Child Protection Consultant Paediatrican Lead

2.4 Recommendation

State the action being requested. Use one of the following directions for the meeting. No other terminology should be used.

- **Assurance** – For Members' information only.

- Data available so far indicates no significant increase in children harmed, although our IRD stats remain high.
- Governance within the CP team is continuously reviewed and strengthened
- The team is preparing for a period of change with staff vacancies, which will result in a temporary reduction to delivery of core functions. Key responsibilities such as attendance to IRDs will be sustained, as will staff access to advice and support/supervision
- Training via Teams is available to the wider workforce, including e-learning
- Supervision model to Health Visitors currently being reviewed to strengthen governance

- A gap analysis has been submitted to Children's Services Lead in preparation for resource impact of the implementation of the new CP guidance
- A Public Protection draft governance framework is currently being prepared, in response to the Board meeting the visions within the Promise

3 List of appendices

Appendix 1: Acronyms (IRD breakdown):
CSE: Child Sexual Exploitation
DA: Domestic Abuse
#: fracture
NMIB: Non mobile Infant Bruising
NOCAP: referrals from National Crime Agency
PF request: Procurator Fiscal requesting interview of children victim/witness to crime

Evidence base:

SOLACE

Children and Young People (Scotland) Act 2014
Children's Hearing (Scotland) Act 2011
Data Protection Act 2018
Human Rights Act, 1998
Children (Scotland) Act 1995;
United Nations Convention on the Rights of the Child, 1991
Fife Inter-agency Child Protection Guidance 2016
Fife Children's Services Plan Updated March 2016
Getting it Right in Fife Framework
National Guidance for Child Protection in Scotland
Scottish Government (2013) Child Protection Guidance for Health Professionals
Scottish Government Child Protection Guidance 2021

national-guidance-ch
ild-protection-scotlan

CMO directive re CP guidance 2021

Chief Medical Officer
- final version - SGHD

Glossary of terms:

CSA: Child Sexual Abuse
CPC: Child Protection Committee
ED: Emergency Department
ICR: Initial Case Review
IRD: Inter-agency Referral Discussion
MCN: Managed Clinical Network
SCR: Significant Case Review (Now known as Learning Reviews)

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NHS Fife

Meeting:	**Public Health & Wellbeing Committee**
Meeting date:	**10 January 2022**
Title:	**Adult Support and Protection Biennial Report 2018 – 2020; Update report**
Responsible Executive:	**Janette Owens, Director of Nursing**
Report author	**Janette Owens, Director of Nursing**

1 Purpose

The purpose of this paper is to present the Fife Adult Support and Protection (ASP) Biennial Report 2018 – 2020, and to provide an update on recent activity, including feedback from the Joint Inspection of Adult Support and Protection Measures in Fife.

This is presented to the Public Health & Wellbeing Committee for:

- Assurance
- Discussion

This report relates to a:

- Government policy/directive
- Local policy

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

- Person Centred
- Safe

2 Report summary

2.1 Situation

The biennial report provides an analysis of the types of harm investigated and the profile of adults at risk for whom an investigation has taken place. It summarises local activity over the 2018 - 2020 and the key actions that have been taken under statutory functions as laid down in Adult Support and Protection (Scotland) Act 2007. There is a consideration of the impact of ASP work, current challenges and our response to these, and sets out the focus for development and improvement.

Information from the **Adult Support and Protection Committee Quarterly Statistical Report** is also provided, focussing on activity between July and

September 2021 and feedback from the **Joint Inspection** of adult support and protection measures in Fife is provided.

2.2 Background

The Biennial Report (appendix 1):
The Adult Support and Protection Committee has been provided with detailed statistical summary reports following the submission of the Scottish Government data return. Reports provide trend analysis, information on types of harm being investigated, demographic details of adults at risk and has helped to inform the local improvement planning discussions for 2021/22. In addition, it has prompted a number of interagency self-evaluation activities to provide context to emerging trends.

Adult Support & Protection Report Q2 July – September 2021 (appendix 2):
The following report details the number and source of Adult Support & Protection referrals received on a quarterly basis. This may be used by individual agencies for monitoring and contextual purposes should notable changes be observed. Following inspection feedback and in line with the SE&I workplan to develop a performance framework, it is proposed that a number of additional indicators be discussed for addition to future reports. During Q2 (Jul to Sep 2021), there were 657 reports of harm recorded for 558 individuals.

Joint inspection report of adult support and protection services in Fife
Inspectors from the Care Inspectorate, Healthcare Improvement Scotland and Her Majesty's Inspectorate of Constabulary in Scotland carried out an inspection in Fife between May 2021 and August 2021.

The purpose of this was to provide assurance to the Scottish Government about local partnership areas' effective operation of adult support and protection processes, and leadership for adult support and protection services.

The Adult Support and Protection partnership refers to Social Work, Health and Police. In Fife, Housing and Scottish Fire and Rescue Services are included in our strategic leadership group but were not included for the purpose of this inspection.

The report of the joint inspection of adult support and protection measures in Fife, published 10th August 2021, has found clear strengths in ensuring adults at risk of harm are safe, protected and supported and a small number of improvement areas identified.

2.3 Assessment

Reports of Harm:
Biennial report: The number of Reports of harm has continued to increase in Fife on an annual basis. Whilst Police and NHS remain the largest single organisations who report harm, the significant increase in the number of referrals has come from 'other organisations' and from members of the public.

The different types of harm being reported is testament to the work undertaken to continue to raise awareness of what constitutes harm and how to report it.

In 2018-19, 2710 reports of harm were received, increasing to 2967 in 2019-20, and giving a total of 5677 reports of harm over the two-year period. This compares to a total of 4065 over the previous two years and represents an increase of 39.7% since the last biennial report.

During Q2 (Jul to Sep 2021), there were 657 reports of harm recorded for 558 individuals.

2.3.1 Quality/ Patient Care

Types of harm:
In Fife, 724 investigations were undertaken in 2018-20, this is a reduction from 823 in the previous two years. There has been a significant decrease in investigations in care home settings from 194 (23.6% of investigations) in 2016-18 to 70 (9.7% of investigations) in 2018-20.

Psychological and emotional harm Many people experience psychological and emotional harm as a result of threats of harm, being left alone, humiliation, intimidation, causing distress, verbal abuse, bullying, blaming, constant criticism, controlling, depriving contact with others. Almost one in four investigations **(24.6%)** carried out related to an individual at risk of psychological or emotional harm. This is a significant increase from the last report (12% of investigations).
Financial harm Financial harm covers theft, fraud, pressure to hand over or sign over property or money, misuse of property or welfare benefits, stopping someone getting their money or possessions, being scammed by rogue traders, online scams, by email or by post. One in five investigations **(20.6%)** cites financial harm as the main type of harm reported.
Physical harm Physical harm means any nonaccidental trauma, injury, or condition, including inadequate nourishment that, if left unattended, could result in death, disfigurement, illness, or temporary or permanent disability of any part or function of the body, including inadequate nourishment. Physical harm was the main type of harm investigated in **19.1%** of investigations.
Self-harm Self-harm is when somebody intentionally damages or injures their body. There has been a substantial increase in the number of investigations where self-harm is reported as the main type of harm. In 2016-18, 5% of investigations related to self-harm this has risen to **18.6%** of investigations in 2018-20.
Neglect Neglect is a form of abuse where the perpetrator, who is responsible for caring for someone who is unable to care for themselves, fails to do so. It can be a result of carelessness, indifference, or unwillingness and abuse. In the previous report one in every five investigations (21%) had recorded 'neglect' as the main type of harm. This has now fallen to **9.7%** of investigations.

Sexual harm
Any type of sexual activity without consent is considered sexual harm. Sexual harm involves imposing some form of sexual act on a person who doesn't want it. This means the person does not consent. Sometimes, a person is not legally capable of consenting, or refusing consent to a sexual act. The proportion of investigations where sexual harm is the main type of harm remains fairly low (6.4%) and broadly similar to the previous report (5%). In 2019-20 there were 17 cases of sexual harm investigated.

Adult Support & Protection Report Q2 July – Sep 2021

Type of Harm	Q2 20/21 Jul-Sep	Q3 20/21 Oct-Dec	Q4 20/21 Jan-Mar	Q1 21/22 Apr-Jun	Q2 21/22 Jul-Sep	Trend	Total 20/21 Q1+Q2	Total 21/22 Q1+Q2	Trend
Financial	24	28	39	9	26	17	47	35	-12
Neglect	9	9	11	10	6	-4	12	16	4
Not known	1	0	1	1	4	3	1	5	4
Physical	28	28	36	22	16	-6	53	38	-15
Psychological	29	28	22	15	19	4	46	34	-12
Self-harm	24	15	24	25	15	-10	38	40	2
Sexual	9	3	5	9	8	-1	12	17	5
TOTAL	**124**	**111**	**138**	**91**	**94**	**3**	**209**	**185**	**-24**

Feedback from the Joint inspection report of adult support and protection services in Fife
The inspection report concluded that Fife Adult Support and Protection Partnership's key processes for adult support and protection were effective with some areas for improvement.

There were clear strengths supporting positive experiences and outcomes for adults at risk of harm, which collectively outweighed the areas for improvement.

The partnership's strategic leadership for adult support and protection was found to be very effective and demonstrated major strengths supporting positive experiences and outcomes for adults at risk of harm.

Fife partnership carried out almost all aspects of adult support and protection well. Social work staff, health professionals, and police officers worked collaboratively to make sure adults at risk of harm were safe, supported, and protected.

Reducing Harm
Actions taken to reduce harm
Priority areas:
- Service user engagement
- How to support people at risk of harm who are resistant or refuse any intervention
- Adults living at home and receiving care
- Adults living in care settings

To support this work and in line with statutory functions, the ASP committee has:

- Undertaken changes to procedures and practices, including a review of the large scale investigation procedure
- Provided information and Advice: the Committee acknowledges the importance of continually raising understanding and awareness of how to identify and report harm
- Improving skills and knowledge: Comprehensive learning and development opportunities have been made available
- Developed a service user engagement strategy

2.3.2 Workforce

The importance of multi-agency working is key.

2.3.3 Financial

n/a

2.3.4 Risk Assessment/Management

The emergence of COVID-19 created new and unprecedented national challenges to our working practices, the identification of adults at risk of harm, and the types of harm experienced.

Processes are under review to ensure that there is an effective gateway to Adult Support & Protection services for those who need it, particularly for younger adults at risk of harm and those transitioning from children to adult services.

It continues to be a challenge to embed a systematic approach to collecting data on outcomes and experiences of the adult protection journey. Not just in relation to adults at risk and if applicable, their carer/family, but also from staff involved in the adult protection process.

2.3.5 Equality and Diversity, including health inequalities

Full impact of health inequalities is considered

2.3.6 Other impact

2.3.7 Communication, involvement, engagement and consultation

ASP Committee, COPS

2.3.8 Route to the Meeting

EDG 16.12.2021

2.4 Recommendation

The Report is for assurance.

Appendices:

- Biennial Report
- ASPC Report Q2

Report Author: Janette Owens

Fife Adult Support & Protection
www.fifedirect.org.uk/adultprotection

Fife Adult Support & Protection Committee

Biennial Report 2018-20

October 2020

Contents

Foreword

As Independent Chair of Fife Adult Support and Protection Committee I am delighted to introduce this Biennial Report. This biennial report provides an analysis of the types of harm investigated and the profile of adults at risk for whom an investigation has taken place. It summarises local activity over the past two years and the key actions we have taken under our statutory functions. There is a consideration of the impact of our work, current challenges and our response to these, and sets out our focus for development and improvement over the next two years.

The Committee has worked hard to fulfil its functions as laid down in Adult Support and Protection (Scotland) Act 2007. Through commitment, creativity and strong partner working the Committee and Working Group members have; taken forward awareness raising of Adult Support and Protection; endeavoured to ensure service users have opportunities to be heard and be involved in developments; scrutinised data and developed tools to enable deeper analysis and interpretation; updated and developed policy and procedure and developed learning opportunities to ensure a partnership confident in the application of Adult Support and Protection legislation and resilient to the challenges faced in practice.

Our priorities during this period have been guided by our Improvement Plan 2018/20. Much work is being carried out to align and link National and Local priorities alongside learning from initial and significant case reviews within our Improvement Plan 2021/23.

Increasingly the Committee is working alongside colleagues in child protection and MAPPA (Multi-agency Public Protection Arrangements) to ensure there are shared learning opportunities, robust support and protection for young people transitioning into adulthood and a mutual understanding of protection, harm and responsibility across all partners working with children and adults alike.

All agencies represented on the Committee have a key role to play in the partnership and their support have been greatly valued. I am encouraged by all the hard work undertaken by frontline practitioners to help keep adults in Fife safe and would like to express my thanks to them all.

Alan Small, Fife Adult Support and Protection Committee Chair

Key Statistics 2018-20

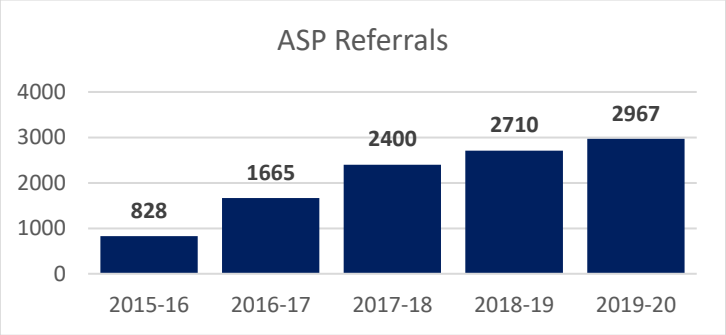
For the past two years the Committee has been provided with detailed statistical summary reports following the submission of the Scottish Government data return. Reports provide trend analysis, information on types of harm being investigated, demographic details of adults at risk and has helped to inform our local improvement planning discussions for 2021/22. In addition, it has prompted a number of interagency self-evaluation activities to provide context to emerging trends. A summary of the data is provided below.

Reports of harm

The number of Reports of harm has continued to increase in Fife on an annual basis. Whilst Police and NHS remain the largest single organisations who report harm, the significant increase in the number of referrals has come from 'other organisations' and from members of the public. The different types of harm being reported is testament to the work undertaken to continue to raise awareness of what constitutes harm and how to report it.

There has also been a slight increase in self-reported harm from 78 reports in 2016-18 to 99 in 2018-20. This may be an indication that adults are better informed in relation to being at risk of harm and more confident in reporting it.

In 2018-19, 2710 reports of harm were received, increasing to 2967 in 2019-20, and giving a total of 5677 reports of harm over the two-year period. This compares to a total of 4065 over the previous two years and represents an increase of 39.7% since the last biennial report.



Overall profile of adults at risk of harm

Over the past two years, 59% of investigations related to an individual who was aged 16-65. This is a significant change from the previous report where, for the majority of investigations (69%), the adult involved was aged 65+. There has been a 94.9% increase in investigations for adults aged under 65 between 2016-17 and 2019-20. In the same time frame there has been a 51.9% decrease in investigations for adults over 65. For adults aged over 65, the type of harm most likely to be investigated is financial harm, for adults aged under 65, investigations are more likely to relate to psychological/emotional or physical harm.

As in previous years the majority of investigations (56%) relate to an adult who identifies as female.

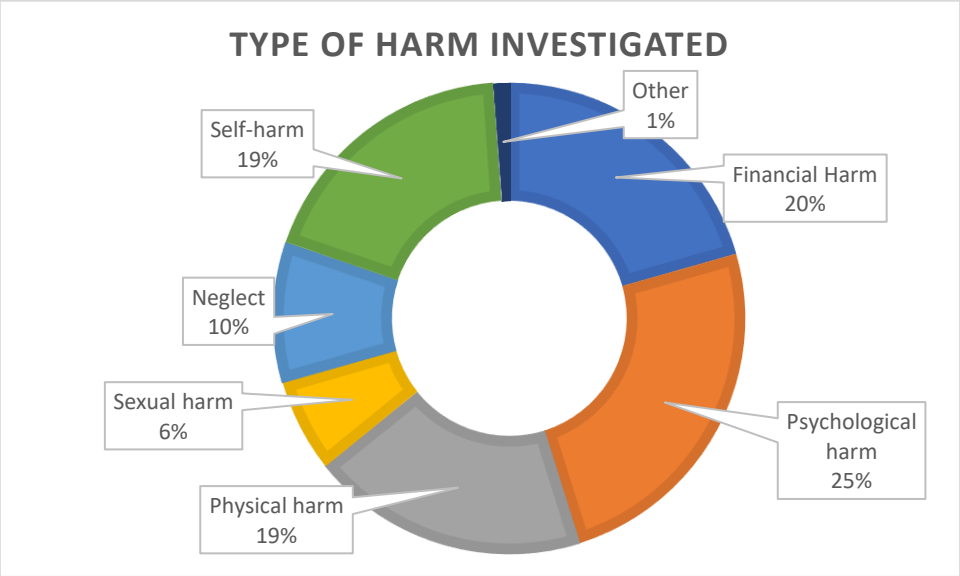
More than one in every four investigations (27.7%) relate to an adult with a physical disability. There has been a significant drop in investigations where the adult is recorded as having 'dementia' although this may be due to a change in reporting practices. The committee is exploring this further and there are indications that this may be due to how some of the information is recorded and reported on.

There continues to be a very low number of investigations for adults at risk who are from a minority ethnic group (less than 1% of investigations where ethnicity is recorded), however this is reflective of the population in Fife as a whole.

Types of harm investigated

In Fife, 724 investigations were undertaken in 2018-20, this is a reduction from 823 in the previous two years. There has been a significant decrease in investigations in care home settings from 194 (23.6% of investigations) in 2016-18 to 70 (9.7% of investigations) in 2018-20. This trend will be explored in the coming months to gain further insight.

In 2018-20, one in every four investigations (25%) relate to a report of psychological and emotional harm. High numbers of investigations also relate to financial (20%) and physical harm (19%). There has been a significant increase in investigations relating to self-harm (19%) in the two-year period. The chart below shows the main type of harm investigated for the 724 investigations undertaken over the two-year period.



For each type of harm investigated, there are some notable differences in the age, gender, and main client type of the adult at risk. Whilst caution must be taken interpreting the data, as numbers are small and there has been a change to reporting methods in the past two years, a summary of trend and profiling data for each type of harm is provided below.

Psychological and emotional harm

Many people experience psychological and emotional harm as a result of threats of harm, being left alone, humiliation, intimidation, causing distress, verbal abuse, bullying, blaming, constant criticism, controlling, depriving contact with others.

Almost one in four investigations (24.6%) carried out related to an individual at risk of psychological or emotional harm. This is a significant increase from the last report (12% of investigations). Potentially this is due to raising awareness in our communities about what constitutes harm and reinforcing the message that all types of harm (not just physical or financial harm) should be reported.

In 2019-20, the majority (60.7%) of investigations where psychological and emotional harm are reported are where the adult at risk is under 65. This accounts for 18.9% of all investigations for this

age group compared with 4.5 % of investigations where the adult at risk is aged over 65. For adults aged under 25, 40% of investigations (16/40) relate to emotional harm.

Data shows that 61% of investigations where psychological harm is reported are for female adults. Incidents happen primarily in the adults own home (62.6%) and where mental ill health, 'other' disability, or physical disability is the main reason the adult is at risk.

One in every three investigations (34.5%) where the adult at risk has mental ill health recorded as primary client group, was related to emotional or psychological harm.

Financial harm

Financial harm covers theft, fraud, pressure to hand over or sign over property or money, misuse of property or welfare benefits, stopping someone getting their money or possessions, being scammed by rogue traders, online scams, by email or by post.

One in five investigations (20.6%) cites financial harm as the main type of harm reported. This is similar to the last biennial report (19%).

In 2019-20, whilst the count of investigations for people aged 16-65 and 65+ is similar, one in every three investigations (33.1%) where the person is over 65 relates to financial harm compared with one in five investigations (19.7%) where the person is aged under 65.

For adults at risk of harm aged 80+, 39.1% of investigations related to financial harm, making financial harm the most common type of harm investigated for this age group. Financial harm is also the most common type of harm investigated for adults aged 40-64 (27% of investigations in this age group relate to financial harm).

In Fife, a financial harm working group has been established to respond to the risk of adults at risk becoming victims of financial harm.

Physical harm

Physical harm means any nonaccidental trauma, injury, or condition, including inadequate nourishment that, if left unattended, could result in death, disfigurement, illness, or temporary or permanent disability of any part or function of the body, including inadequate nourishment.

Physical harm was the main type of harm investigated in 19.1% of investigations. The proportion of investigations where physical harm was recorded as the main type of harm has reduced from 27% in the previous biennial report.

The data from 2019-20 shows that around a quarter (26.3%) of physical harm investigations are for adults who have a learning disability, indeed 43.8% of all investigations where the adult at risk has a learning disability relate to physical harm.

The majority of investigations relate to an adult under 65 (57.8%), however a significant number of investigations where the person is aged over 85 (26.4% of investigations in this age group) relate to physical harm.

The most likely location for physical harm is own home, however a significant number of investigations in care homes are where physical harm is a factor (43% of investigations where care home was the location of harm are related to physical harm).

Self-harm

Self-harm is when somebody intentionally damages or injures their body.

There has been a substantial increase in the number of investigations where self-harm is reported as the main type of harm. In 2016-18, 5% of investigations related to self-harm this has risen to 18.6% of investigations in 2018-20.

Where an investigation has been undertaken and self-harm is the primary type of harm, the person at risk is predominantly aged 16-65 (86% of all self-harm investigations in 2019-20). Where substance misuse is the client main category, 50% (5/10) of investigations relate to self-harm.

The Committee will consider the value of setting up an interagency short life working group to look at this increase in reports of self-harm, specifically in younger age groups. The aim of this is to improve identification of young adults at risk, strengthening links with partners such as Fife Drug and Alcohol partnership, Transitions team, and Fife Suicide Prevention Forum.

Neglect

Neglect is a form of abuse where the perpetrator, who is responsible for caring for someone who is unable to care for themselves, fails to do so. It can be a result of carelessness, indifference, or unwillingness and abuse.

In the previous report one in every five investigations (21%) had recorded 'neglect' as the main type of harm. This has now fallen to 9.7% of investigations.

In 2019-20 there were 36 investigations relating to neglect, there appear to be no specific trends in relation to gender, age or client group. As with other types of harm it is more likely to occur in an individual's own home than in other settings.

Sexual harm

Any type of sexual activity without consent is considered sexual harm. Sexual harm involves imposing some form of sexual act on a person who doesn't want it. This means the person does not consent. Sometimes, a person is not legally capable of consenting, or refusing consent to a sexual act.

The proportion of investigations where sexual harm is the main type of harm remains fairly low (6.4%) and broadly similar to the previous report (5%). In 2019-20 there were 17 cases of sexual harm investigated. Of these 16 of the 17 were where the adult at risk was under 65 and 14 of the 17 were female. The most likely location of sexual harm reported was recorded as 'own home' or 'other private address'.

Location of harm investigated

As in previous years, the most commonly reported place that alleged harm occurred, resulting in an investigation, was in the adult's own home (71% of investigations where the location is known). We will continue to work with communities and agencies with access to homes as part of their job role to ensure that they are confident and competent in recognising, responding and reporting harm identified or disclosed. This will be particularly important in light of the impact of COVID-19.

There has continued to be a reduction in investigations where the location of harm is reported as a care home from 194 in 2016-18 to 70 in 2018-20 (a reduction of 124 investigations or 63.9% over 2 years). Where a care home is the location of harm, the main type of harm reported is physical harm (43.2% of investigations in care homes).

Outcome of investigation

Around half of investigations in 2018-20 are recorded as no further action (50.5%). A spot check of data showed that in many cases there was further action taken but not by social work, so for example a referral had been made to a third sector organisation. Through the social work performance monitoring protocol, recording of process outcomes will be monitored more closely to ensure that the outcomes are being recorded consistently and we can extract more meaningful data in relation to process outcomes.

In the past two years we have seen an increase in both the number of initial and review case conferences, a total of 175 case conferences were convened in 2018-20, compared with 108 in the previous two years.

Large scale investigations totalled four, comprising three in 2019-20 and one in 2018-19.

During 2018/20 five initial case reviews were discussed by the Committee's case review working group. Of these, one initial case review has met the criteria to progress to significant case review. Key characteristics and themes have been extracted and presented to the Committee. These include complex areas including suicide and mental ill health.

Actions taken to reduce harm

There has been considerable activity undertaken in 2018-20 under the auspices of the Committee. The previous report identified the following priority areas for 2018-20

- Service user engagement
- How to support people at risk of harm who are resistant or refuse any intervention
- Adults living at home and receiving care
- Adults living in care settings

To support this work and in line with statutory functions the Committee has; developed, revised and approved policies and procedures; information has been disseminated to staff and partner agencies; and actions have been taken to enhance learning and knowledge across Fife communities. The actions taken under each of the statutory functions is summarised below.

Changes to procedures and practices

To improve practice and consistency, the Committee has reviewed and/or published several strategies and procedures during the two-year period including;

- A review of the Large-Scale Investigation (LSI) Procedure
- Development of Interagency chronology protocol
- Development of Engagement escalation process and revised multiple report of harm protocol
- Missing person strategy developed

The implementation of a social work Adult Protection performance monitoring protocol has enabled further analysis of the management of information on an ongoing basis. The process has enabled social work managers to monitor and scrutinise data in relation to activity, timeliness and delay reasons, thresholds and process outcomes. It has stimulated discussions and peer review activities. Self-evaluation activities and improvement actions are set and reviewed on a quarterly basis. A consultation about the approach was held with staff in December 2019 and following positive feedback and the approach will be embedded over the next two years.

Information and advice

The Committee acknowledge the importance of continually raising understanding and awareness of how to identify and report harm. Over the past two years we have;

- Coordinated awareness raising events for Adult Protection Awareness Week (February)
- Delivered 7-minute briefings to interagency staff based on identified gaps in learning (A 7 Minute Briefing is a tool used to promote learning and reflection on a specific topic in 7 minutes. The tool is often used to deliver learning when a gap is identified in practice).
- Developed a service user engagement strategy
- An Engagement and Participation Coordinator working directly with community groups
- Reviewed the ASP Website
- Distributed the monthly ASP newsletter
- Set up the Financial Harm (short life) working group where a Financial Harm Protocol has been drafted and is currently being embedded in to practice.
- Progressed the development of a regular, local practitioners form

Improving skills and knowledge

Comprehensive learning and development opportunities have been made available to staff in both statutory and voluntary sectors in Fife. Some, such as the Council Officer modules, are more specific and targeted to certain parts of the workforce. Training opportunities developed by the Committee through 2019/20 include:

- Harm in the home training for Care at home and housing support provider managers
- Harm in care settings training for care home managers
- Interagency crossing the acts training
- Investigative interview training
- IRD Aide Memoire
- 2nd Person Aide Memoire

A full list of training options available- Fife ASP Training Courses.

In addition to evaluating individual courses at the point of completion, it is the intention to develop an annual interagency staff survey which will link to the ASP competency framework and measure staff confidence, any gaps in knowledge, and will also aim to better understand experiences of staff involved in the prevention of harm or supporting adults who have been harmed, ensuring that staff feel supported.

Service user engagement

Service User Engagement was a key area for development in the previous improvement plan. A service user engagement strategy has been developed, highlighting areas of good practice and areas for further development. To achieve the vision and ambitions set out in the strategy, we need to reassess our approach to gathering feedback and adopt a systematic approach to gathering and reporting on all stakeholder feedback. The Committee will endeavour to consider new and creative opportunities to gather feedback from service users, carer and family (where appropriate) alike. Consideration is being given to a regular, local service user forum aligned with the practitioner forum. We will drive this forward over the next two years.

Outcome of activities

Identifying and reporting harm is key to ensuring that adults at risk are safe from harm. Analysis of data indicates that there has been increased reports of harm from different referral sources. This indicates that a wider range of agencies (and individuals) are confident in recognising and reporting harm. In particular, work done within the NHS to clarify and streamline ASP referral procedures has seen a 28% increase in referrals from 322 in 2018-19 to 411 in 2019-20.

Single and interagency audits have provided evidence of good practice in relation to correct application of thresholds guidance, presence of chronologies, effective multi agency working, analysis of risk and information sharing. They have also demonstrated a range of positive outcomes for the adult at risk. Learning and good practice gleaned from the audits is shared and improvement plans are put in place, embedding a culture of continuous improvement. Over the next two years we will review our audit tools and methodologies to ensure that they are outcome focussed and aligned to national quality indicators.

The number of Adult Protection Investigations in care homes has continued to fall, it is hypothesised that this could be linked to preventative work to reduce the risk of harm, the introduction of the new LSI procedure, and increased professional understanding of the ASP legislation and thresholds as a result of clear leadership and continued professional development and learning. This trend will be investigated further in coming months.

The introduction of the social work performance management protocol has increased opportunities for all social work staff to contribute to identifying ways to continuously improve and streamline practices. It has stimulated peer review activities around thresholds and process outcomes and data quality has also improved. It is anticipated that improved performance management processes will support managers to easily identify trends and also to identify if staff require support for example to meet deadlines in relation to timeliness.

Challenges faced

The emergence of COVID-19 will of course create new and unprecedented national challenges to our working practices, the identification of adults at risk of harm, and the types of harm experienced. The impact of the virus to adults at risk has yet to be fully understood. We are in the process of developing a COVID-19 recovery plan to ensure that adults at risk of harm continue to be identified at the earliest possible stage and that they receive effective, person centred and timely support. Separate to this plan, but interlinking, we will develop a comprehensive Communications plan. Due to the challenges faced as a result of COVID19, the updated Adult Support and Protection Committee Improvement Plan has been delayed and will now cover 2021/2023.

Over the past two years we have seen an increase in investigations for younger adults and a change in the predominant types of harm that are being investigated. Psychological / emotional harm and self-harm has increased. We will review our processes to ensure that there is an effective gateway to Adult Support & Protection services for those who need it, particularly for younger adults at risk of harm and those transitioning from children's to adult services.

We continuously strive to identify adults at risk of harm and during 2018-20 reports of harm have continued on an upward trajectory. Whilst this can be used as a measure of success, there is no doubt that this puts pressure on social work and partner agencies to provide an effective and timely response to Adult Protection referrals. Social Work Managers need to have access to accurate, timely performance data so as they can manage workload efficiently and support staff to achieve challenging service standards, offering guidance where required.

It continues to be a challenge to embed a systematic approach to collecting data on outcomes and experiences of the adult protection journey. Not just in relation to adults at risk and if applicable, their carer/family, but also from staff involved in the adult protection process. The Service User Engagement strategy has set out a vision for increased opportunities for adults at risk to participate in performance planning and share experiences, we need to build on this impetus to ensure that this ambition is achieved. Over the next two years there will be a focus on reviewing our audit tools and approach to self-evaluation, building in feedback mechanisms and outcome measurement tools will be integral to this. We will develop mechanisms to systematically collect data on experiences from staff, adults at risk and their carers. We will draw on data and information from all available sources to ensure that decision making can be evidence led and fully informed by all stakeholders.

Plans for 2021/23

The Committee has outlined priority areas to include in its next improvement plan. These have yet to be developed into specific, measurable actions. The focus will be on;

- Developing and implementing a COVID-19 Recovery Plan
- Ensuring that all adults at risk of harm are recognised and responded to at the earliest stage
- Ensuring that young adults at risk of harm receive a timely, consistent and person-centred interagency response
- Transforming our approach in relation to collecting and using data and information to measure and continuously improve the quality of our processes and outcomes for people at risk of harm.
- Working in partnership with Fife Suicide Prevention Forum to reduce the number of people who complete suicide
- Continue to embed our Financial Harm Protocol in our practice
- Consideration to be given to links between Homelessness and Adult Support and Protection in Fife and to take forward actions to reduce and support this population
- To continue to strive to ensure that service users, their carers and family have opportunities to influence practice and provide feedback of their experiences

The rationale for setting the above objectives has been eluded to throughout the report. Primarily there is a need to respond quickly and effectively to the COVID-19 pandemic and the impact this has both on working practices and risk of harm. It is important to acknowledge that COVID19 only impacted on one month (March 2020) of the time frame considered within this Biennial Report. Linked to this is a commitment to ensure that all adults at risk of harm are recognised and responded to at the earliest possible stage. This will be achieved by developing a comprehensive communications strategy to reinforce the message that Adult Protection is everyone's business.

Our data has shown that there has been an increase in investigations where the adult at risk was under 65, and that often the types of harm experienced in this age range can differ from older age groups. We are committed to evaluating our pathways and strengthening our partnerships to ensure that younger adults at risk of harm receive a timely, consistent and person-centred interagency response.

Underpinning all of the above will be a focus on transforming the way we collect and use data, including through audits, stakeholder feedback, and other self-evaluation activity. This will enable us to gain greater insight of the quality of our response to reports of harm, and the lived experiences of adults at risk, carers and interagency staff involved in adult protection work.

Further information in relation to Adult Support and Protection and Fife's proprieties going forward can be found at www.fifedirect.org.uk/adultprotection

Chairs closing remarks

There has been considerable work undertaken by all partners during 2019/2020 under the auspices of the Committee. The Committee has evidenced strength and resilience during periods of particular and unexpected adversity, primarily those relating to COVID19. Recovery planning is underway and we will endeavour to ensure that learning identified during this time is embedded into practice and that adults at risk of harm continue to receive timely and person centred support.

Once again, I would like to thank everyone in Fife who is involved in preventing harm and supporting those who have been harmed.

I very much look forward to learning of further successes and initiatives undertaken by the partnership to help keep adults safe.

Alan Small, Fife Adult Support and Protection Committee Chair

Appendix 1

Summary Tables:

Section A: Data on referrals

Q1: Summary of Referrals over the past 5 years

	2015-16	2016-17	2017-18	2018-19	2019-20
Q1	220	375	510	757	725
Q2	197	427	502	659	757
Q3	188	410	588	671	730
Q4	223	453	800	623	755
Total	**828**	**1665**	**2400**	**2710**	**2967**

Q2: Referrals by Source –over the last 5 years[1]

Categories	2015-16	2016-17	2017-18	2018-19	2019-20
NHS	101	229	365	322	411
GPs	13	45	64	131	180
Scottish Ambulance Service	0	3	3	0	3
Police	78	87	249	375	377
Scottish Fire & Rescue Service	7	77	74	63	69
Office of Public Guardian	0	3	2	0	2
Mental Welfare Commission	0	0	0	0	0
Healthcare Improvement Scotland	0	0	0	0	0
Care Inspectorate	2	15	31	0	7
Other organisation	0	462	692	990	1002
Social Work	90	216	258	293	310
Council	124	272	343	194	193
Self (Adult at risk of harm)	19	38	40	49	50
Family	0	39	48	0	117
Friend/Neighbour	0	136	13	0	35
Unpaid carer	0	0	0	0	0
Other member of public	99	7	178	218	122
Anonymous	6	25	33	74	89
Others	289	11	7	1	0
Total	**828**	**1665**	**2400**	**2710**	**2967**

Outcome of referral–over the last 5 years (Section E)

Outcome	2015-16	2016-17	2017-18	2018-19	2019-20
Further Adult Protection Action	450	610	1398	1825	2103
Further Non-AP Action	238	301	332	242	256
No further action	115	713	610	560	518
Not recorded	25	41	60	83	90
Total	**828**	**1665**	**2400**	**2710**	**2967**

Investigations – over the last 5 years (Section B)

	2015-16	2016-17	2017-18	2018-19	2019-20
Number of Investigations	333	444	379	339	385

[1] Please note that Scottish Ambulance Service and Family are new dropdown categories to enable reports. The decline in 'other member of public' can be attributed to referrals being correctly classified into Friend/ Neighbour or Family for 2019-20

Investigations by client group - over the last 5 years (Section B)

Client groups	2015-16	2016-17	2017 - 18	2018-19	2019-20
Dementia	173	157	101	3	10
Mental health problem	24	37	54	40	58
Learning disability	29	63	70	44	57
Physical disability	29	54	46	97	109
Infirmity due to Age	23	49	48	47	53
Substance misuse	2	19	11	1	10
Other	53	65	49	107	88
Total	**333**	**444**	**379**	**339**	**385**

Investigations by type of harm - over the last 5 years (Section B)

Type of harm	2015-16	2016-17	2017-18	2018-19	2019-20
Financial Harm	47	68	91	52	97
Psychological harm	30	46	49	94	84
Physical harm	99	120	106	43	95
Sexual harm	12	20	19	29	17
Neglect	73	104	66	34	36
Self-harm	26	19	23	85	50
Other	46	67	25	2	6
Total	**333**	**444**	**379**	**339**	**385**

Investigation by location where principal harm took place - over the last 5 years (Section B)

	2015-16	2016-17	2017-18	2018-19	2019-20
Own home	167	264	246	226	227
Other private address	9	6	13	9	14
Care home	136	128	66	33	37
Sheltered housing or other supported accommodation	4	17	5	9	7
Independent Hospital	0	1	0	1	3
NHS	10	16	19	11	14
Day centre	1	1	5	0	1
Public place	5	9	20	27	16
Not known	1	2	5	23	66
Total	**333**	**444**	**379**	**339**	**385**

Outcome of Investigations - over the last 5 years (Section E)

Outcome	2015-16	2016-17	2017-18	2018-19	2019-20
Further AP action	Not Monitored	75	48	34	44
Further non-AP action		214	166	102	131
No further action		137	157	165	201
Not known (ongoing)		18	8	38	9
Total		**444**	**379**	**339**	**385**

Number of Investigations by Age and Gender - over the last 3 years (Section B)

Age Group	Number of investigations by age and gender											
	2017-18				2018-19				2019-20			
	Male	Female	Not known	All adults	Male	Female	Not known	All adults	Male	Female	Not known	All adults
16-24	7	18	0	25	17	15	0	32	16	22	2	**40**
25-39	10	8	0	18	28	26	0	54	37	29		**66**
40-64	49	49	0	98	56	60	0	116	55	67		**122**
65-69	13	13	0	26	6	9	0	15	10	8		**18**
70-74	14	19	0	33	9	10	0	19	6	11		**17**
75-79	22	21	0	43	9	13	0	22	9	16		**25**
80-84	30	35	0	65	10	20	0	30	17	27		**44**
85+	26	45	0	71	15	36	0	51	17	36		**53**
Not known	0	0	0	0	0	0	0	0				**0**
Total	171	208	0	**379**	150	189	0	**339**	167	216	2	**385**

Number of Investigations by Age and Ethnic Group - over the last 3 years (Section B)

	2017-18								2018-19								2019-20							
Age Group	White	Mixed or multiple ethnic groups	Asian, Asian Scottish or Asian British	African	Caribbean or Black	Other ethnic group	Not known	All adults	White	Mixed or multiple ethnic groups	Asian, Asian Scottish or Asian British	African	Caribbean or Black	Other ethnic group	Not known	All adults	White	Mixed or multiple ethnic groups	Asian, Asian Scottish or Asian British	African	Caribbean or Black	Other ethnic group	Not known	All adults
16-24	23	0	0	0	0	1	1	**25**	27	1	0	0	0	1	3	**32**	37	0	1	0	0	0	2	**40**
25-39	18	0	0	0	0	0	0	**18**	48	0	2	0	0	1	3	**54**	63	0	0	0	0	1	2	**66**
40-64	95	1	0	0	0	0	2	**98**	101	0	1	0	0	3	11	**116**	115	0	0	0	0	0	7	**122**
65-69	25	0	0	0	0	0	1	**26**	13	0	0	0	0	0	2	**15**	15	0	0	0	0	0	3	**18**
70-74	32	0	0	0	0	0	1	**33**	16	0	0	0	0	0	3	**19**	16	0	0	0	0	0	1	**17**
75-79	43	0	0	0	0	0	0	**43**	19	0	0	0	0	0	3	**22**	22	0	0	0	0	0	3	**25**
80-84	64	0	0	0	0	0	1	**65**	30	0	0	0	0	0	0	**30**	36	0	0	0	0	0	8	**44**
85+	64	1	0	0	0	2	4	**71**	47	0	0	0	0	0	4	**51**	48	0	1	0	0	0	4	**53**
Not known	0	0	0	0	0	0	0	**0**	0	0	0	0	0	0	0	**0**		0	0	0	0	0	0	**0**
Total	364	2	0	0	0	3	10	379	301	1	3	0	0	5	29	339	352	0	2	0	0	1	30	385

ASP Case Conferences - over the last 5 years (Section C)

Type of ASP Case Conference	2015-16	2016-17	2017-18	2018-19	2019-20
Initial ASP case conference	48	29	44	59	58
Review ASP case conference	23	15	20	33	25
ASP case conference*	0	0	0	0	0
Total	**71**	**44**	**64**	**92**	**83**

Number of LSI commenced - over the last 5 years (Section D)

	2015-16	2016-17	2017-18	2018-19	2019-20
Total number of LSI	7	4	3	1	3

Fife Adult Support & Protection
www.fifedirect.org.uk/adultprotection

Adult Support and Protection Committee
Quarterly Statistical Report

Date: 11th October 2021

Introduction

The following report details the number and source of Adult Support & Protection referrals received on a quarterly basis. This may be used by individual agencies for monitoring and contextual purposes should notable changes be observed.

Further information on investigations concluded within the quarter includes the type / location of harm investigated and a profile of the adults involved which allows quarterly monitoring of the information which will be provided to the Scottish Government on an annual basis.

Following inspection feedback and in line with the SE&I workplan to develop a performance framework, it is proposed that a number of additional indicators be discussed for addition to future reports.

ASP Referrals (SOURCE)

During Q2 (Jul to Sep 2021), there were 657 reports of harm recorded for 558 individuals.

This represents a decrease of 18% on the previous quarter (-145 reports, from 802 in Q1 to 657 in Q2) and a reduction of 20% on the same period of the previous year (-165 reports, from 822 in Q2 of 2020/21). It should be noted, however, that the quarters for comparison (Q2 of 2020/21 and Q1 of 2021/22) were higher than usual (800+ reports) with levels last period (Q1) rising by 148 reports as compared to the previous quarter.

Police continue to make the highest number of referrals (22% of total or 143 of 657 reports). Other sources with a higher volume of harm reporting during Q2 as compared to the previous quarter include Other Agency (+13), Care Inspectorate (+8) and Family (+7).

The number and source of reports of harm received on a quarterly basis are shown on the page overleaf. The list of referral sources is refined prior to submission to the Scottish Government. The cumulative number of individuals referred in the year will be provided in this report.

Referral Source	Q2 2020/21 (Jul to Sep)	Q3 2020/21 (Oct to Dec)	Q4 2020/21 (Jan to Mar)	Q1 2021/22 (Apr to Jun)	Q2 2021/22 (Jul to Sep)	Trend	Cumulative Total 2020/21	Cumulative Total 2021/22	Trend	Year End Total 2020/21
Agency notification	29	32	24	48	42	-6	49	90	41	105
Ambulance Service	4	7	12	18	7	-11	11	25	14	30
Anonymous	7	10	4	2	3	1	19	5	-14	33
Care Inspectorate	3	4	3	3	11	8	4	14	10	11
Careers	0	0	0	0	0	0	1	0	-1	1
Councillor / Elected Member	1	0	0	1	1	0	1	2	1	1
Education (Fife / Other LA)	1	0	0	4	2	-2	7	6	-1	7
External support worker	107	83	78	73	59	-14	196	132	-64	357
Family	45	32	38	37	44	7	90	81	-9	160
Fife Council Housing	23	25	31	29	24	-5	42	53	11	98
Fire Service	22	17	7	21	9	-12	33	30	-3	57
Friend / Neighbour	16	13	14	13	14	1	44	27	-17	71
Healthcare Improvement Scotland	1	0	0	0	0	0	1	0	-1	1
Internal (Other SW Team)	61	64	71	65	57	-8	104	122	18	239
Legal (Lawyer / PF / Prison)	1	0	1	0	0	0	1	0	-1	2
Not recorded	10	7	4	7	4	-3	27	11	-16	38
Office of Public Guardian	2	1	0	1	2	1	2	3	1	3
Other agency	53	78	45	50	63	13	95	113	18	218
Other Fife Council Service	26	24	25	28	20	-8	59	48	-11	108
Other Housing Agency	9	16	13	22	22	0	25	44	19	54
Other Local Authority	3	3	6	3	2	-1	8	5	-3	17
Police	213	155	165	207	143	-64	345	350	5	665
Primary Health	42	39	22	30	22	-8	76	52	-24	137
Reporter	1	1	0	0	0	0	1	0	-1	2
Public Health Nurse	5	1	1	3	6	3	5	9	4	7
Secondary Health	123	66	72	114	91	-23	199	205	6	337
Self	10	7	15	18	8	-10	15	26	11	37
Voluntary Organisation	3	1	1	1	0	-1	5	1	-4	7
Welfare Fund	1	2	2	4	1	-3	1	5	4	5
TOTAL	**822**	**688**	**654**	**802**	**657**	**-145**	**1466**	**1459**	**-7**	**2808**

Questions to consider:

- *Overall, have the number of referrals notably increased or decreased this quarter? Possible reasons?*
- *Has there been a notable increase or decrease from any particular source? Why?*
- *Have the referrals in your agency notably increased or decreased? Why?*
- *Are there actions your agency has taken / could take to increase early identification of harm?*
- *Do you have any good practice to share?*
- *What possible impact has Covid-19 had on recognising and reporting harm this quarter?*

ASP Investigations

During Q2 (Jul to Sep 2021), there were 94 investigations relating to 93 individuals. This represents a small rise as compared to the previous period (+3, 91 in Q1). Individuals are counted more than once where there have been multiple investigations.

Age and Gender Demographics

Age Range	Female	Male	TOTAL
16 to 24	5	6	11
25 to 39	10	13	23
40 to 64	14	5	19
65 to 69	2	2	4
70 to 74	4	1	5
75 to 79	8	4	12
80 to 84	7	4	11
85+	6	3	9
TOTAL	**56**	**38**	**94**

A higher proportion (60%) of investigations relate to adults identifying as female (56 of 94).

Continuing the trend observed over the past two years, a higher proportion of investigations involve individuals under 65 (56% or 53 of 94). However, there has been a rise in investigations relating to persons aged 75+ this quarter, namely 34% in Q2 (32 of 94) as compared with 16% in Q1 (15 of 91).

Client Main Category

Main Client Group	Q2 20/21 Jul-Sep	Q3 20/21 Oct-Dec	Q4 20/21 Jan-Mar	Q1 21/22 Apr-Jun	Q2 21/22 Jul-Sep	Trend	Total 20/21 Q1+Q2	Total 21/22 Q1+Q2	Trend
Dementia	3	3	5	1	1	0	3	2	-1
Infirmity due to age	16	15	16	8	17	9	25	25	0
Learning disability	12	9	15	10	10	0	26	20	-6
Mental health	31	31	25	14	15	1	44	29	-15
Other	26	26	39	33	28	-5	48	61	13
Physical disability	35	26	36	24	21	-3	59	45	-14
Substance misuse	1	1	2	1	2	1	4	3	-1
TOTAL	**124**	**111**	**138**	**91**	**94**	**3**	**209**	**185**	**-24**

There continues to be a high proportion of clients categorised as 'Other' on the SW case management system (30% of total, 28 of 94 in Q2). There has also been a rise in 'Infirmity due to age' (+9 on last quarter).

Main Category of Harm

Type of Harm	Q2 20/21 Jul-Sep	Q3 20/21 Oct-Dec	Q4 20/21 Jan-Mar	Q1 21/22 Apr-Jun	Q2 21/22 Jul-Sep	Trend	Total 20/21 Q1+Q2	Total 21/22 Q1+Q2	Trend
Financial harm	24	28	39	9	26	17	47	35	-12
Neglect	9	9	11	10	6	-4	12	16	4
Not known	1	0	1	1	4	3	1	5	4
Physical harm	28	28	36	22	16	-6	53	38	-15
Psychological harm	29	28	22	15	19	4	46	34	-12
Self-harm	24	15	24	25	15	-10	38	40	2
Sexual harm	9	3	5	9	8	-1	12	17	5
TOTAL	**124**	**111**	**138**	**91**	**94**	**3**	**209**	**185**	**-24**

During Q2 (Jul to Sep 2021), the highest number of investigations relate to financial harm (28% or 26 of 94).

Incident Location

The most likely location of harm continues to be within the individual's own home (53% or 50 of 94). For a third of cases (33%), the location of harm is recorded as not known (31 of 94). A small number of investigations have been undertaken (3) where the location was recorded as a care home.

Location of Harm	Q2 20/21 Jul-Sep	Q3 20/21 Oct-Dec	Q4 20/21 Jan-Mar	Q1 21/22 Apr-Jun	Q2 20/21 Jul-Sep	Trend	Total 20/21 Q1+Q2	Total 20/21 Q1+Q2	Trend
Care home	5	5	9	5	3	-2	9	8	-1
NHS	2	1	5	0	1	1	3	1	-2
Not known	28	22	45	27	31	4	41	58	17
Private address	5	3	2	4	4	0	9	8	-1
Own home	74	74	70	46	50	4	128	96	-32
Public place	5	2	4	5	4	-1	9	9	0
Sheltered housing	5	4	3	4	1	-3	10	5	-5
TOTAL	**124**	**111**	**138**	**91**	**94**	**3**	**209**	**185**	**-24**

Additional Measures 2021/22

Following inspection feedback and in line with the SE&I workplan to include additional measures, the previous report proposed that further indicators be selected from the quarterly SW case file audit for further scrutiny. This will be progressed next quarter following further discussion with the AS&P Quality Assurance and Development Officer and the AS&P Coordinator. Data reporting and performance monitoring is now being carried out by the Performance Improvement and Planning Team.

If you have comments or questions about this report, please contact Katie Jones (PIP Officer) at: Katie.Jones@fife.gov.uk

Fife NHS Board

CONFIRMED

NOTES OF THE PUBLIC HEALTH ASSURANCE COMMITTEE MEETING HELD ON WEDNESDAY, 20 OCTOBER 2021 AT 1030AM VIA MICROSOFT TEAMS

Present:	**Joy Tomlinson (JT)**	**Director of Public Health (Chair)**
	Olukemi Adeyemi (OA)	Consultant in Public Health
	Lynn Barker	Associate Director of Nursing
	George Brown (GB)	Emergency Planning Officer
	Hazel Close (HC)	Lead Pharmacist Public Health
	Sharon Crabb (SC)	Interim Service Manager (for JON)
	Esther Curnock (EC)	Deputy Director of Public Health
	Duncan Fortescue-Webb (DFW)	Consultant in Public Health Medicine
	Sarah Nealon (SN)	Project Support Officer
	Emma O'Keefe (EO'K)	Consultant in Dental Public Health
Apologies:	Fiona Bellamy (FB)	Senior Health Protection Nurse Specialist
	Lynn Burnett (LB)	Health Protection Nurse Consultant
	Cathy Cooke (CC)	Public Health Scientist
	Julie O'Neill (JON)	Service Manager
In Attendance:	Shona Lumsden	PA to Director of Public Health

ACTION

1. WELCOME AND APOLOGIES

JT welcomed everyone to the meeting. Apologies were noted as above.

2. MINUTE OF THE MEETING HELD ON 10 AUGUST 2021

Minutes of previous meeting tabled for approval. Please send any comments/amendments to SN by Friday, 25 October. **ALL**

3. MATTERS ARISING

See separate Action log.

4. TESTING REPORT TO CLINICAL GOVERNANCE COMMITTEE (CGC)

JT explained we have received a request from the Clinical Governance Committee to provide an update at their next meeting; following discussion, agreed that this paper will cover Testing and Test & Protect. It was noted there may be a further request for the papers to be submitted to the newly formed Public Health & Wellbeing Committee. **DFW**

ACTION

DFW reported that we are in a good position with testing, particularly community testing and that we have essentially reached our intended delivery of services.
Case rates are generally increasing across Scotland with Fife being no exception. Demand for testing in Fife appears to be declining slowly which creates its own risk and could potentially see undertesting if this continues. Ensuring we are testing in the right area is often difficult therefore a review is being done weekly to take our best inference and to relocate mobile vans relatively quickly.
The Communications and Engagement subgroup are working to engage with communities to increase the likelihood of testing.
An additional challenge that faces us is the potential for severe/bad weather this winter which could affect mobile testing sites. Mobile sites run the risk of having to be closed therefore limiting access for members of the public and staff.
Another risk is there is uncertainty around how long the funding will continue for Test and Protect. Many staff contracts are due to finish at the end of March 2022 . It is hoped we get some clarity around this in a week or two.
As we go further into winter we can expect to see an increase of cases based on last winter's experience. Some events such as COP26 may see an increase in transmission. This will likely add pressure on the contact tracing system.
It was agreed to produce a report for Clinical Governance Committee and Public Health & Wellbeing Committee with the theme being 'preparing for winter'. **DFW**
SL to forward dates of future committee Clinical Governance Committee meetings. **SL**

5. UPDATE NO CERVIX EXCLUSION INCIDENT (verbal update)

OA provided an update on the Cervical Screening incident discussed at the last meeting. The multidisciplinary team continue to collate figures. Every patient that is still alive and identified as having been incorrectly excluded or not enough information available have been contacted and invited for colposcopy assessment. It was noted that some have not attended. Overall since March, in Fife we have investigated 191 cases. Out of the 191 patients, 44 are deceased however these cases will still be reviewed. Conclusion for this element of the investigation – there is no further action required for 149 cases. Another 40 out of the 191 were either individuals from the records that were incorrectly excluded and still within the cervical screening age and were put back into the screening programme or if they were over the age range, were referred for colposcopy screening.
For those referred for colposcopy screening, 6 clinics have been run since July. The final picture from these clinics is pending at this point.
JT explained it had been the intention to have a written report at

today's meeting ready for submission to CGC but because of the ongoing national elements of this investigation it was agreed to defer this until the outcomes of the local investigations and national investigations are complete. The local team are waiting additional national data before we conclude the report. It is likely this will be with us in November, so report will be tabled in December at the earliest.

6. TERMS OF REFERENCE

A draft copy of the PHAC ToR was tabled for information and comment.

Once the NHS Board has finalized the Public Health & Wellbeing Assurance group terms of reference in November we can look in detail at the link between PHAC, CGC and the Public Health & Wellbeing committee. It was suggested that we encompass successes as well as the risks into the ToR for this committee. Sharing of good practice evidence base is always a good thing to articulate and showcase

EC suggested removed Item 3.2 and to look at more generic functions rather than a Covid statement.

LB suggested a change of wording for Item 3.5 to make it more meaningful to this group.

LB suggested removing the element around professional registration.

EOK agreed to liaise with paeds/ICU in GDC for thoughts. **EOK**

JT requested that final comments be passed to her by Friday, 22 October. A final draft will be prepared taking into consideration the Terms of Reference of the new Public Health & Wellbeing Assurance group.

RISK MANAGEMENT

7. IDENTIFIED NEAR MISSES, CRITICAL INCIDENTS & LEARNING

7.1 Testing Samples Collected by Member of the Public

DFW reported on the outcome from the recent incident and advised that a system has been put in place to verify the person collecting samples. It is clear that the responsibility lies with the site test lead. This has been integrated into the SOP and it is felt this is unlikely to happen again. It was agreed to verify the changes made are working and to consider using the 'Ask 5' approach to achieve this. **DFW**

7.2 Wrong Second Covid19 Vaccination

EC reported that discussions are ongoing with FCVC and a Clinical Assurance group has been formed which is looking at issues being reported. The volume of issues being raised led to development of the Clinical Assurance Group. This will sit under the flu/covid (FVCV) programme board. It is a positive development. ToR for this group will be discussed under AOB.

EC noted that an IMT will take place this afternoon regarding a

further incident around vaccine type.

ACTION

8. NEW PROSPECTIVE RISKS

8.1 COP26 (Health Protection & Resilience)

GB provided a brief update on COP26 planning meetings which are taking place. He noted that world leaders will only be in Scotland for 2/3 days out of the 15 days so this will be the peak time of concern. The blue zone is a UN zone and not part of Scotland anymore and will be patrolled by UN troops.

A reporting process will commence on Monday, 25 October with reports being submitted twice daily during COP26 and a reporting template has been produced.

Police Scotland are suggesting the main risk will be from protestors. Work has been underway to update the NHS Fife Major Incident Plan and the Mass Casualty Plan. Training has also been ongoing. We do not know if there will be any delegates residing in Fife.

From a workforce perspective it would be helpful to have clarity on transport network disruptions.

8.2 Consideration of New Screening Risk

It was agreed to produce an overarching risk for the restart of the screening programmes. **OA**

8.3 Re-emerging infections

EC explained she had heard there was a new UK level group looking at pandemic awareness with a Scottish element. No further information available on this as yet however there was an expectation that future pandemic planning was broader than flu. It was agreed to pause this item as a new risk but to keep under review.

9. REVIEW OF CURRENT RISKS ON PUBLIC HEALTH REGISTER

9.1 518 Resilience

On 23 September an emergency planning workshop looking at major incident planning was held for the Executive Team. A virtual control room within Microsoft Teams has been set up for Executives oncall and familiarisation is ongoing. Various forms and templates have been uploaded on to the virtual control room which can be used in an incident. Notes from the learning on the day and a few final actions to have to be followed through then we will feed back to the group.

Cyber threat training sessions have been carried out for front line staff.

Recruitment of Head of Resilience is underway with interviews to be held early November. Risk remains moderate. It was agreed to update this risk at the December meeting.

Update was agreed.

9.2 528 Pandemic Flu Planning

It was agreed to reconvene the local group who can learn from our current experiences and having worked through a pandemic what are the key things we know we are going to need. Having this agreed through a multidisciplinary group would be beneficial.
It was agreed to update this risk at the December meeting.

Update agreed.

9.3 1729 Suspicion of Malignancy

It was noted there is no change to the risk level. This is an historical investigation and we now have processes in place to manage this risk. A look back is ongoing to ensure the process is in place and is working. The national advice is that this risk should stay on local risk registers and that there will also be ongoing work looking at the national element of this risk.
Next review date – being considered nationally with no plans to review in the immediate future. This will provide time locally to carry out the audit. It was agreed to update this risk at the first meeting in 2022.

Update agreed.

9.4 1837 Pregnancy and Newborn Screening

JT reported there is no change to this risk. There is a long term issue in collating the data within the clinical system which relies a lot on manual completion. It was agreed to update this risk at the first meeting in 2022.

Update agreed.

9.5 1904 Coronovirus Disease 2019 (Covid-19) Pandemic

No further changes have been made to this risk and it was agreed to update at the December meeting. SN to clarify if high level risks are required to be updated monthly. **SN**

Update agreed.

9.6 1905 Contact Tracing including TTIS Programme

DF reported our current position is good however winter is expected to be difficult although this can be tempered by improving vaccination rates and boosters. This should hopefully reduce the spread of infection and reduce hospitalisations.
DF provided an update on the digital tracing model being introduced. The quality of the information recorded is not as robust as during traditional contact tracing interviews. There may be whole proportions of the population who may not be engaging with digital tracing. A national improvement process is underway to try to

ensure we are getting as much as we can from Digital tracing. We will continue to offer a contract tracing service that meets the current contact tracing management framework.
JT reported there are ongoing discussions around contact tracing for the future. These are being taken forward by DsPH and SG through the tactical operating group and there will be a wider stakeholder discussion about this. Continuity of service provision has been highlighted and a recognition that this is a service we will need to retain. There is a lot of uncertainty in the medium term.

Update agreed.

9.7 1906 COVID19 Testing Programme
DFWs view is that the risk around testing is reduced because we have provided the sites and we have managed to recruit staff. Less risk because there are alternative testing options available through UK testing sites run by Scottish Ambulance Service. There are also good home kits available for LFT and PCRs so we have other routes for testing through alternative pathways.
It was agreed to reduce the risk level to Moderate 9. Testing risk will be updated at the first meeting in 2022.

Update agreed. Risk level reduced to Moderate 9.

9.8 1907 Public Health Oversight of Covid-19 in Care Homes
JT reported this risk level is unchanged at present however the risk wording needs updated. It was agreed that a re-wording of the risk be brought to the December meeting for approval. **FB**

Update agreed.

9.9 1908 Handling of Excess Deaths during the Global Covid-19 Pandemic
This risk remains unchanged. Multidisciplinary meetings taking place with an overview of this. It was agreed to update this risk at the December meeting.

Update agreed.

9.10 2005 Covid Vaccinations – Vaccine Effectiveness
It was agreed this risk would be removed from the PH Risk Register as it has been transferred over to the FCVC programme board.

Update agreed.

9.11 2025 Covid 19 Vaccinations – Long Term Infrastructure
It was agreed that this risk would be removed from the PH Risk Register as it has transferred to the FCVC programme board. EC will complete the high level risk statement for immunisations.

Update agreed.

9.12 2130 Data Flow
This risk is due to be updated on 29 October.
DFW reported that overall the general data flow is working well however there have been had a couple of enquiries from NHS Lothian requesting results not being available for clinical purposes.
It was agreed that this risk would sit with the T&P Oversight Group.

Update agreed.

9.13 2131 Test & Protect – Community Testing
It was agreed that this risk would sit with the T&P Oversight Group

Update agreed.

9.14 2141 Test & Protect
It was agreed to retain this on the PH Risk Register.

Update agreed.

10. ANY ISSUES TO ESCALATE TO CLINICAL GOVERNANCE

- Test and Test & Protect papers to be prepared for future Clinical Governance Committee or Public Health & Wellbeing Assurance Committee.

- There will be a delay submitting the lessons learned report covering the no-Cervix incident. Anticipated submission date December 2021

11. ANY OTHER COMPETENT BUSINESS

Clinical Oversight & Assurance group ToR. SN to circulate by email. **SN**

12. DATE OF NEXT MEETING

Tuesday, 14 December 2021 at 10am via MST.