# NHS Fife Clinical Governance Committee

*Thu 13 January 2022, 14:00 - 15:00*

**MS Teams**

# Agenda

**14:00 - 14:00**
0 min

## 1. Apologies for Absence

*Christina Cooper*

**14:00 - 14:00**
0 min

## 2. Declaration of Members' Interests

*Christina Cooper*

**14:00 - 14:00**
0 min

## 3. Minutes of the last Meeting held on Wednesday 3 November 2021

*Enclosed* *Christina Cooper*

Item 3 - CGC Minutes 3 November 2021 - Unconfirmed.pdf (11 pages)

**14:00 - 14:00**
0 min

## 4. Matters Arising / Action List

*Enclosed* *Christina Cooper*

Item 4 - CGC Action List 13 January 2022.pdf (1 pages)

**14:00 - 14:20**
20 min

## 5. COVID-19 UPDATES

### 5.1. Testing & Tracing Update

*Enclosed* *Dr Joy Tomlinson / Dr Chris McKenna*

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

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

*Enclosed* *Nicky Connor*

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

**14:20 - 14:40**
20 min

## 6. QUALITY / PERFORMANCE

### 6.1. Integrated Performance & Quality Report

*Enclosed* *Dr Chris McKenna / Janette Owens*

Item 6.1 - SBAR IPQR.pdf (3 pages)
Item 6.1 - IPQR.pdf (44 pages)

### 6.2. Joint Remobilisation Plan 4 2021/22

*Enclosed* *Janette Owens*

Item 6.2 - Joint Remobilisation Plan 4 2021-22.pdf (4 pages)

### 6.3. Healthcare Associated Infection Report (HAIRT)

*Enclosed* *Janette Owens*

Item 6.3 - SBAR Healthcare Associated Infection Report (HAIRT).pdf (6 pages)
Item 6.3 - Appendix 1 - HAIRT Report December 2021.pdf (15 pages)
Item 6.3 - Appendix 2 - ICC Notes 1 December 2021.pdf (8 pages)

**14:40 - 14:55**
15 min

## 7. ANNUAL REPORTS

### 7.1. Organisational Duty of Candour Annual Report (Interim)

*Enclosed* *Dr Chris McKenna*

Item 7.1 - SBAR Organisational Duty of Candour Annual Report (Interim) .pdf (4 pages)
Item 7.1 - Organisational Duty of Candour Annual Report (Interim) .pdf (20 pages)

### 7.2. Fife Child Protection Annual Report

*Enclosed* *Janette Owens*

Item 7.2 - SBAR Fife Child Protection Annual Report.pdf (9 pages)

### 7.3. Adult Support and Protection Biennial Report 2018 – 2020

*Enclosed* *Janette Owens*

Item 7.3 - SBAR Adult Support and Protection Biennial Report 2018 – 2020 Update Report.pdf (5 pages)
Item 7.3 - Appendix 1 - Biennial Report 29.10.2020.pdf (18 pages)
Item 7.3 - Appendix 2 - ASPC Report Q2 Jul to Sep 2021.pdf (4 pages)

**14:55 - 15:00**
5 min

## 8. LINKED COMMITTEE MINUTES

### 8.1. Acute Services Division Clinical Governance Committee dated 10 November 2021 (unconfirmed)

*Enclosed*

Item 8.1 - Cover Paper - Acute Services Division Clinical Governance Committee dated 10 November 2021 (unconfirmed).pdf (1 pages)
Item 8.1 - Acute Services Division Clinical Governance Committee dated 10 November 2021 (unconfirmed).pdf (20 pages)

### 8.2. Area Clinical Forum dated 7 October 2021 (confirmed) & 9 December 2021 (unconfirmed)

*Enclosed*

Item 8.2 - Area Clinical Forum dated 7 October 2021 (confirmed).pdf (5 pages)
Item 8.2 - Area Clinical Forum dated 9 December 2021 (unconfirmed).pdf (4 pages)

### 8.3. Health and Safety Sub-Committee dated 10 December 2021 (unconfirmed)

*Enclosed*

Item 8.3 - Health and Safety Sub-Committee dated 10 December 2021 (unconfirmed).pdf (3 pages)

### 8.4. Infection Control Committee dated 1 December 2021 (unconfirmed)

*Enclosed*

Item 8.4 - Infection Control Committee dated 1 December 2021 (unconfirmed).pdf (8 pages)

### 8.5. Public Health Assurance Committee dated 20 October 2021 (unconfirmed)

*Enclosed*

Item 8.5 - Public Health Assurance Committee dated 20 October 2021 (confirmed).pdf (7 pages)

### 8.6. Area Medical Committee dated 12 October 2021 (unconfirmed)

Item 8.6 - Area Medical Committee dated 12 October 2021 (unconfirmed).pdf (7 pages)

**15:00 - 15:00**
0 min

## 9. ESCALATION OF ISSUES TO NHS FIFE BOARD

**15:00 - 15:00**
0 min

## 10. ANY OTHER BUSINESS

**15:00 - 15:00**
0 min

## 11. DATE OF NEXT MEETING - THURSDAY 10 MARCH 2022

**Fife NHS Board**

UNCONFIRMED

**MINUTE OF THE NHS FIFE CLINICAL GOVERNANCE COMMITTEE HELD ON WEDNESDAY 3 NOVEMBER 2021 AT 2PM VIA MS TEAMS**

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

**In Attendance:**
L Campbell, Associate Director of Nursing
N Connor, Director of Health & Social Care
L Cooper, Immunisation Programme Director *(agenda item 5.2)*
G Couser, Head of Quality & Clinical Governance
C Dobson, Director of Acute Services
S Garden, Director of Pharmacy & Medicines
A Graham, Associate Director of Digital & Information
Dr G MacIntosh, Head of Corporate Governance & Board Secretary
M McGurk, Director of Finance & Strategy
J Morrice, Associate Medical Director, Women & Children's Services
E Muir, Clinical Effectiveness Co-ordinator
H Thomson, Board Committee Support Officer (Minutes)

The Chair welcomed everyone to the meeting and extended a warm welcome to A Wood, who is attending her first meeting since being appointed as a new Non-Executive Director of the Board. The Chair thanked the continued efforts of all NHS Fife staff and volunteers during these challenging times.

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

**1. Apologies for Absence**

Apologies were noted from member Cllr D Graham (Non-Executive Member), and attendees H Hellewell (Associate Medical Director, H&SCP) and M Wood (interim Associate Medical Director, Surgery, Medicine & Diagnostics).

**2. Declaration of Members' Interests**

There were no declarations of interest made by members.

## 3. Minutes of the Previous Meeting held on 17 September 2021

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

## 4. Matters Arising / Action List

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

## 5. COVID-19 UPDATE

### 5.1. General Covid-19 Update

The Director of Public Health provided a verbal update on Covid-19, noting we are in a relatively stable position in both Fife and Scotland.

Newly reported cases, however, remain high, and the Estimated Dissemination Ratio (EDR) is around one. It was advised there is a reduction in positive cases amongst the younger population, and the 35 – 44 age group has the highest number of cases. High rates of testing continue, and the overall positivity rate has reduced slightly for Fife, which brings this closer to the national average. An overview of the statistics over the previous weeks were provided for both testing and positive cases.

It was advised that the testing programme continues and is under review on a weekly basis. In terms of contact testing, this remains aligned with the national programme.

It was noted that, after six months, immunity starts to wane from the first and second vaccinations and the population are being strongly encouraged to take the Covid-19 booster vaccination. Messaging includes reinforcing safety measures such as mask wearing and social distancing.

Following a question, it was advised around two thirds of those who are presently requiring hospital treatment are double vaccinated, though those who are vaccinated tend to become less unwell than the unvaccinated.

The impact of positive rates across the population continues to be visible in hospitals, and pressures continue within our critical care services. The Medical Director highlighted the continued pressures and noted the overall situation with Covid-19 remains serious. The importance of continuing to support staff was highlighted.

The Committee **noted** the general update on Covid-19 and thanked our valued staff and volunteers for their continued efforts.

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

The Immunisation Programme Director joined the meeting and provided an overview of the FVCV programme, as outlined in the paper. It was advised the complex delivery plan is evolving at pace and regular discussions are taking place.

It was advised that the high-level risk noted in the paper relates to infrastructure and this has now been reviewed and moved to a moderate risk, due to the new posts that are now in place for the programme. Further work is still required around infrastructure.

It was advised that data is collated on a weekly basis in terms of number of vaccines and an overview was provided on the most recent data available. It was reported that boosters are a significant part of delivery and the workforce are committed to delivering the high level of activity safely.

A member requested that assurance be provided to the Committee on actual against projection data on delivery of vaccinations. It was advised the Programme Board review this data regularly, and an update will be provided to the Committee going forward.

**Action: Director of Health & Social Care**

The Committee **noted** the detail in the paper and took assurance from the ongoing planning and delivery of the Autumn/Winter Vaccination programme.

## 6. GOVERNANCE / ASSURANCE

### 6.1. Board Assurance Framework (BAF) – Quality & Safety

The Medical Director provided an update on progress of revising the NHS Fife Board Assurance Framework for Quality & Safety.

The Medical Director questioned the risks set out within the current BAF and if the wording on the risk descriptions articulates a reflection of the current risk profile within Quality & Safety. An overview of the four options that had been discussed on risk descriptions was provided.

Following discussion, it was agreed a second BAF for Covid-19 is not required, as the consequences of Covid are intertwined within the Quality & Safety BAF. It was agreed an adapted version of option three detailed within the paper was the preferred option.

The Medical Director outlined the review of linked risks, and the summary of current linked risks. It was advised that high risks that sit within Health & Social Care Services, Health Services within the Health & Social Care Partnership, and Health Services in Acute are still to be reviewed.

Discussion took place on linked and integrated risks. It was highlighted there is a mixture of operational and strategic risks within the BAF, and clear definitions at corporate level are required.

It was advised that a Board Development Session on risk management is in the process of being arranged and it was agreed to include a full review on how risks are articulated and a full review on linked risks. An update on the BAF for Quality & Safety will be brought back to the Committee at a future meeting.

The Committee:

- **Considered** the questions set out in the SBAR; and
- **Supported** the direction of travel in relation to the review of risks.

## 6.2. Board Assurance Framework (BAF) – Strategic Planning

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

It was advised that a review was conducted a few months ago and this highlighted the same issues with risk descriptions as the Quality & Safety BAF.

Activity is underway for mitigating the high risks and a range of actions over the coming six months should move the risk scores towards moderate or low. It was advised a Portfolio Board has been established to support strategy development and delivery, and the first meeting is being held on 4 November 2021. An additional risk was suggested to be added to ensure we have what is needed to deliver the strategy in terms of recognised priorities for the population of Fife.

Following a question, it was advised current 'strategies' that sit within various areas will become strategic frameworks and will underpin and support the overall strategy. It was noted the risks are still high and are partly in relation to the governance of and project management capacity for strategy development, which had not progressed until more recently.

It was agreed a broader discussion on the risks will be challenged through the Board Development Session. An update on the BAF for Strategic Planning will be brought back to the Committee at a future meeting.

The Committee **discussed** and **approved** the current position in relation to the Strategic Planning risk.

## 6.3. Board Assurance Framework (BAF) – Digital & Information

The Associate Director of Digital & Information provided an update on the NHS Board Assurance Framework for Digital & Information and advised that this BAF highlights the financial implications and delivery of the Digital & Information Strategic Framework.

A new linked high risk has been added, which relates to an internal audit finding reported to the Audit & Risk Committee. The removal of a previously linked risk has been reassessed as a moderate risk level, and more detail is provided in the paper.

In terms of financial priorities, it was noted that there are areas which are desirable, if subject to securing funding, and areas which are essential to support the Digital & Information Strategy. In response, the governance around the framework was outlined. Assurance was provided on the delivery of the strategy, which was discussed at the last Clinical Governance Committee and is also on the workplan as a regular update item.

The Digital & Information BAF will also form part of the broader discussion on risks through the Board Development Session. An update on the BAF for Digital & Information will be brought back to the Committee at a future meeting.

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

**6.4. Internal Audit Report - Clinical Governance Strategy & Assurance**

This item was covered under agenda item 7.3

**6.5. Annual Internal Audit Report 2020/21**

The Director of Finance & Strategy advised that the Annual Internal Audit Report 2020/21 has been shared with all the Standing Committees of the Board and is part of the Annual Assurance work that supports the Annual Accounts process.

The positive areas of the report, pertinent to this Committee, were highlighted.

The recommendation for the Committee to actively consider the issue of patient safety due to increased waiting times was questioned, and it was advised that this risk will feature as part of the Quality & Safety BAF review. An update will be reflected in the Quality & Safety BAF at the next Committee meeting in January 2022.

The Committee took **assurance** from this annual report and specifically **noted** the aspects pertinent to this Committee's areas of work.

**6.6. Annual Workplan**

The Head of Quality & Clinical Governance advised that the Annual Workplan is presented to the Committee for assurance and will be reviewed after this meeting to reflect any updates or considerations for future meetings.

The Committee **noted** the up-to-date Clinical Governance Committee Annual Workplan.

**7. STRATEGY / PLANNING**

**7.1. Strategic Planning & Resource Allocation 2022/23**

The Director of Finance & Strategy spoke to the Strategic Planning & Resource Allocation (SPRA) 2022/23 paper.

It was advised that this is the second year the SPRA process has been carried out, and lessons have been learned from the previous year, including making better use of streams of information e.g., workforce strategy. The timeline for the process is detailed in the paper, and it was noted the Committee will receive an interim update and position statement in January 2022.

**Action: Director of Finance & Strategy**

Following a question, an explanation was provided on how the SPRA will be linked into the red corporate risks, and how the prioritisation process builds into the red risks within the BAFs. It was noted our planning process will support and inform the overall risk profile within the organisation.

The Committee **noted** the update to the Strategic Planning and Resource Allocation methodology and the timeline for delivery.

## 7.2. Redesign of Urgent Care

The Medical Director provided an update on the paper, which outlines the changes within urgent care delivery and the direction of travel from Scottish Government. It was noted the paper is a work in progress and highlights the changes made that continue to be developed and refined. The paper has also been discussed at the Staff Governance Committee.

The flow and navigation hub has been put in place as part of the initial redesign in December 2020, and work is ongoing in developing the hub going forward.

The Medical Director expanded on the paper and discussed: the four workstreams within the governance structure; engagement & feedback from patients; GP admissions pathway; and workforce. A brief operational update was also provided, as outlined in the paper.

It was noted funding has become available from the Scottish Government called 'Interface Care'. The funding will enhance the current offer we provide and support the ambulatory options available to patients, specifically designed to reduce a patient's length of stay in hospital for certain conditions. It will also maximise the use of ambulatory services and Hospital@Home.

Following a question, it was advised that local comms and publicity has been carried out around the population contacting NHS24 prior to attendance at the Emergency Department, and further comms, both at local and national level, in this area is needed. It was also advised further detail is required to identify those who contacted NHS24 and were appropriately routed to the Emergency Department, or if they attended on their own accord. It was noted NHS24 are also under a lot of pressure.

Following a question on the current pressures and if they are impeding on progress of urgent care reforms, it was reported there is a positive impact on those who use the NHS24 system and come through the flow and navigation hub.

It was agreed to bring back to a future meeting, a visual on the impact of the changes on the Emergency Department. It was advised data is already being collated and the level of detail needs to be considered for the Committee.

**Action: Medical Director**

It was requested acronyms be spelt out in full within future committee papers.

The Committee **noted** the contents of the Redesign of Urgent Care paper and **agreed** the new governance structure with links to both Senior Leadership Teams.

## 7.3. Clinical Governance Strategy

The Head of Quality & Clinical Governance delivered a presentation on the Clinical Governance Strategy.

It was highlighted communication and engagement with staff will be of critical importance to the success of the framework. The framework and delivery plan will be shared through digital platforms between January and February 2022 for engagement & feedback from services. This will be brought back to the Committee in March 2022.

**Action: Head of Quality & Clinical Governance**

The Head of Quality & Clinical Governance and team were thanked for all their hard work in the development of the Clinical Governance Strategy.

The presentation will be shared with the Committee.

**Action: Head of Quality & Clinical Governance**

**7.4. Primary Care Improvement Plan – Memorandum of Understanding (MOU)2 Update**

The Director of Health & Social Care presented an overview of the Primary Care Improvement Plan MOU2 risk.

Assurance was provided that the Primary Care Improvement Plan – MOU2 was discussed in detail at the Staff Governance Committee in relation to the workforce aspects.

It was noted there are risks in relation to delivery, finance, and workforce. The key risks were outlined, and it was advised the risks are being addressed through a number of channels.

The Vaccination Transformation Programmes was outlined, and it was noted a risk in this area is not currently being highlighted.

It was advised that the paper describes what is contained within a Community Care and Treatment Service (CTAC) and it was highlighted this will not be delivered in full by April 2022. It was advised that this risk is not unique to Fife and is a challenge to implement nationally. Discussions are taking place nationally regarding requirements around the transitionary payments and a set of principles are anticipated to be published.

In relation to supporting delivery of quality, close working is ongoing and fuller guidance is awaited on further implementation of other aspects of the MOU. It was highlighted General Practices are working hard and are under pressure due to levels of demand.

The Director of Pharmacy & Medicines advised that the impact of pharmacotherapy has been measured and funding will be shaped on how this will be used to optimise delivery. Following a question, it was advised a mixed model is in place in terms of acute prescriptions, discharge letters and outpatient recommendations. A focus is to fully transfer delivery of those functions.

Following a question, it was advised private pharmacies are not directly involved in delivery in pharmacotherapy practice, and their focus is on serial prescribing only. A requested target of 20% has been set for all repeat chronic medicines to go through community pharmacies serial prescribing service until April 2022, and from then, to increase to 40%.

A request was made to expand on the financial risks, and it was advised the financial risk, as detailed in the paper, is being experienced across all Health Boards and Partnerships in Scotland. No agreed position was reported in terms of any additional support, and it was advised this is being engaged with, within the Scottish Government.

Regular updates will be provided to the Committee going forward.

The Committee **considered** and **discussed** the implications of the report and **noted** the financial and associated risks.

## 8. QUALITY / PERFORMANCE

### 8.1. Integrated Performance & Quality Report (IPQR)

The Director of Nursing reported the standard and quality of care of patients remains high, and staff are working incredibly hard to keep patients safe. The Director of Nursing provided an overview on the relevant section within the IPQR.

The inpatient Falls (with harm) was expanded on, and it was advised this is achieving target, and work is ongoing in the background to continue to achieve the target. The key challenges to falls were outlined. New audit work in relation to falls is being carried out, and falls is a key component of care being taking forward nationally; the new measurement package is being currently being finalised. It was reported that a Falls Champion network has been delayed due to workforce pressures, and a falls reduction initiative is taking place across all mental health wards.

It was reported that pressure ulcers performance is not reaching target; however, the target is being re-set nationally. It was advised that collaborative work is ongoing around pressure ulcers, and it was also advised there has been really good quality improvement work ongoing within the communities, which is having a positive impact on patient outcomes.

Following a question, assurance was provided that wards are being supported where there are particular issues with pressure ulcers. It was noted frailer patients are coming into hospital and there is an increase in critical care pressure ulcers, due to Covid.

Concern was raised for the areas that are not achieving target. The Director of Nursing assured the Committee that work is ongoing to achieve targets. The challenges in achieving targets were recognised, and it was advised the remobilisation plan going forward will provide more context.

It was agreed the format of presenting information and data within the IPQR needs reviewed, building on the discussion at the Board's recent Active Governance session, and this will be taken forward.

The Committee **examined** and **considered** NHS Fife performance in the areas above.

### 8.2. Health Associated Infection Report (HAIRT)

The Director of Nursing presented on the HAIRT, and advised that partnership working with Excellence in Care and Digital Colleagues has taken place around the development of a clinical risk assessment for multi drug resistant organisms. The assessment is being rolled out across Fife and has been recognised nationally.

Following a question, it was advised that the Urinary Catheter Group is well established and are working hard with microbiologists and our senior team to improve the targets. In terms of c-section infections, it was advised that surveillance was stopped by the Scottish Government last year, and local data is thus unable to be correlated against national data. Close monitoring continues with c-sections and infections.

The Committee **noted** the HAIRT report.

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

The Head of Quality & Clinical Governance provided background on the National Hub for Reviewing and Learning from the Deaths of Children & Young People and advised the National Hub went live on 1 October 2021. The purpose of the National Hub is to ensure that every death of a child or young person has a consistent and quality review undertaken, with the completion of a standardised data set, which will be shared with Health Boards across Scotland.

It was reported that Scotland is an outlier in terms of children and young people's deaths and has one of the highest rates. Further detail was provided, as outlined in the paper.

It was noted that the National Hub is around understanding social determinants that may have contributed to the death of the child or young person, and multi-agency input is very important.

The risks associated to delivery of the guidance were highlighted, and the risks and mitigations were outlined.

In terms of governance, a Child and Young Persons' Governance Group is being established and will meet on a quarterly basis. The Group will report into the Clinical Governance Oversight Group, and an Annual Report will be provided to the Clinical Governance Committee that summarises activity that has been undertaken.

The Committee:
- **Noted** the progress made to ensure NHS Fife aligns to the national guidance;
- **Endorsed** the new governance requirements to deliver the guidance; and
- **Noted** the risks

## 9. PERSON CENTRED CARE / PARTICIPATION / ENGAGEMENT

### 9.1. Volunteering Annual Report 2020/21

The Director of Nursing presented the first Volunteering Annual Report 2020/21 and highlighted the key points from the report, including the development of the Community Listening Service, which has been nominated for a national award.

The levels of managing and supporting volunteers was questioned, and if further investment would be sought. It was advised this is being managed and closely monitored.

The Committee **endorsed** the Volunteering Annual Report 2020/21.

**9.2. Complaints Report**

The Director of Nursing gave an overview of the Complaints Report and advised that an updated report is being presented to the Executive Directors' Group on 4 November 2021, which includes detail on locations and themes. The Organisational Learning Group will be key in recognising themes and taking action.

It was reported that the complaints process has slowed down due to the pandemic and discussions have been taking place on challenges being faced around complaints management. It was advised that the Datix system is being reviewed to provide more detailed reporting easily.

The Committee **supported** the direction of travel indicated in the report:

**10. ANNUAL REPORTS**

**10.1. Medical & Appraisal Revalidation Annual Report 2020/21**

The Medical Director advised that the Medical & Appraisal Revalidation Annual Report 2020/21 was discussed in detail at the Staff Governance Committee.

The Committee **noted** the Medical & Appraisal Revalidation Annual Report 2020/21.

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

The Committee **noted** the Prevention & Control of Infection Annual Report.

**10.3. Organisational Duty of Candour Annual Report (Interim)**

The Medical Director explained the position of the interim Organisational Duty of Candour Annual Report and advised that NHS Fife has a statutory requirement to publish the report this financial year, which will be challenging.

It was noted there is a lag in the detail within the interim report, and the position was recognised by the Committee. An update, with amended data, will be provided to the Committee at the next meeting. It was noted a final report is expected to be completed by January 2022, which will then go onward to the Board.

**Action: Medical Director**

The Committee **noted** the interim Organisational Duty of Candour Annual Report.

**11. LINKED COMMITTEE MINUTES**

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

11.1. Acute Services Division Clinical Governance Committee dated 15/09/21 (unconfirmed)
11.2. Fife Area Drugs & Therapeutics Committee dated 13/10/21 (unconfirmed)
11.3. Fife Health & Social Care Partnership Clinical and Care Governance Committee dated 04/08/21 (confirmed) & 08/09/21 (confirmed)
11.4. Digital and Information Board dated 21/07/21 (confirmed)
11.5. Health and Safety Sub-Committee dated 14/09/21 (unconfirmed)
11.6. Infection Control Committee dated 06/10/21 (unconfirmed)
11.7. Area Medical Committee dated 21/08/21 (confirmed)
11.8. Cancer Governance and Strategy Group dated 17/08/21 (unconfirmed)
11.9. Research, Innovation & Oversight Group dated 14/10/21 (unconfirmed)
11.10. Public Health Assurance Committee dated 10/08/21 (confirmed)

It was advised that the Cancer Governance and Strategy Group is newly established, and the Committee were encouraged to read the minutes.

## 12. ESCALATION OF ISSUES TO NHS FIFE BOARD

There were no issues to escalate to NHS Fife Board.

## 13. ANY OTHER BUSINESS

There was no other business.

**Date of Next Meeting** – Thursday 13 January 2022 at 2pm via MS Teams.

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

# CLINICAL GOVERNANCE COMMITTEE – ACTION LIST

**Meeting Date:** Thursday 13 January 2022

| NO. | DATE OF MEETING | AGENDA ITEM / TOPIC | ACTION | LEAD | TIMESCALE | COMMENTS / PROGRESS | RAG |
|---|---|---|---|---|---|---|---|
| **1.** | 03/11/21 | **Strategic Planning & Resource Allocation 2022/23** | The Committee to receive an interim update and position statement in January 2022. | **MM** | ~~13/01/22~~ 10/03/22 | To be carried forward to March 2022 meeting. | Deadline not reached |
| **2.** | 03/11/21 | **Redesign of Urgent Care** | A visual on the impact of the changes on the Emergency Department to be provided to the Committee. | **CMcK** | 10/03/22 | | Deadline not reached |
| **3.** | 03/11/21 | **Clinical Governance Strategy** | An update on the framework and delivery plan to be brought back to the Committee. | **GC** | 10/03/22 | | Deadline not reached |
| **4.** | 03/11/21 | | The presentation to be shared with the Committee. | **GC** | Nov '21 | 16/11/21 – Circulated. | Closed |
| **5.** | 03/11/21 | **Flu Vaccination & Covid Vaccination (FVCV) Programme Update** | Assurance to be provided to the Committee on actual against projection data on delivery of vaccinations. | **NC** | 13/01/22 | On agenda. An update will be provided to the Committee going forward | Closed |
| **6.** | 03/11/21 | **Organisational Duty of Candour Annual Report (Interim)** | An update, with amended data, to be provided to the Committee at the next meeting. | **CMcK** | 13/01/22 | On agenda | Closed |

# NHS Fife

| | |
|---|---|
| **Meeting:** | **Clinical Governance Committee** |
| **Meeting date:** | **13 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 Clinical Governance 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.

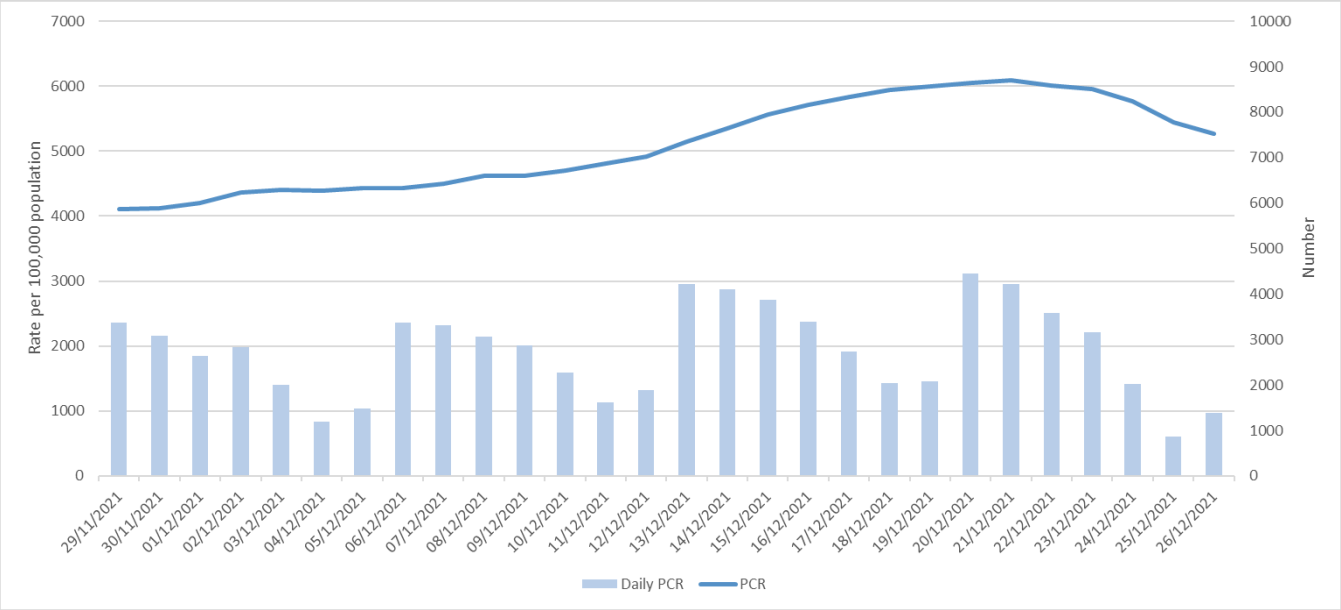
### 2.2 Background

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**

Sharon Crabb
Interim Service Manager
sharon.crabb@nhs.scot

Abbi Noble
Public Health Intelligence Officer
abbi.noble3@nhs.scot

# NHS Fife

| | |
|---|---|
| **Meeting:** | **Clinical Governance Committee** |
| **Meeting date:** | **13 January 2022** |
| **Title:** | **FVCV Programme Delivery Update** |
| **Responsible Executive:** | **Nicky Connor, Director of Health and Social Care** |
| **Report Authors:** | **Lisa Cooper, Immunisation Programme Director**<br>**Emma Strachan, FVCV PMO Project Manager** |

## 1 Purpose

**This report is presented to the Clinical Governance 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 Clinical Governance 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 (Appendix 1)**

- 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**

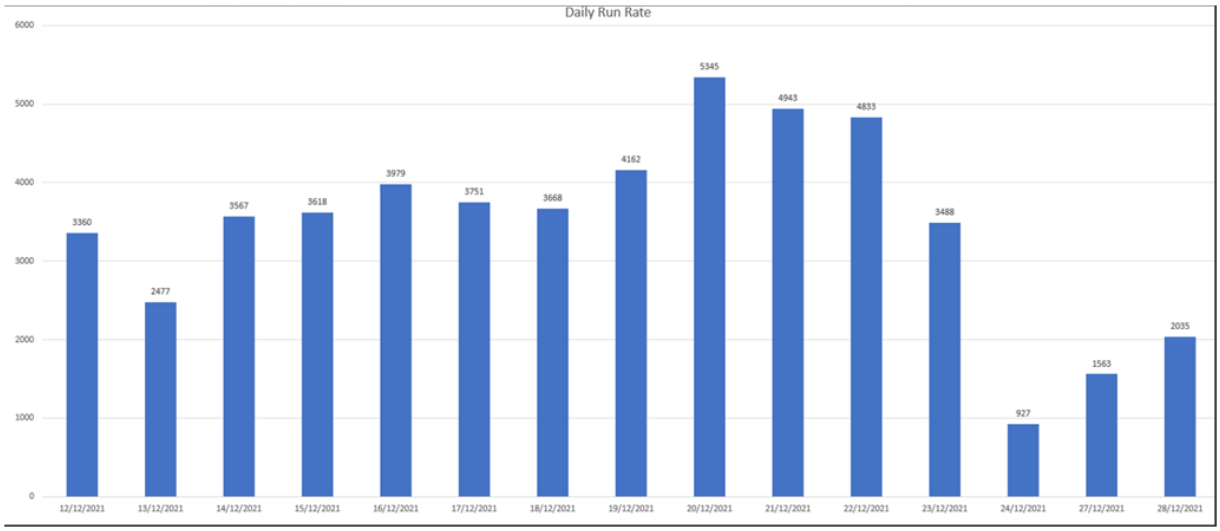
National assessment on the run rate across all health boards took place (determined by number of appointments available per day), to estimate the increased pace required in each health board to achieve 80% uptake. This assessment indicated that NHS Fife would require a 50% daily increase in daily appointments.

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 Clinical Governance Committee is invited to take **assurance** from the report, to **discuss** the progress achieved and updated information regarding the programme, and ongoing 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:** | **Clinical Governance Committee** |
| **Meeting date:** | **13 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 Clinical Governance 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

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

Performance, particularly in relation to Waiting Times across Acute Services and the Health & Social Care Partnership has been hugely affected during the pandemic. NHS Fife is working according to the Joint Fife Remobilisation Plan for 2021/22 (RMP4), and the IPQR provides a high-level activity summary on Page 4. This will be updated monthly until the end of the FY.

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

Performance is also reported for Adverse Events, SAB (Community), ECB (Community) and C Diff (Community), but these do not have targets.

| Measure | Update | Local/National Target | Current Status |
|---|---|---|---|
| HSMR | Quarterly | 1.00 (Scotland average) | Above Scottish average |
| Falls | Monthly | 7.68 per 1,000 TOBD | Achieving |
| Falls With Harm | Monthly | 1.65 per 1,000 TOBD | Not achieving |
| Pressure Ulcers | Monthly | 0.42 per 1,000 TOBD | Not achieving |
| CS SSI [1] | Quarterly | 2.5% | Not achieving |
| SAB (HAI/HCAI) | Monthly | 18.8 per 100,000 TOBD | Achieving |
| ECB (HAI/HCAI) | Monthly | 33.0 per 100,000 TOBD | Not achieving |
| C Diff (HAI/HCAI) | Monthly | 6.5 per 100,000 TOBD | Not achieving |
| Complaints (S1) | Monthly | 80% | Not achieving |
| Complaints (S2) [2] | Monthly | 65% | Not achieving |

[1] Formal data collection continues to be 'paused' (as per instruction from Scottish Government), but we are able to report on local data up to the end of June 2021

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

### 2.3.1 Quality/ Patient Care

Not applicable.

### 2.3.2 Workforce

Not applicable.

### 2.3.3 Financial

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

### 2.3.4 Risk Assessment/Management

Not applicable.

### 2.3.5 Equality and Diversity, including health inequalities

Not applicable.

### 2.3.6 Other impact

None.

### 2.3.7 Communication, involvement, engagement and consultation

The NHS Fife Board Members 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 CG Committee is requested to:

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

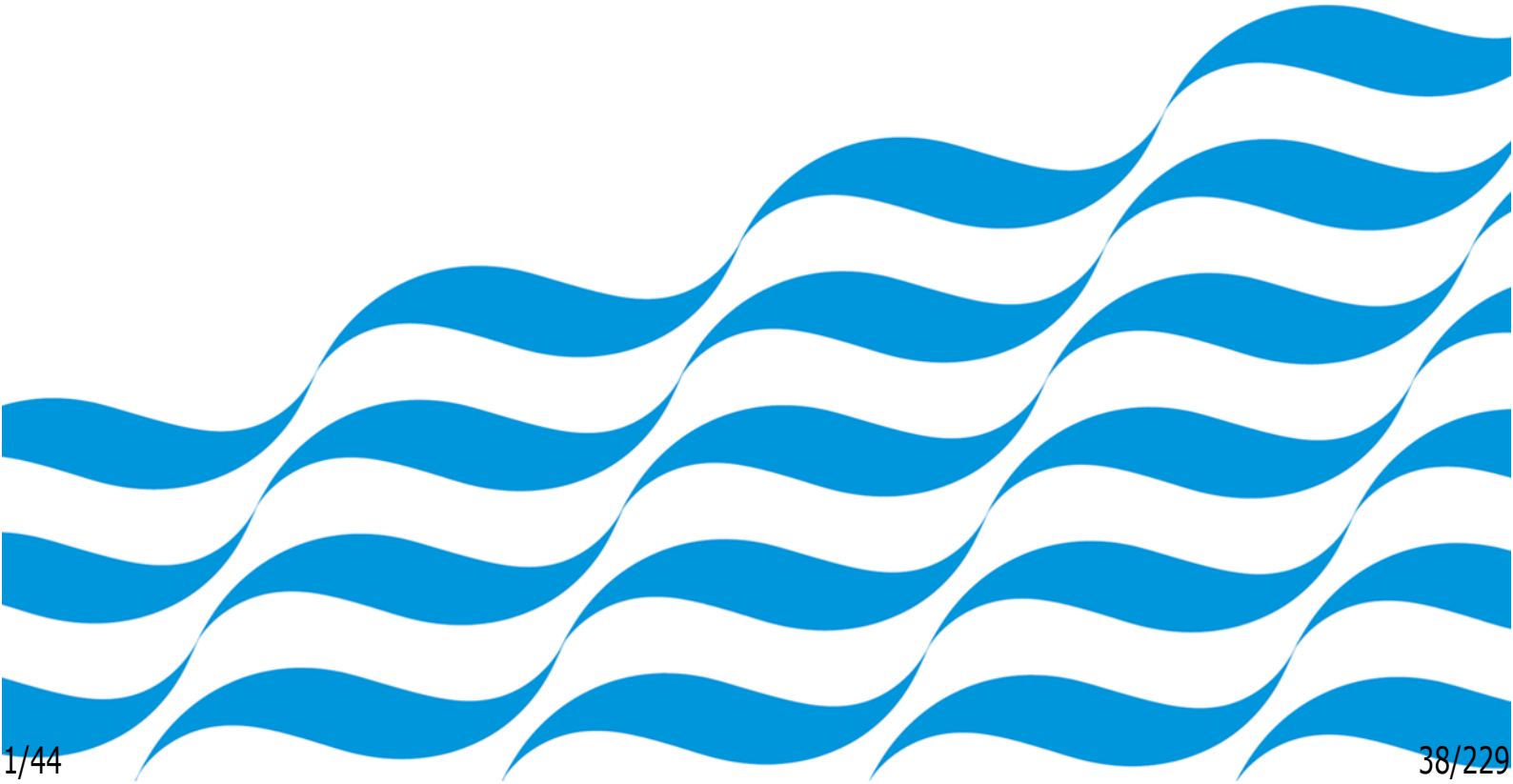
# 3 List of appendices

None

**Report Contact**
Bryan Archibald
Head of Performance
Email bryan.archibald@nhs.scot

# Fife Integrated Performance & Quality Report

**Produced in 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%** |

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%** |

| | | Target | Current |
|---|---|---|---|

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 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



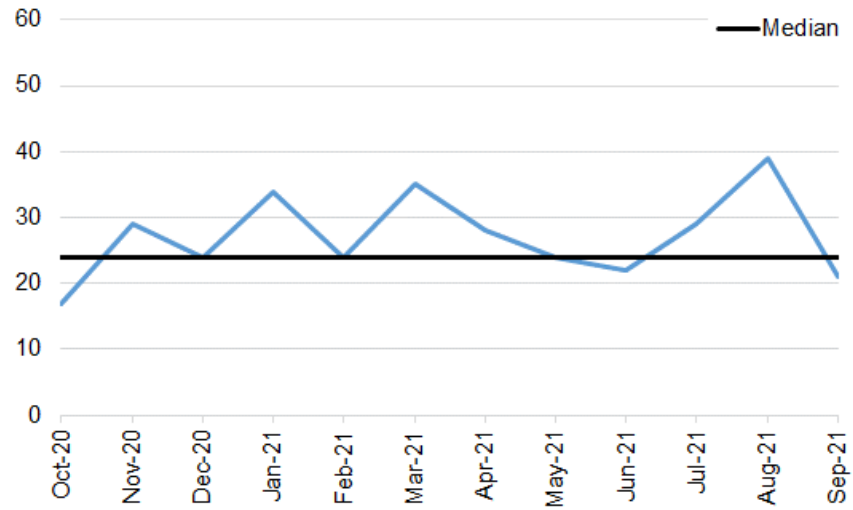
## Finance, Performance & Resources: Finance

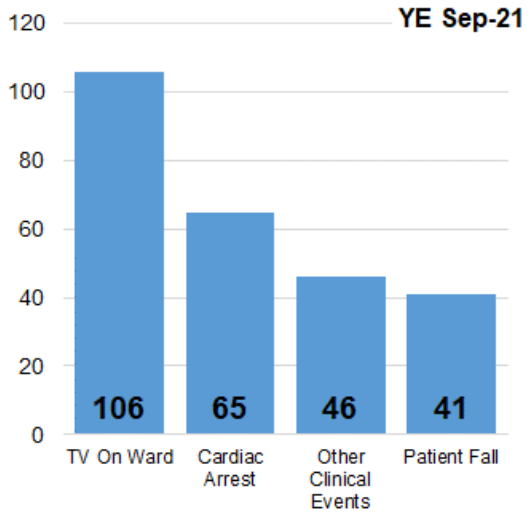


## Staff Governance

## 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

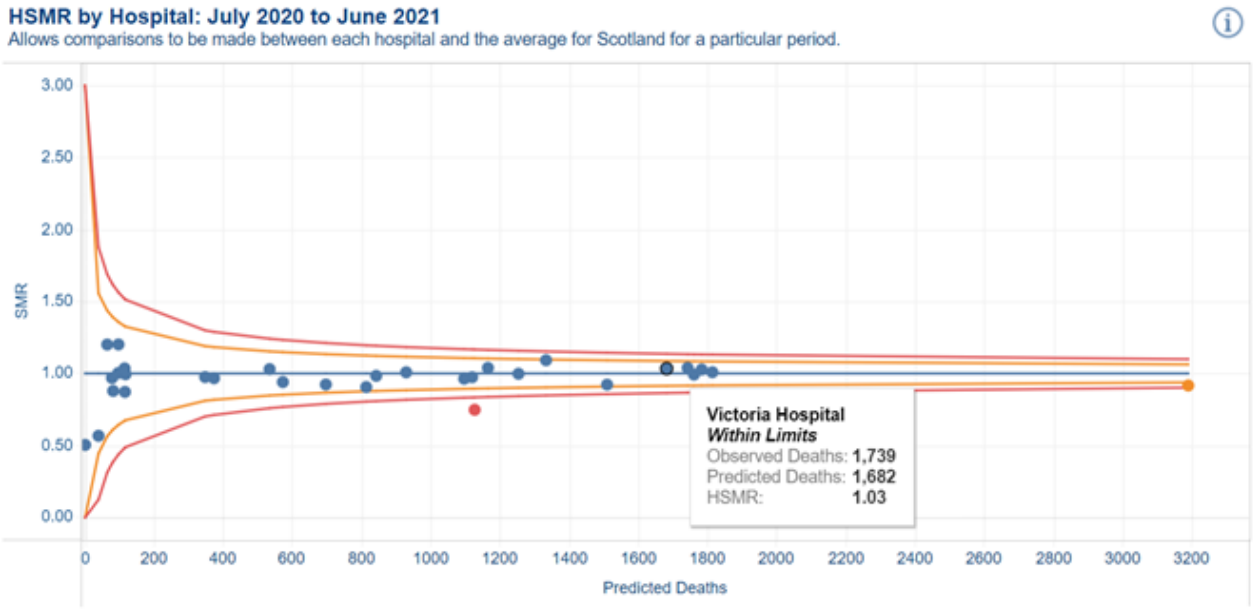
## HSMR

*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.



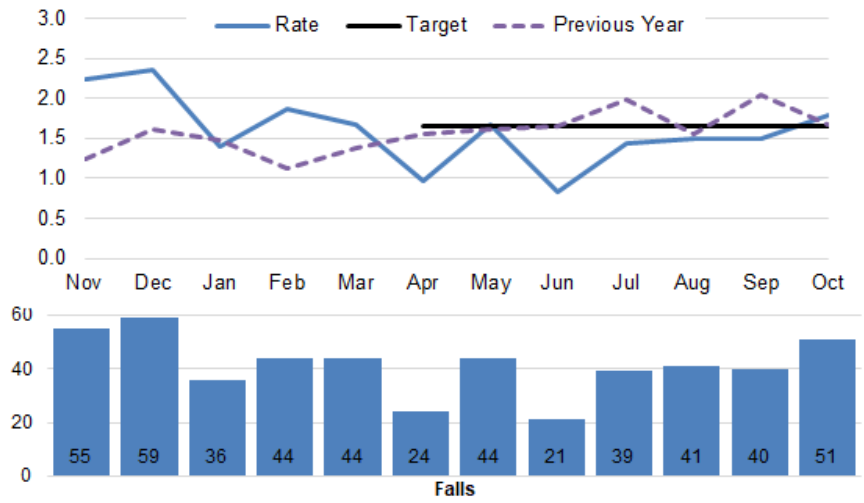

**Commentary**

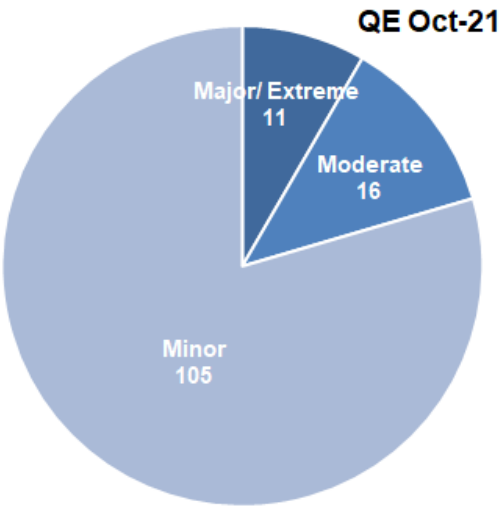
The HSMR for NHS Fife has remained above the 1.00 mean for all periods since the measure was changed two years ago. This should be seen as normal variation, but we will continue to monitor this closely. The difference between actual and predicted number of deaths in the year ending June produced a ratio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

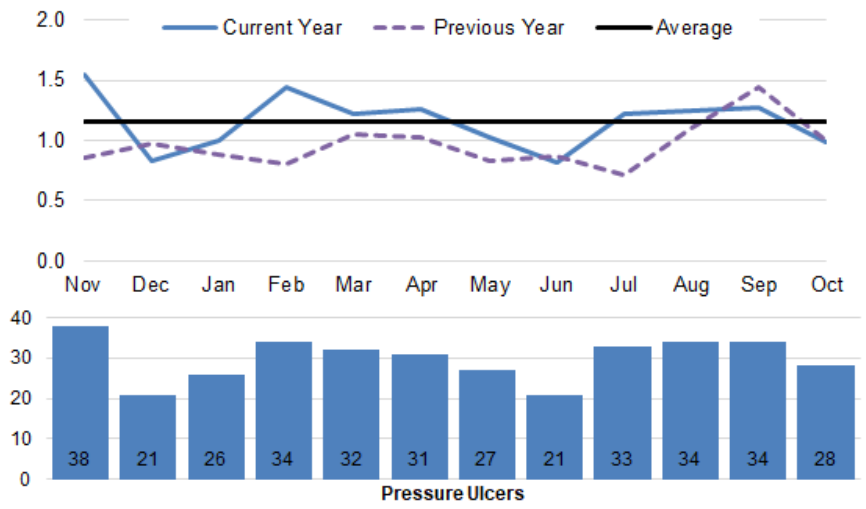
### IMPROVEMENT ACTIONS

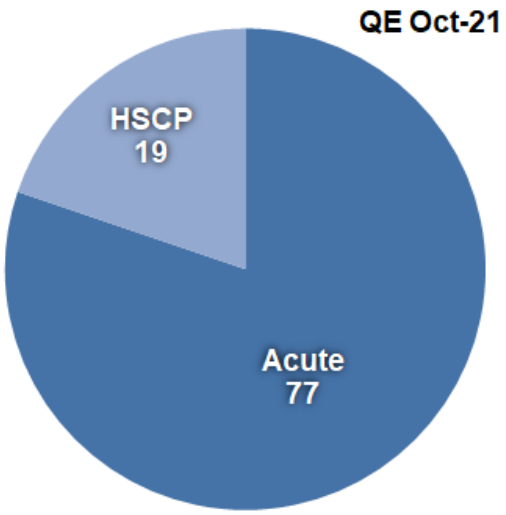
| | |
|---|---|
| **20.3 Falls Audit** | ***By Feb-22*** |
| A new national driver diagram and measurement package have still to be finalised and as already reported have been tested in four boards across Scotland in May and June. As previously noted, due to current challenges NHS Fife documentation 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

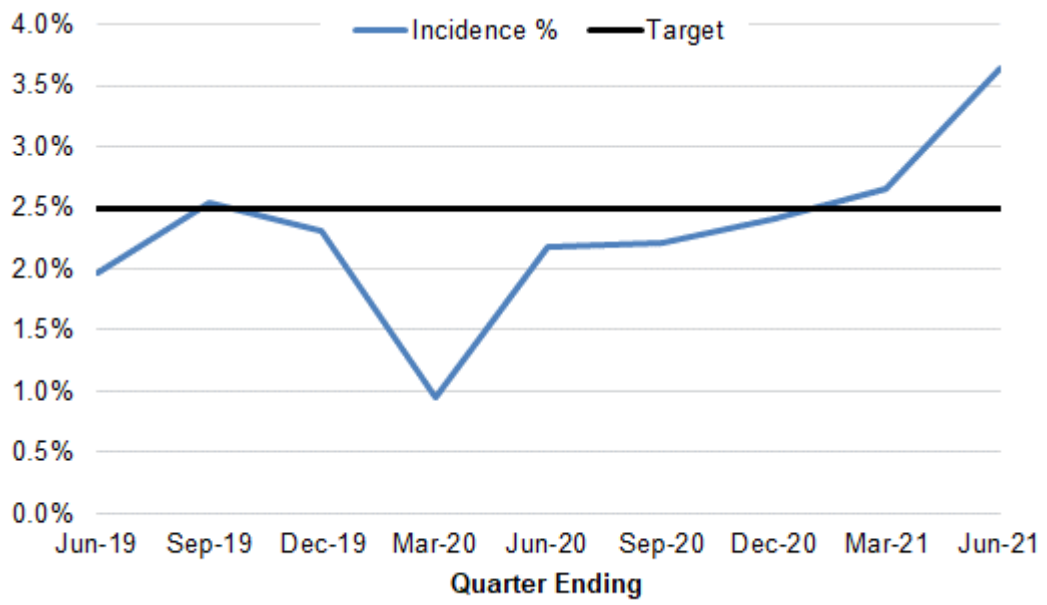
Analysing impact of COVID-19 on clinical pathway for handling Pressure Ulcers, and taking appropriate action to improve performance – this continues to require an agile response

| 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.<br>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.<br>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.

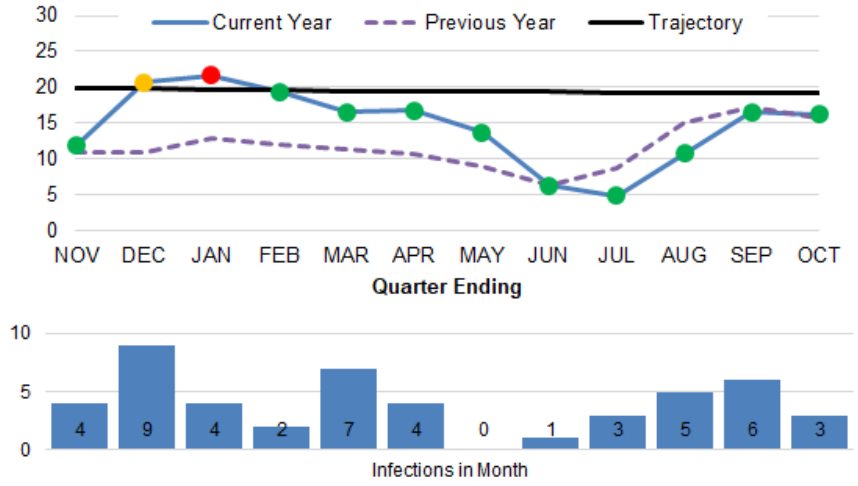
Due to the ongoing Covid-19 pandemic, there is currently no date (set by ARHAI) for resumption of SSI surveillance.

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)

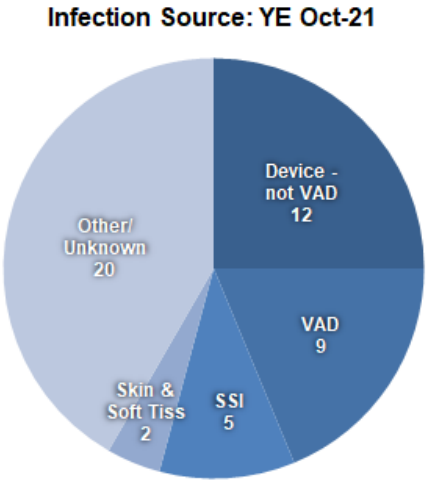
*Reduce Hospital Infection Rate by 10% (in comparison to FY 2018/19 rate) by the end of FY 2021/22*

**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

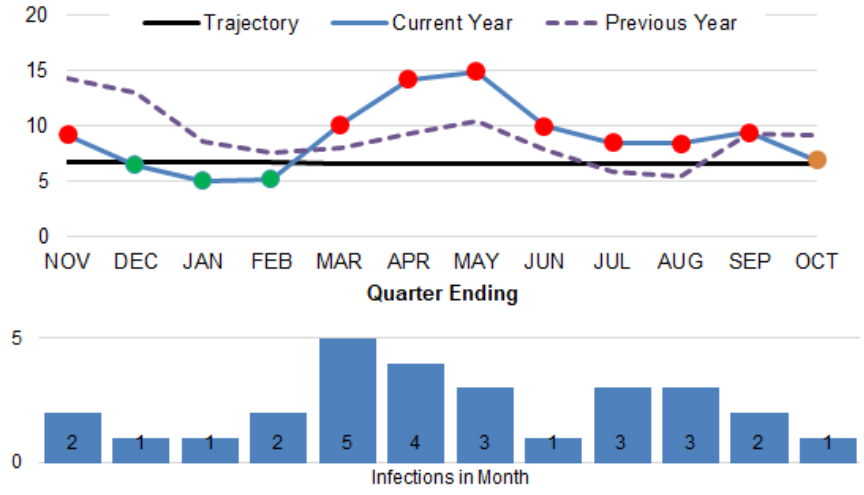
Vascular access devices and medical devices such as urinary catheters are risk factors identified for SAB, and infections in these areas need to be minimised in order to achieve the 10% reduction by March 2022

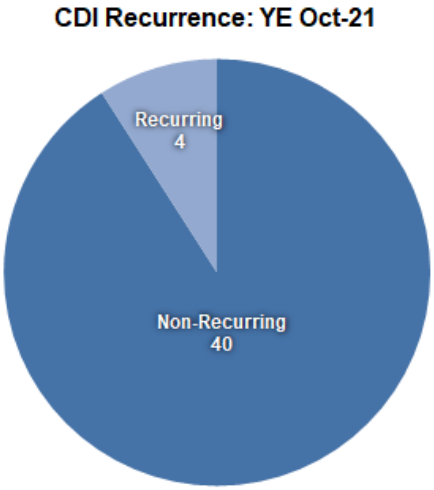
| IMPROVEMENT ACTIONS | |
|---|---|
| **20.1 Reduce the number of SAB in PWIDs** | ***By Mar-22*** |
| The incidence of SABs in PWIDs has continued to reduce, with only 4 cases identified in 2021 to date (compared to 5 in 2020 and 14 in 2019). The PGD for Antibiotic prescribing is now in progress by Addiction Services and IPCT continue to support AS with SAB improvements, albeit a planned November meeting had to be cancelled.<br>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.

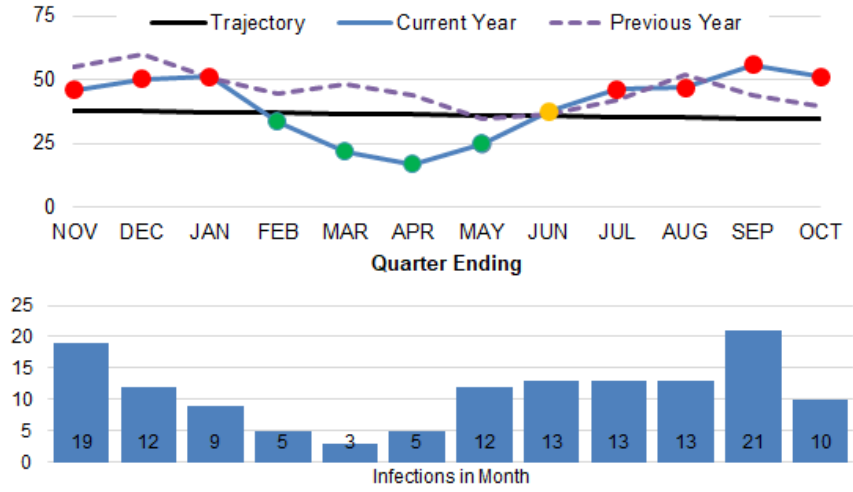
IPCN ward visits reinforce SICPs and transmission-based precautions, provide education to staff to promote optimum CDI management and daily Medical Management form completion.

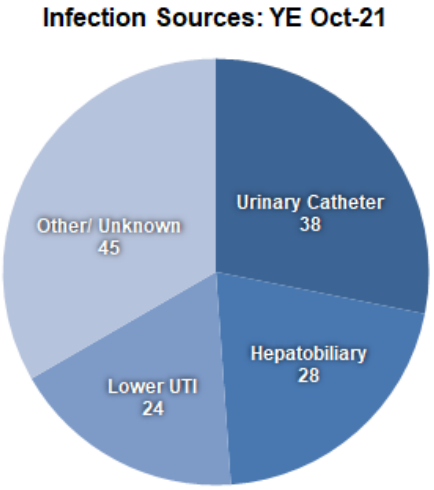
The Ward Dashboard utilised by clinical staff to access and display 'days since last CDI' in each ward for public assurance is currently inaccessible, so wards are currently being updated by the IPC surveillance team.

## 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

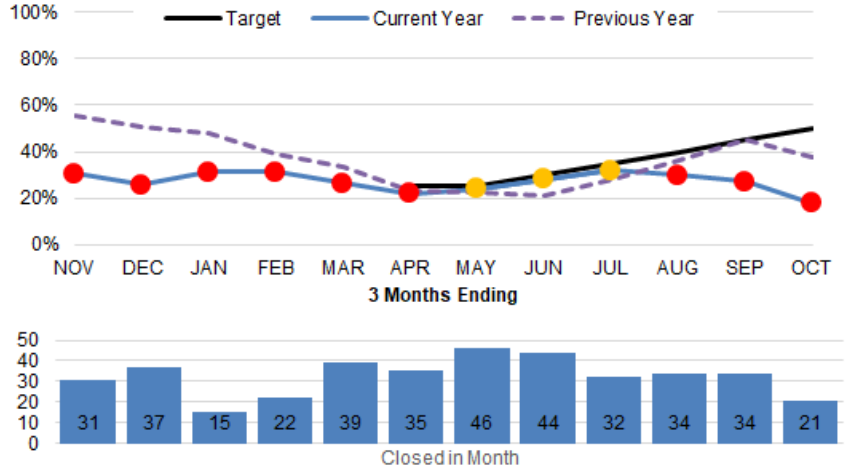
**IMPROVEMENT ACTIONS**

| **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

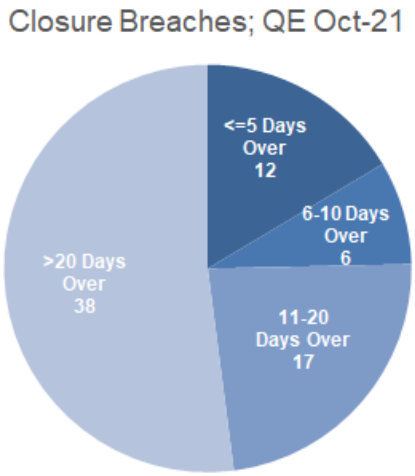
*At least 65% of Stage 2 complaints are completed within 20 working days (50% by October 2021)*

**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** |

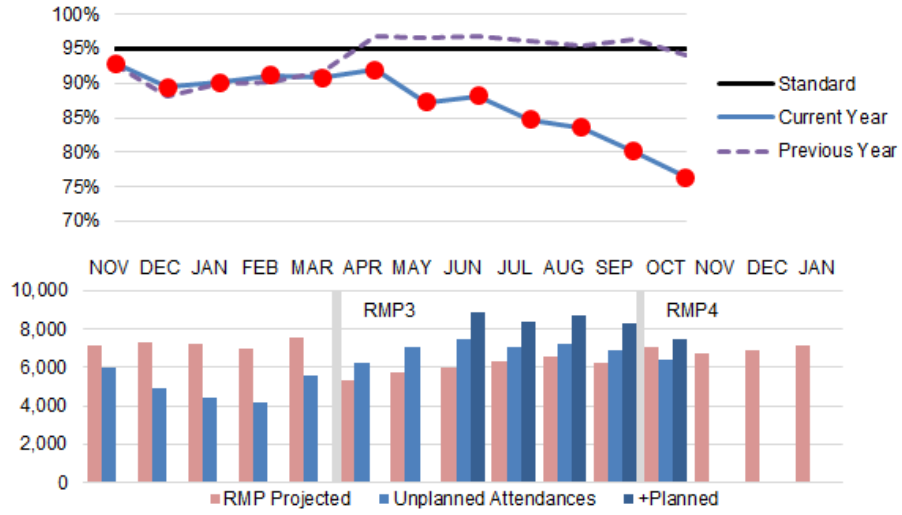
This action aims to improve overall quality by delivering education programmes at induction and bespoke training sessions across the Clinical Services. While some training sessions have been delivered virtually, this is on hold due to the ongoing response to COVID-19 and current capacity issues.

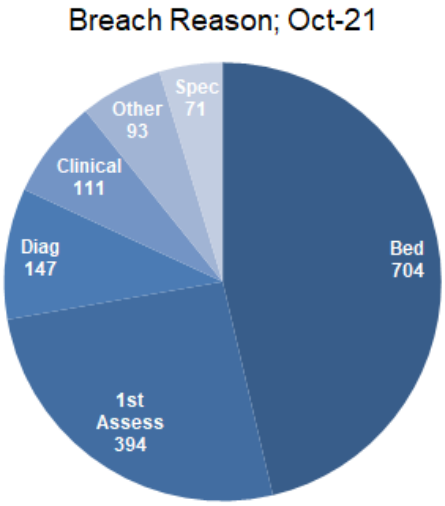
Bespoke training sessions with Fife Wide & Fife East took place in May and June, and the aim was that these would restart during the remainder of 2021, however, there has not been the capacity to do so.

## 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

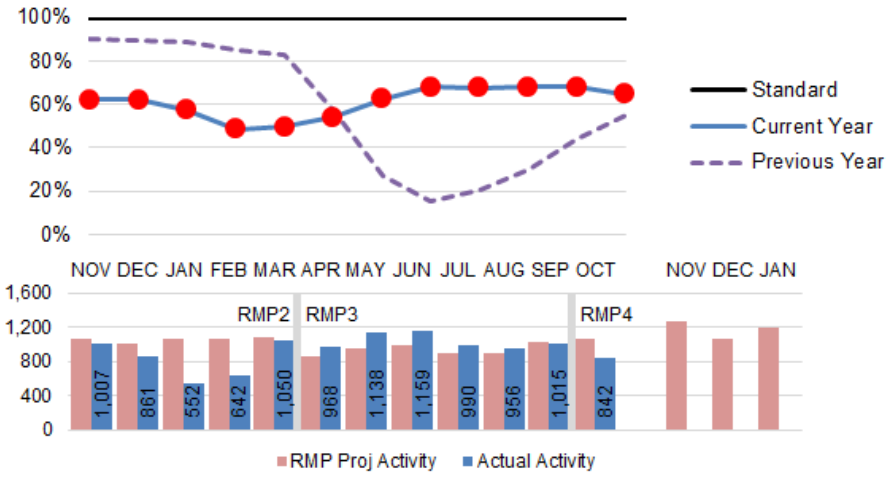
- Achievement of 4-hour access Standard
- Delivery of an integrated Flow and Navigation HUB
- Increased patient demand for urgent care

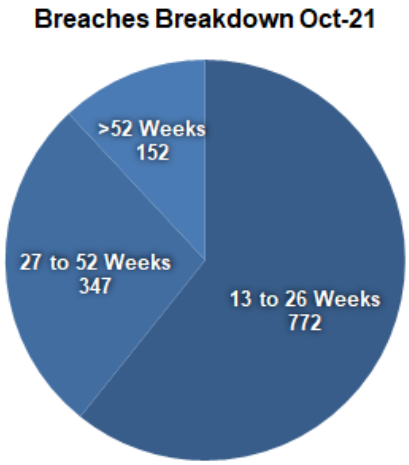
| IMPROVEMENT ACTIONS | |
|---|---|
| **21.2 Integration of the Redesign of Urgent Care model and the Flow & Navigation Hub** | **By Mar-22** |
| Virtual Flow and Navigation appointments to ED are now in place and the Hub has expanded to handle GP calls previously taken by ANPs into AU1. Early indication 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

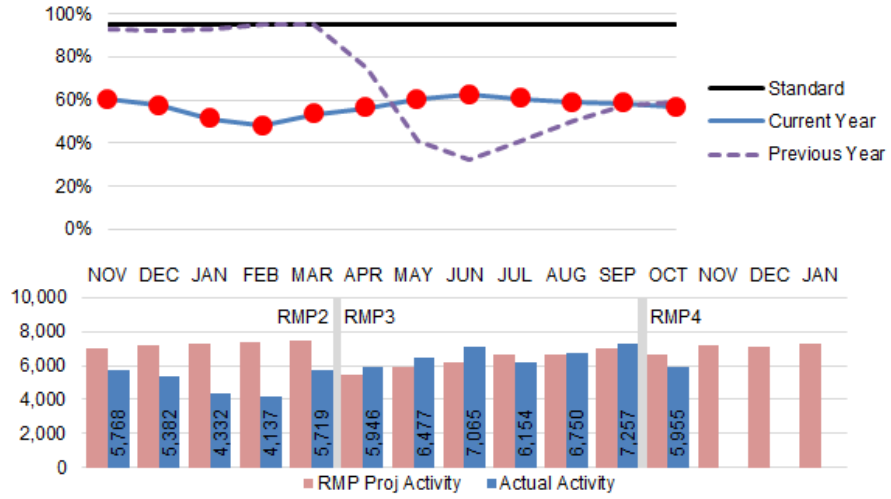
- Reduced Theatre Capacity due to current infection control and social distancing measures
- Clinical Prioritisation leading to long waits for lower priority patients
- Increased demand as a result of backlog in outpatients and change in case mix
- Increased unscheduled workload
- Staff vacancies, absence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

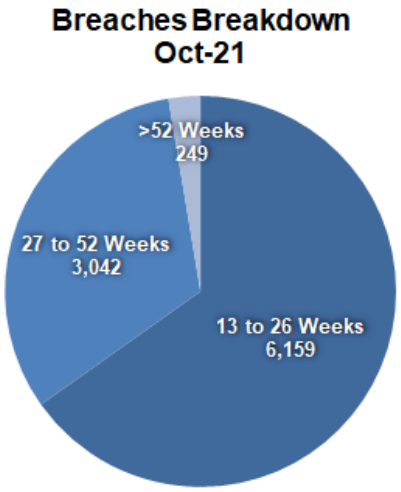
| IMPROVEMENT ACTIONS | |
|---|---|
| **22.1 Monitor and review DCAQ against waiting times improvement plan, secure additional funding from SG and amend plan prior to formal review in September** | **Complete Sep-21** |
| **22.2 Redesign Pre-assessment to increase capacity and flexibility around theatre 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

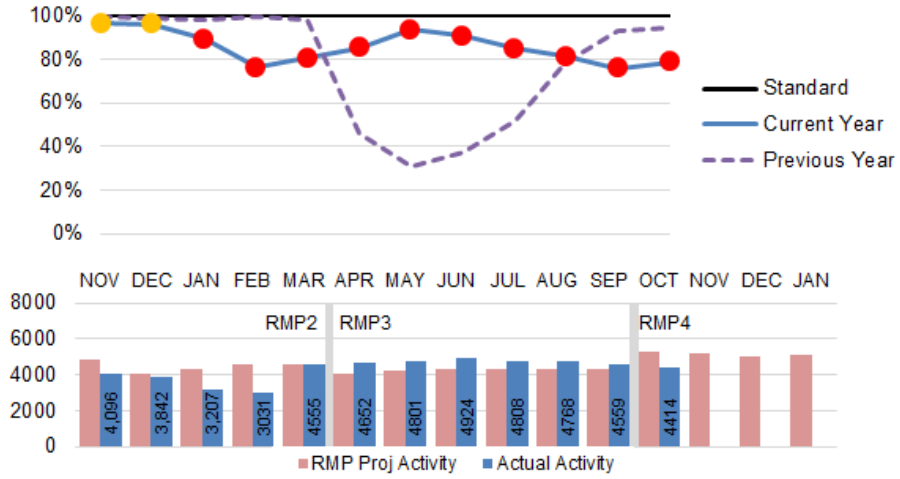
- Reduced Clinic capacity due to current infection control and social distancing measures
- Clinical Prioritisation leading to long waits for lower priority patients
- Increased demand as a result of unmet need and change in case mix of referrals
- Increased unscheduled workload
- Staff vacancies, absence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

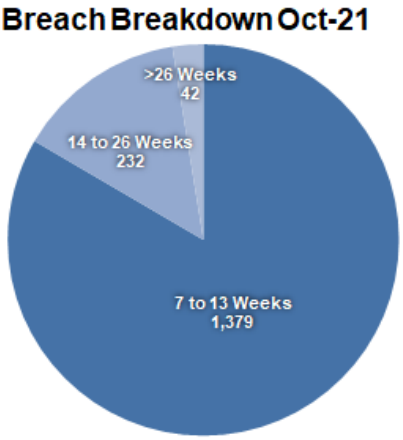
| IMPROVEMENT ACTIONS | |
|---|---|
| **22.1 Monitor and review DCAQ against waiting times improvement plan, secure additional funding from SG and amend plan prior to formal review in September** | **Complete Sep-21** |
| **22.2 Deliver appropriate elements of Modernising outpatients and unscheduled 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

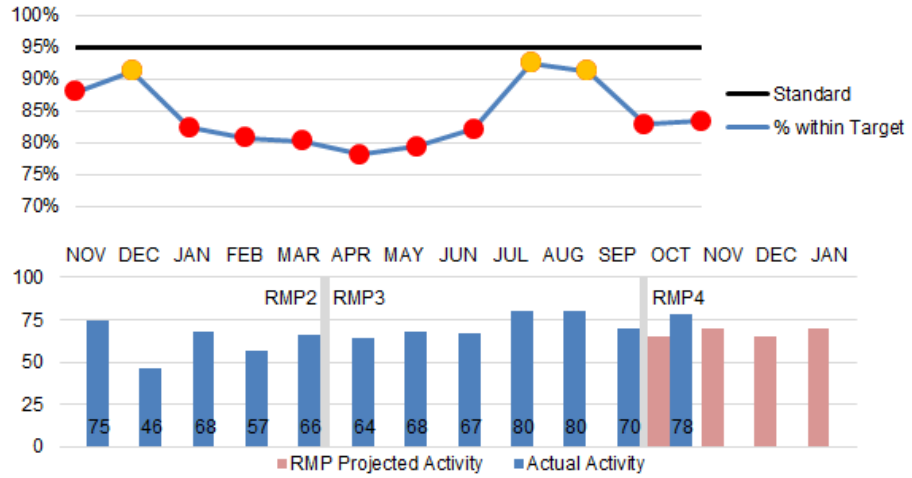
- Reduced diagnostic capacity due to current infection control and social distancing measures
- Clinical Prioritisation leading to long waits for lower priority patients
- Increased demand as a result of unmet need, backlog in outpatients and change in case mix of referrals
- Staff vacancies, absence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

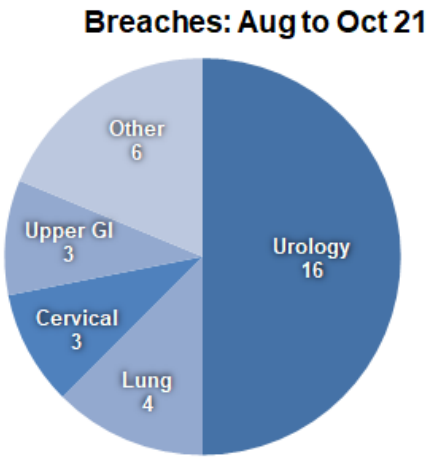
| IMPROVEMENT ACTIONS | |
|---|---|
| **22.1 Monitor and review DCAQ against waiting times improvement plan, secure additional funding from SG and amend plan prior to formal review in September** | **Complete Sep-21** |
| **22.2 Explore implementation of point of care testing in endoscopy** | **By Mar-22** |
| 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

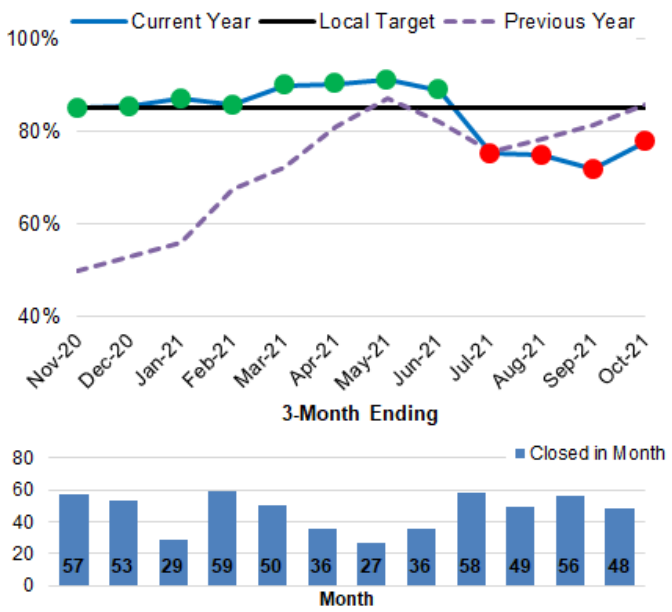
- Prostate cancer pathway (remains the most challenged pathway in NHS Fife)
- Increased number of referrals into the breast service, converting to cancers
- Catch up with the paused screening services (which will increase the number of patients requiring to be seen)
- Introduction of the robot may impact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

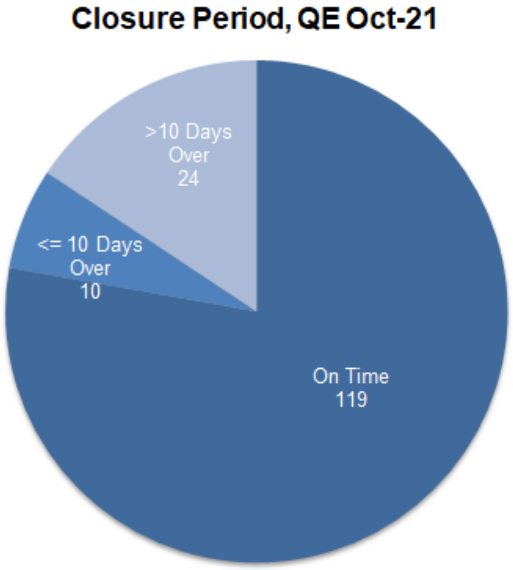
| IMPROVEMENT ACTIONS | |
|---|---|
| **20.3 Robust review of timed cancer pathways to ensure up to date and with clear escalation points** | **By Mar-22** |
| This will be addressed as part of the overall recovery work and in line with priorities set within the Cancer Recovery Plan and by the leadership 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** |

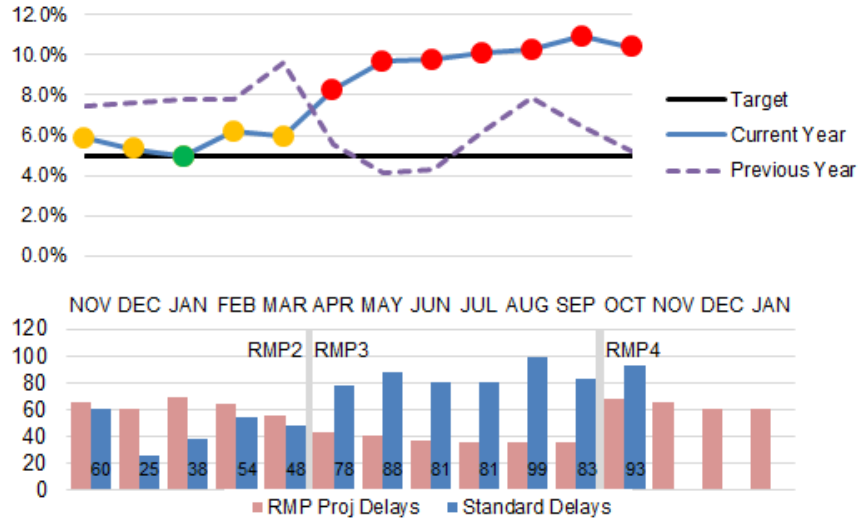
The first EDG Paper (1.0 - Process) passed through EDG in February. The Scottish Information Commissioner's Office has commended the work NHS Fife has undertaken so far to remedy the Board's previous low level of FOISA compliance.

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

## Delayed Discharges (Bed Days Lost)

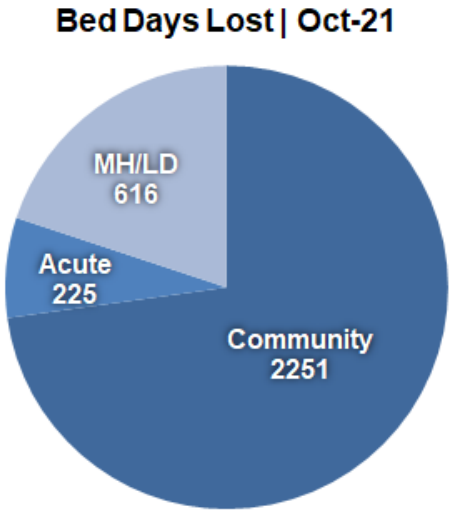
*We will limit the hospital bed days lost due to patients in delay, excluding Code 9, to 5% of the overall beds occupied*

**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

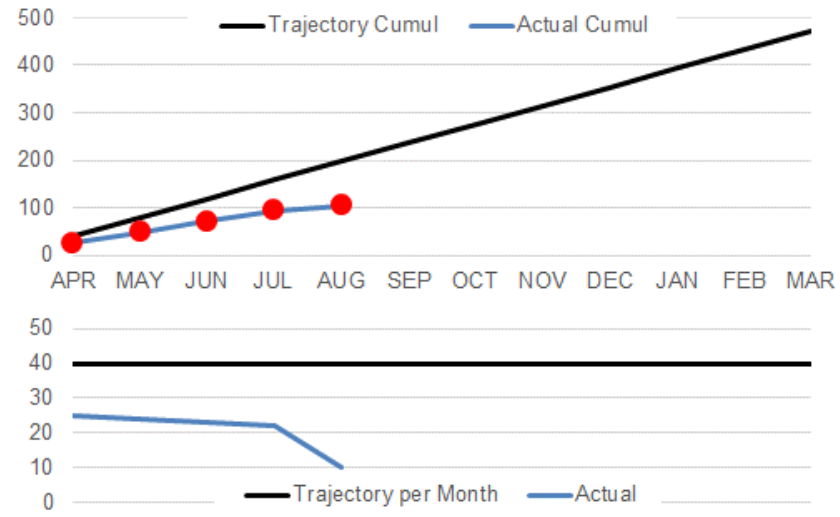
- Capacity in the community – demand for complex packages of care has increased significantly
- Information sharing – H&SC workforce having access to a shared IT, for example Trak, Clinical Portal
- Workforce – Ensuring adequate and safe staffing levels to cover the additional demand to facilitate discharge from the acute setting to the community hospitals and social care provision

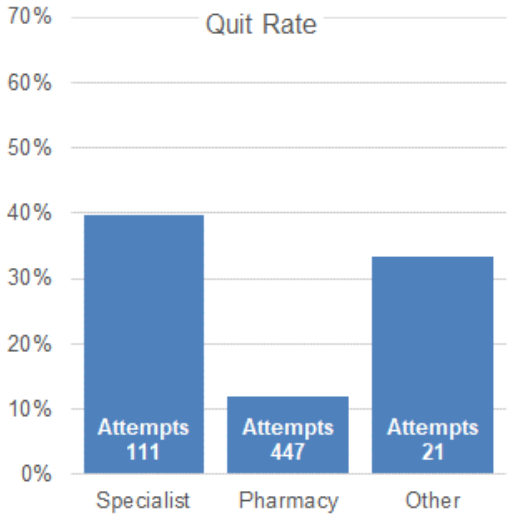
| IMPROVEMENT ACTIONS | |
|---|---|
| **21.1 Progress HomeFirst model / Develop a 'Home First' Strategy** | **By Mar-22** |
| The Oversight "Home First" group meeting with H&SC, NHS Fife, Fife Council and Scottish Care took place in April. Seven subgroups are taking forward the operational actions to 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 | 473 |
| | Achieved | 62.5% | 62.0% | 61.0% | 59.5% | 52.8% | | | | | | | |
| **Scotland** | Achieved | | | | | | | | | | | | |

### KEY CHALLENGE(S) IN 2021/22

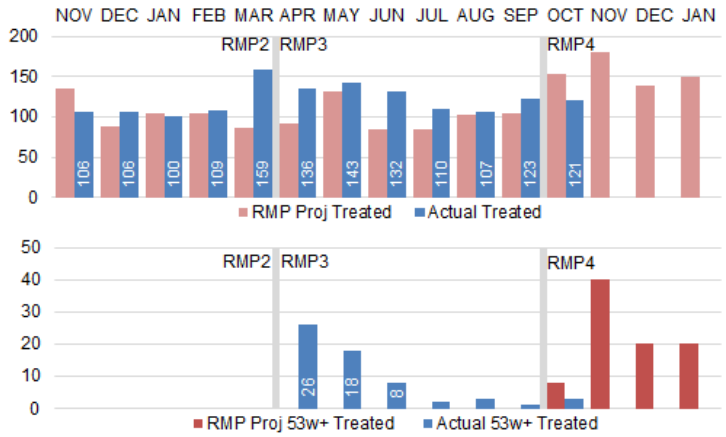
- Remobilising face to face delivery in a variety of settings due to venue availability and capacity
- Moving from remote delivery to face to face provision, patients having confidence in returning to a medical setting
- Potential for slower recovery for services as they may require to rebuild trust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

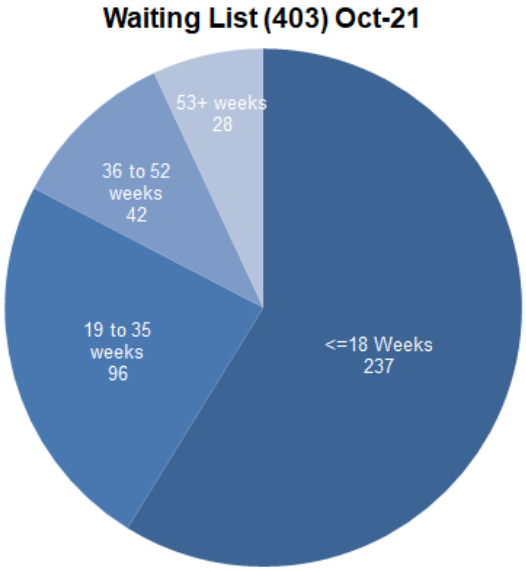
| IMPROVEMENT ACTIONS | |
|---|---|
| **20.2 Test Champix prescribing at point of contact within hospital respiratory clinic** | **Complete Oct-21** |
| **20.3 'Better Beginnings' class for pregnant women** | **Complete Oct-21** |
| **20.4 Enable staff access to medication whilst at work** | **By TBD** |
| 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

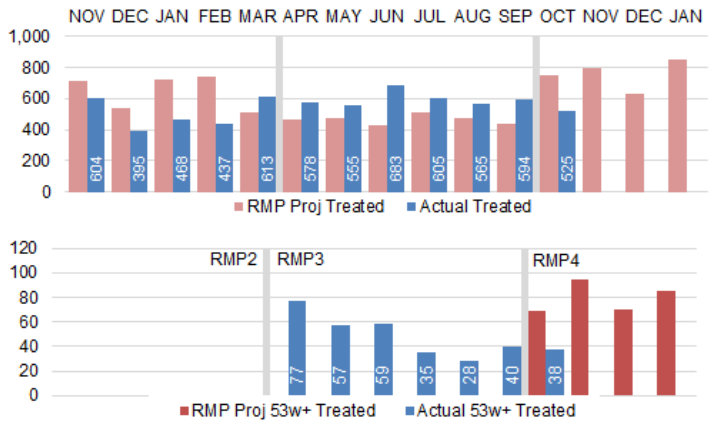
### IMPROVEMENT ACTIONS

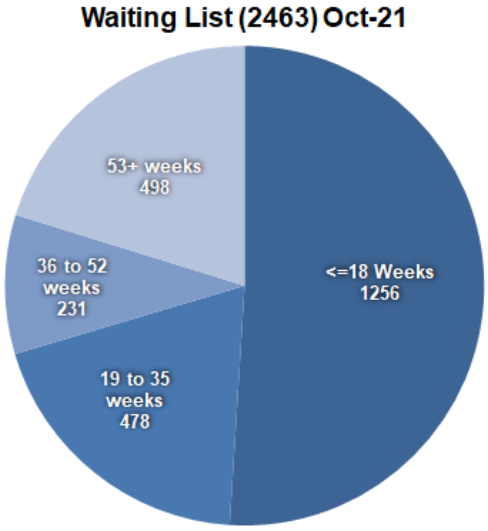
| | |
|---|---|
| **21.1 Re-design of Group Therapy Programme** | **Complete Jul-21** |
| **21.3 Build CAMHS Urgent Response Team (CURT)** | **By Mar-22** |
| The CURT model is in place - full implementation will be delivered on the successful recruitment of an additional Senior Nurse and support worker. 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.<br>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.<br>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

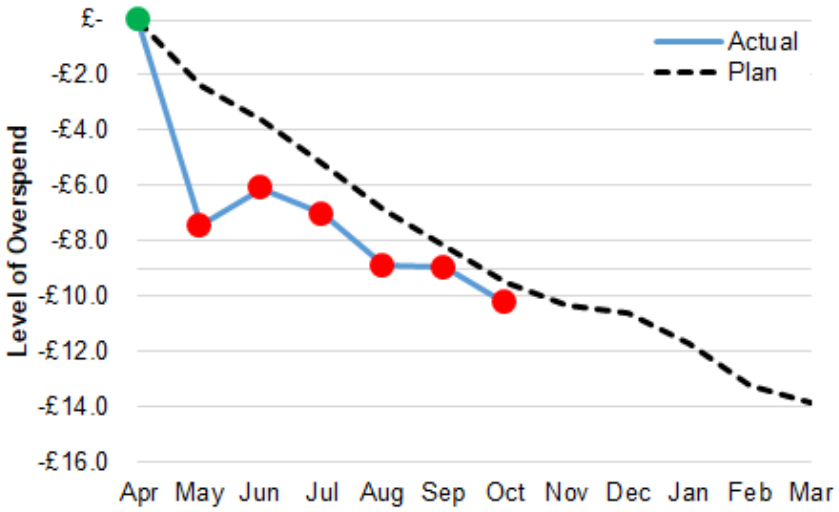
- Meeting waiting times and waiting list trajectories in line with timescales set out for allocation of new resource
- Recruitment of staff required to achieve the above at a time of national workforce pressures
- Progressing vision for PTs within the timeframe required to sustain improved performance

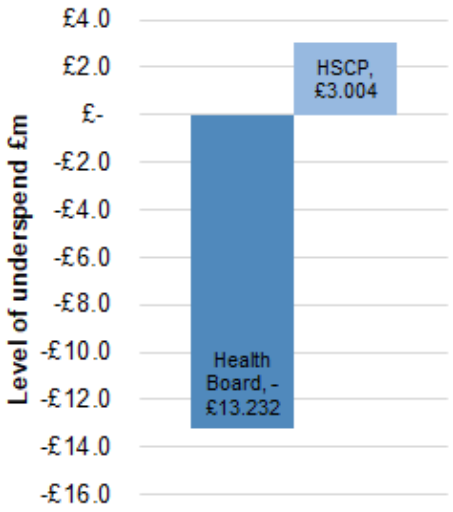
| IMPROVEMENT ACTIONS | |
|---|---|
| **20.5 Trial of new group-based PT options** | **Complete Sep-21** |
| **22.1 Increase access via Guided self-help service** | **Complete Sep-21** |
| **22.2 Expansion of skill mix model to increase delivery of low intensity interventions in Clinical Health Psychology 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 | ENP | | 120 | | 120 | |
| Anticipated | Golden Jubilee SLA | | -24 | | -24 | |
| Anticipated | PCIF | | 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** |

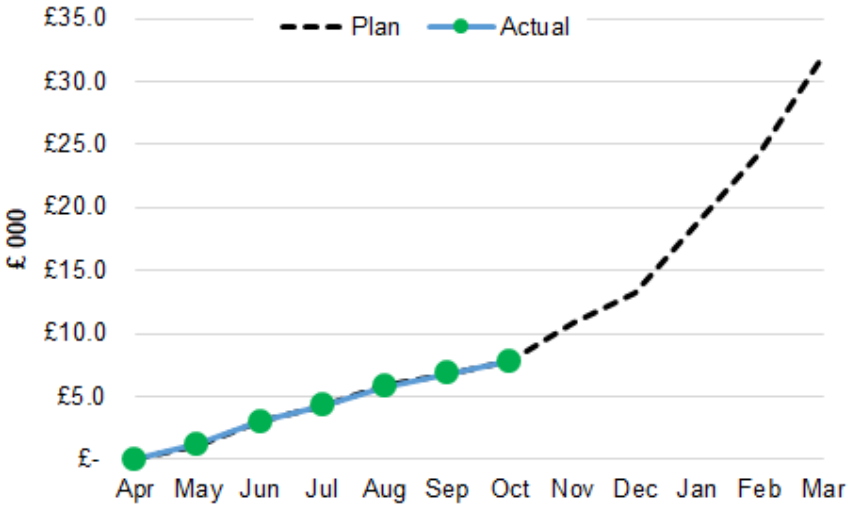
**Appendix 6: Anticipated Funding from Health Delegated Earmarked Reserve**

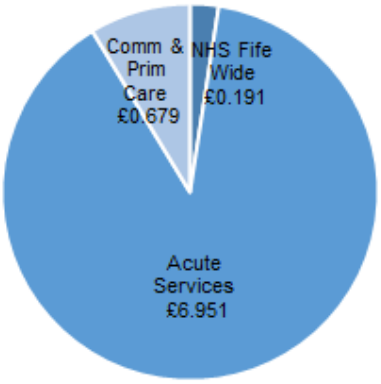
| Health Delegated Earmarked Reserve | | Included within Health | | |
|---|---|---|---|---|
| | Total | To M7 | Anticipated | Balance |
| | £000's | £000's | £000's | £000's |
| Vaccine | 740 | 740 | | 0 |
| Care homes | 526 | 82 | | 444 |
| Urgent Care Redesign | 935 | 408 | | 527 |
| Flu | 203 | 203 | 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<br><br>Routine Expenditure | Pending Board Approval<br><br>£'000 | Cumulative Adjustment to September<br><br>£'000 | October Adjustment<br><br>£'000 | Total October<br><br>£'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** |

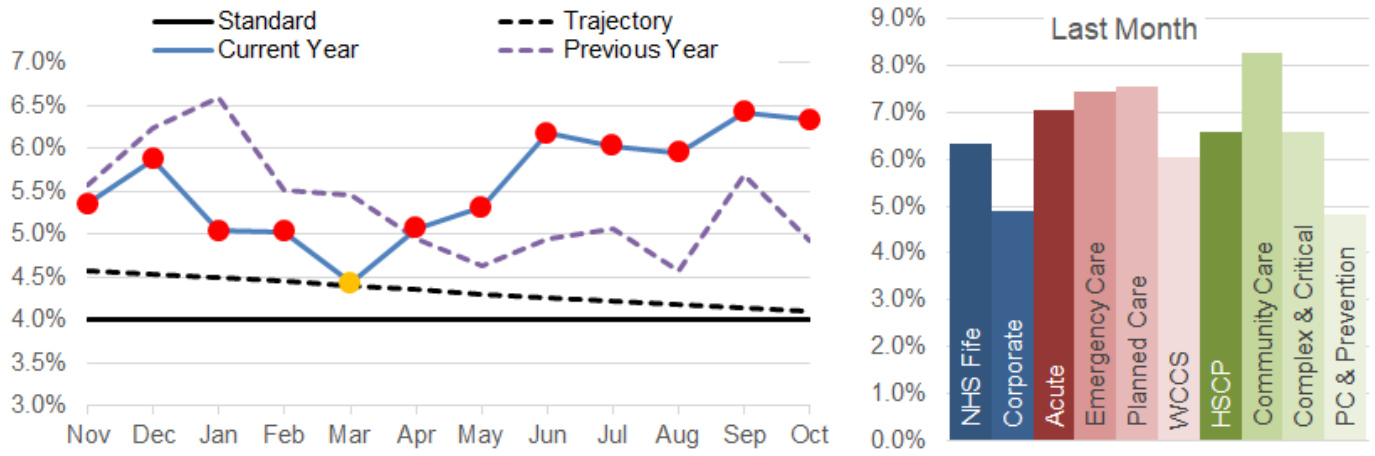
| | | | | |
|---|---|---|---|---|
| **ANTICIPATED ALLOCATIONS 2021/22** | | | | |
| Elective Orthopaedic Centre | 15,907 | 0 | 0 | 15,907 |
| HEPMA | 1,100 | 0 | 0 | 1,100 |
| Kincardine Health Centre | 323 | 0 | 0 | 323 |
| Lochgelly Health Centre | 517 | 0 | 0 | 517 |
| Mental Health Review | 76 | 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.<br>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:** | **Clinical Governance Committee** |
| **Meeting date:** | **13 January 2022** |
| **Title:** | **Joint Remobilisation Plan 4 2021/22** |
| **Responsible Executive:** | **Margo McGurk, Director of Finance and Strategy** |
| **Report Author:** | **Susan Fraser, Associate Director of Planning and Performance** |

## 1 Purpose

**This is presented to the Clinical Governance Committee for:**

- Assurance

**This report relates to the:**

- Fife Joint Remobilisation Plan 4 (2021/22)

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

- Safe
- Effective
- Person Centred

## 2 Report summary

### 2.1 Situation

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

### 2.2 Background

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

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

## 2.3 Assessment

The guidance document issued in July 2021 described a different approach and requirements for RMP4 since the submission of RMP3. We were required to provide a shorter strategic organisational overview with specific delivery action plans to be delivered by March 2022. We will be required to report progress against deliverables to the Scottish Government for Quarter 3 (January 2022) and Quarter 4 April 2022) of 2021/22.

The delivery action plan of the Remobilisation Plan 4 is being monitored and progress documented on a monthly basis. Only completed actions and those actions that are unlikely or at risk of not being delivered are reported to the committees. Key themes relate to resource (workforce and funding) and current services pressures.

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

*Primary, Community and Social Care*

- ✓ Development of a Specialist Respiratory team to support a wide range of respiratory conditions to work collaboratively with the wider Community Teams to support patients, both acutely and long term with COVID.
- ✓ Develop a new Fife laryngectomy service in collaboration with Acute Services.
- ✓ Working towards reinstatement of the diagnostic pathway for Children and Young People, subject to restrictions and guidance.

*Mental Health*

- ✓ Resumption of activity in AMH Day Hospitals.

*Cancer Performance and Early Diagnosis*

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

*Planned Care, Electives and Diagnostics*

- ✓ Secure additional Waiting Times funding to increase capacity and enable waiting list reduction.
- ✓ Introduce PIR (Patient Initiated Review) within Medical Paediatrics.
- ✓ Introduction of Robotic Assisted Surgery to improve clinical outcomes.
- ✓ Continue to increase the number of Nurse Endoscopist posts which is one of the priorities to creating a future sustainable workforce.
- ✓ Remobilisation of Elective pathway in a phased manner with the need to maintain adequate red and amber capacity.
- ✓ Review the model of collection for issuing repeat prescriptions for patients on ADHD/sleep medication.
- ✓ Introduction of home spirometry.
- ✓ **Developmental assessments for Global Developmental Delay to be re-established.**

*Workforce*

- ✓ Potential long term COVID-19 health issues for staff to be addressed through incorporating national guidance from developing evidence into our policy, practice and service delivery arrangements.
- ✓ Continue to ensure Workforce Mobilisation Hubs are robust and flexible to adapt to future challenges.
- ✓ Workforce Planning & Mobilisation Silver Group to continue into 2021/2022 and review workforce deployment mechanisms to address the changing workforce needs across the year.
- ✓ Adapt our onboarding and development delivery approach through the use of e-enabled fast-track induction and other training.

*Digital*

- ✓ ServiceNow - Migration to joint South-East activity to modernise the IT Service Management suite offering improved automation and slicker processes for activities such as ‘Joiners, movers and leavers’ consistent SLA/OLA’s and much improved self-help solutions.
- ✓ ITIL Process Maturity Improvement - Assess and benchmark our maturity against the 5 lifecycles and 27 processes of ITIL.
- ✓ Infrastructure and Network Connectivity - Initiate an architectural review of our infrastructure to support remobilisation including a review of licensing to ensure we have sufficient capacity to support the increase in digital usage.

### Actions unlikely to meet target

*Public Health*

- ■ Improve the health of the Black and Minority Ethnic Community.
- ■ Take forward the recommendations from the Independent Expert Reference Group on COVID-19 and Ethnicity on behalf of NHS Fife.

**Actions at risk**

*Pandemic Response*

- Test, Trace, Isolate and Support in Fife is delivered effectively, risks are managed adequately, and the programme is demonstrating improvements in performance over time.

*Primary, Community and Social Care*

- Redesign by recruiting Advanced Nurse Practitioners who can support the Consultant Rheumatologists in the delivery of the service. This will reduce the reliance on agency medical locum staffing.

*Planned Care, Electives and Diagnostics*

- Exploring Locum Consultant recruitment options.
- Develop and implement plan to deliver all sleep studies in Community setting.
- Near Me Phase 2 - Further develop communication and stakeholder engagement strategy
- Patient Self- Booking - Support Patient Self-Booking across acute and community services. Linked to the Digital Hub is also the emerging capability for pathways to be enhanced by Remote Health Pathways, with COVID discharge and Pre-operative Assessment being identified as high impact areas for consideration.

*Pharmacy*

- Implementation and roll out of HEPMA.

*Workforce*

- Consolidate our workforce sustainability planning, with employee wellbeing at the heart of everything we do. We will review the workforce plans to consider the impact on service re-design, technology enabled care and digital ways of working.
- Consolidation of our Staffing Bank management arrangements.
- Staff personal/professional development needs that have been delayed or restricted due to COVID-19 response to be prioritised as restrictions are eased through Directorate development delivery plans.

*Digital*

- Digital Business Continuity and Disaster Recovery (BC/DR) Plan - Creating and maintaining a robust organisational BC/DR plan following initial review. This programme will have a strong emphasis on full business impact analysis to understand the impact of services not being available on the organisation.
- Paper-lite - Subject to agreed funding, the ambition is to accelerate the Paper-lite programme. Reducing paper to the patient and clinician.

Progress of Winter Preparedness in RMP4 is being reported through the Winter Planning Monthly Report with 15 actions completed so far but 20 are at risk of not meeting deadline with 4 unlikely to meet target date.

### 2.3.1 Quality/ Patient Care

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

### 2.3.2 Workforce

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

### 2.3.3 Financial

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

### 2.3.4 Risk Assessment/Management

A Risk Assessment is contained within the Remobilisation Plan.

### 2.3.5 Equality and Diversity, including health inequalities

Remobilisation Plan included the appropriate equality and diversity impact assessment process as part of the restart process.

### 2.3.6 Other impact

N/A.

### 2.3.7 Communication, involvement, engagement and consultation

Appropriate communication, involvement, engagement and consultation within the organisation and with key external stakeholders is integral to the implementation of the Remobilisation Plan.

### 2.3.8 Route to the Meeting

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

- Winter Silver Command

## 2.4 Recommendation

The Clinical Governance Committee is asked to:

- **Note** the progress of deliverables within Joint Remobilisation Plan 4 (RMP4) which includes the Winter Plan actions.

## 3 List of appendices

N/A

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

# NHS Fife

| | |
|---|---|
| **Meeting:** | **Clinical Governance Committee** |
| **Meeting date:** | **13 January 2022** |
| **Title:** | **Healthcare Associated Infection Report (HAIRT)** |
| **Responsible Executive:** | **Janette Owens** |
| **Report Author:** | **Julia Cook Infection Control Manager** |

## 1 Purpose

Update for Infection Prevention and Control for January 2022 Clinical Governance Committee to provide assurance that all IP&C priorities are being and will be delivered.

**This is presented to the Clinical Governance Committee for:**

- Assurance

**This report relates to a:**

- National Health & Well-Being Outcomes

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

- Safe
- Effective
- Person Centred

## 2 Report summary

### 2.1 Situation

Update for Infection Prevention and Control for January 2022 Clinical Governance Committee to provide assurance that all IP&C priorities are being and will be delivered. This report is for information for the Committee update based on the most recent HAIRT presented to the Infection Control Committee December 2021

### 2.2 Background

Infection Prevention and Control provide a service to NHS Fife including a planned programme of visits, audit, education and support is provided to staff on an ongoing as well as a National programme of Surveillance for Surgical Site Infections, *Clostridiodies difficile* infection (CDI), *Staphylococcus aureus* bacteraemia (SAB) and *E. coli* bacteraemia (ECB).

**Standards on Reduction of Healthcare Associated Infections**:

October 2019: The New standards have been announced by the Scottish Government's Chief Nursing Officer for the reduction of Healthcare Associated Infections for CDI, SAB and ECB. Please see below for new LDP Standards.

***Clostridioides difficile* Infection (CDI)**

- New LDP standards are to reduce incidence of healthcare associated CDI by 10% from 2019 to 2022, utilising 2018/19 as baseline data.
- Outcome measure - achieve 10% reduction by 2022 in healthcare associated infection rate - rate of 6.5 per 100,000 total bed days.

***Staphylococcus aureus* Bacteraemia SAB**

- New LDP standards are to reduce incidence of healthcare associated SAB by 10% from 2019 to 2022, utilising 2018/19 as baseline data.
- Outcome measure to reduce the rate of SAB from 20.9 per 100,000 total bed days in 2018/19, 10% reduction target rate for 2021/22 is 18.8 per 100,000 total bed days.

***Escherichia coli* Bacteraemias (ECB)**

- New LDP standards are to reduce incidence of healthcare associated ECB by 25% from 2019 to 2022, utilising 2018/19 as baseline data.
- Outcome measure to reduce the rate of ECB by 25% from 44.0 per 100,000 total bed days in 2018/19, target rate for 2021/22 is 33.0 per 100,000 total bed days.

## 2.3 Assessment

**SAB**

For Quarter 2 2021 (April-June) NHS Fife was below the national rate for healthcare associated infection (HCAI).

September and October 2021 saw an increase in the number of SABs, with the cumulative monthly total for Jan-Oct 2021 (67) higher than during the same timeframe in 2020, when there were 61 cases.

**Fife-wide Collaborative Improvement Initiatives: NHS Fife will continue to:**

- Collect and analyse SAB data on a monthly basis to understand the magnitude of the risks to patients in Fife.
- Provide timely feedback of data to key stakeholders to assist teams in minimising the occurrence of SABs where possible.
- Examine the impact of interventions targeted at reducing SABs.
- Use results locally for prioritising resources.
- Use the data to inform clinical practice improvements thereby improving the quality of patient care.
- Ongoing work Addiction Services to continue to reduce the number of SABs within the people who inject drugs (PWID) community.

**CDI**

- For Quarter 2 2021 (April-June 2021) NHS Fife was below the national rate for HCAI and CAI.
- NHS Fife has seen an increase in CDI numbers during 2021 (January-October), when compared with the same time period in the previous 2 years.

**Current CDI initiatives**

- Follow up of all hospital and community cases continues to establish risk factors for CDI
- Monthly CDI reporting to Acute Services & HSCP with summary of all CDI cases
- Enhanced surveillance & HPS trigger tool completion for any triggers/ areas of concerns.
- Dr Venkatesh establishing optimum antimicrobial therapy for multiple recurrence CDI case.
- In 2021 innovative work will be focused on our patients with recurrent CDI.
- From October 2019 each CDI case is assessed for suitability of extended pulsed Fidaxomicin (EPFX) regime aiming to prevent recurrent disease in high risk patients.
- Bezlotoxumab for recurrent CDI currently used in Fife.

**ECB**

- For Quarter 2 2021 (April- June) NHS Fife was below the national rate for HCAI & CAI

**Current ECB Initiatives**

- The Infection Prevention and Control team continue to work with the Urinary Catheter Improvement Group (UCIG).
- This group aims to minimize urinary catheters to prevent catheter associated healthcare infections and trauma associated with UC insertion/maintenance/ removal and self-removal to establish Catheter Improvement work in Fife.
- Infection control surveillance alert the patients care team Manager by Datix when an ECB is associated with a traumatic catheter insertion, removal or maintenance.
- Monthly ECB reports and graphs are distributed within HSCP and Acute services
- Catheter insertion/Maintenance bundles now in MORSE for District nurse documentation
- Patientrack CAUTI bundles still to be implemented for Acute services/HSCP but in progress with eHealth

**COVID-19 pandemic**

The IPCT has continued proactive work in preventing healthcare outbreaks, supporting clinical areas with outbreak management and support the safe remobilisation of services.

**Surgical Site Infection (SSI) Surveillance Programme**

The CNO suspended the national SSI Surveillance programme in March 2020 in response to the COVID-19 pandemic

**Caesarean Section SSI**

Local SSI surveillance is being undertaken by the midwifery team to provide local assurance. The surveillance team are in communication with the team & supporting this work.

**Large Bowel Surgery SSI and Orthopaedic Surgery SSI**

Surveillance has been temporarily paused due to the COVID-19 pandemic as per CNO letter.

**Outbreaks** (September - end of October2021)

- **Norovirus**

There has been NO new ward closures due to a Norovirus outbreak

- **Seasonal Influenza**

There has been NO new closures due to confirmed Influenza

- **COVID-19**

Ten ARHAI Scotland reportable outbreaks/incidents of COVID-19 are detailed in the HIIAT

**Hospital Inspection Team**

NHS Fife have not received any further unannounced Hospital Inspections since last report

**Hand Hygiene**

- Hand Hygiene audit results of all staff groups by individual ward, hospital or directorate within both the Acute services & HSCP should be viewed on 'Ward Dashboard'.
- However, from October 2021 it was noted that Ward Dashboard is no longer available as a link on Intranet. This has been reported to eHealth and a response is awaited.

**Cleaning and the Healthcare Environment**

- Keeping the healthcare environment clean is essential to prevent the spread of infections.
- NHS Boards monitor the cleanliness of hospitals and there is a national target to maintain compliance with standards above 90%.
- The Overall Cleaning Compliance for NHS Fife for Quarter 2 (July - September 2021) was **95.7%**.

**National Cleaning Services Specification**

- The National Cleaning Services Specification – quarterly compliance report results for Quarter 2 (July - September 2021) shows NHS Fife achieving **Green** status.

**Estates Monitoring**

- The National Cleaning Services Specification – quarterly compliance report result for shows Quarter 2 (July - September 2021) NHS Fife achieving **Green** status.

### 2.3.1 Quality/ Patient Care

Effective infection prevention and control are essential to the delivery of high quality patient care and to the provision of a clean and safe environment for patients, visitors and other service users.

### 2.3.2 Workforce

Effective infection prevention and control are essential to the provision of a clean and safe working environment, and to overall staff health and wellbeing.

### 2.3.3 Financial

No financial costs identified in this report.

### 2.3.4 Risk Assessment/Management

Challenges and management of any risks to national infection prevention and control guidance discussed throughout report

### 2.3.5 Equality and Diversity, including health inequalities

Effective infection prevention and control include assessments of equality and diversity impact as appropriate

### 2.3.6 Other impact

N/A

### 2.3.7 Communication, involvement, engagement and consultation

This paper has been considered by the Infection Control Manager

### 2.3.8 Route to the Meeting

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

This is a summary of the HAIRT submitted to the Infection Control Committee December 2021

## 2.4 Recommendation

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

## 3 List of appendices

The following appendices are included with this report:

Appendix 1 – HAIRT Report

Appendix 2 – ICC Notes – 1 December 2021

**Report Contact**
Julia Cook
Infection Control Manager
Email Julia.Cook@nhs.scot

# Final Report for ICC on 1st December 2021
# (Validated Data up to October 2021)

## Section 1– Board Wide Issues
### Key Healthcare Associated Infection Headlines up to 1st of November 2021

**1.1 Achievements:**

***Staphylococcus aureus* Bacteraemia Prevention (SAB)**
During Q2 2021 (April-June), NHS Fife was below the national rate for healthcare associated infection (HCAI) and community associated infection (CAI).

***Clostridioides difficile* Infection (CDI)**
During Q2 2021(April-June), NHS Fife was below the national rate for HCAI & CAI.

***Escherichia coli* Bacteraemias (ECB)**
During Q2 2021 (April-June), NHS Fife was below the national rate for HCAI & CAI.

**1.2 Challenges:**

**SABs**
Vascular access devices (VAD) remain the greatest challenge for Hospital acquired SABs, ongoing improvement works.
September and October 2021 saw an increase in the number of SABs, with the cumulative monthly total for Jan-Oct 2021 (67) higher than during the same timeframe in 2020, when there were 61 cases.

**ECBs**
Lower Urinary tract Infections (UTIs) and Catheter associated UTIs (CAUTIs) remain the prevalent source of ECBs and are therefore the two areas to address to reduce the ECB rate.

**CDI**
So far, NHS Fife has seen an increase in CDI numbers during 2021 (January-October), when compared with the same time period in the previous 2 years.
Whilst Fife's CDI Year ending Q2 2021 rates are below the national rates, the HCAI incidence must still reduce further to meet the HCAI reduction target.

**Caesarean Section SSI/ Large Bowel Surgery SSI/ Orthopaedic Surgery SSI**
National surveillance programme for SSI 2021 has been paused due to the COVID-19 pandemic.

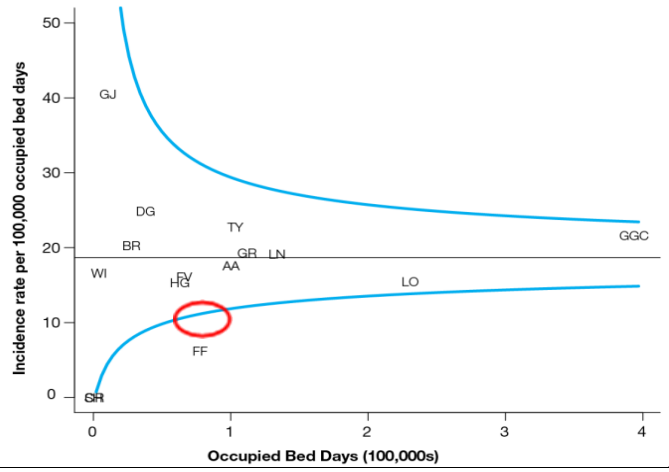
**Final Report for ICC on 1st December 2021**
**(Validated Data up to October 2021)**

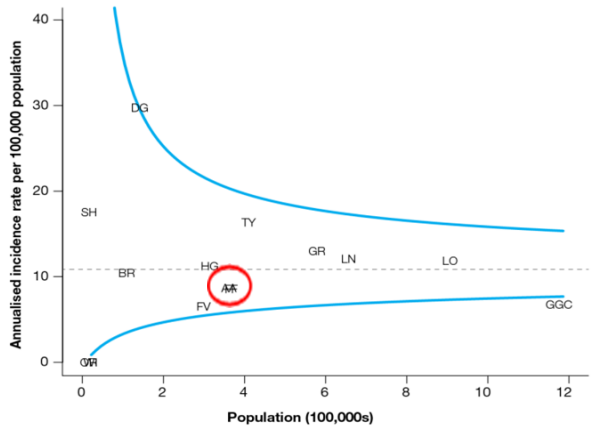
## 2. *Staphylococcus aureus* incorporating MRSA/CPE screening compliance

### 2.1 Trends – Quarterly

| ***Staphylococcus aureus* Bacteraemias (SABs)** | | | | |
|---|---|---|---|---|
| **Local Data: Q3 2021 (Jul-Sep)**<br>**(Q3 2021 National comparison awaited)** | | | | |
| In Q3 2021 NHS Fife had: | 23 SABs | 14 HCAI/HAI<br>9 CAI | This is **UP** from | 12 Cases in Q2 2021 |

| **Q2 2021 (Apr-Jun) - HPS Validated data with commentary** | | | |
|---|---|---|---|
| **Healthcare associated SABs** | | Community associated SABs infection | |
| HCAI SAB rate: **6.3** | **Per 100,000 bed days** | CAI SABs rate: **8.6** | Per 100,000 Pop |
| No of HCAI SABs: 5 | | No of CAI SABs: 8 | |
| This is **BELOW** National rate of 18.7 | | This is **BELOW** National rate of 10.9 | |




For CAI SABs: NHS Fife was **WITHIN** the 95% confidence interval in the funnel plot analysis and for HCAI was **BELOW** the 95% confidence interval.

| **New standards for reducing all Healthcare Associated SAB by 10% by 2022 (from 2018/2019 baseline)** | | |
|---|---|---|
| **Standards application for Fife:** | **SAB Rate Baseline 2018/2019** | **SAB 10% reduction target by 2022** |
| SAB by rate 100,000 Total bed days | **20.9** per 100,000 TBDs | **18.8** 100,000 TBDs |
| SAB by Number of HCAI cases | **76** | **68** |
| **Current 12 Monthly HCAI SAB rates for Year ending June 2021 (HPS)** | | |
| SAB by rate 100,000 Total bed days | **15.7** per 100,000 TBDs | |
| SAB by Number of HCAI cases | **49** | |

**Local Device related SAB surveillance**

- Localised enhanced surveillance focuses on high-risk clinical areas and vascular line SABs.
- Weekly reports issued to Senior Charge Nurses if their ward has failed to achieve **90%** of all PVC being removed prior to the 72hr breach.
- PVC & CVC related SABs will continue to be Datix'd by Dr Morris and undergo a SAER.
- There have been 2 recent dialysis line related SABs (22/9/21 from Ward 21 QMH and 15/10/21 from Renal Outpatients VHK) and the situation has been DATIX`d. Please note that prior to these cases, there had not been a dialysis line related SAB since January 2021. The IPCT continues ongoing surveillance and provides support to the renal staff around VAD care.

| As of **09/11/2021** the number of days since the last confirmed SAB is as follows: | |
|---|---|
| CVC SABs | 58 Days |
| PWID (IVDU) | 9 Days |
| Renal Services Dialysis Line SABs | 25 Days |
| Acute services PVC (Peripheral venous cannula) SABs | 88 Days |

Please see other SAB graphs & report attachments within 4.1b of Agenda

### 2.2 Current SAB Initiatives

*Fife-wide Collaborative Improvement Initiatives: NHS Fife will continue to:*

- Collect and analyse SAB data on a monthly basis to understand the magnitude of the risks to patients in Fife.
- Provide timely feedback of data to key stakeholders to assist teams in minimising the occurrence of SABs where possible.
- Examine the impact of interventions targeted at reducing SABs.
- Use results locally for prioritising resources.
- Use data to inform clinical practice improvements thereby improving the quality of patient care.
- Liaise with Drug addiction services re PWID (IVDU) SABs. PGD for antibiotic prescribing now in progress by Addictions team. IPCT refresher presentation prepared, awaiting input from Addictions Manager. A meeting with Addiction services & IPCT is scheduled 22nd November 2021. A voiced over educational video by IPCT on SAB definitions, signs & symptoms & interventions has been completed & sent to Addiction services for staff training.

### 2.3 National MRSA & CPE screening programme

**MRSA**

An uptake of 90% with application of the MRSA Clinical Risk Assessment (CRA) screening is necessary in order to ensure that the national policy for MRSA screening is effective

NHS Fife achieved **88%** compliance with the **MRSA** CRA in Q3 (Jul-Sep) 2021

This was **DOWN** on Q2 2021 (98%) & **BELOW** the compliance target of 90%.

This National Scottish average for Q3 2021 is still to be published.

**MRSA** Critical risk assessment (CRA) screening KPI compliance summary:

| Quarter | Q3 2019 Jul-Sept | Q4 2019 Oct-Dec | Q1 2020 Jan-Mar | Q2 2020 Apr-Jun | Q3 2020 Jul-Sept | Q4 2020 Oct-Dec | Q1 2021 Jan-Mar | Q2 2021 Apr-Jun | Q3 2021 Jul-Sep |
|---|---|---|---|---|---|---|---|---|---|
| Fife | 93% | 93% | 83% | 98% | 88% | 98% | 95% | 98% | 88% |
| Scotland | 89% | 88% | 88% | 87% | 86% | 82% | 83% | 84% | n/k |

**CPE** (Carbapenemase Producing Enterobacteriaceae)

From April 2018, CRA has also included screening for CPE.

NHS Fife achieved **100%** compliance with the **CPE** CRA for Q3 2021 (Jul-Sep)

This is **UP** from 90% in Q2 2021

The National Scottish average for Q3 2021 is still to be published.

| Quarter | Q3 2019 Jul-Sept | Q4 2019 Oct-Dec | Q1 2020 Jan-Mar | Q2 2020 Apr-Jun | Q3 2020 Jul-Sept | Q4 2020 Oct-Dec | Q1 2021 Jan-Mar | Q2 2021 Apr-Jun | Q3 2021 Jul-Sep |
|---|---|---|---|---|---|---|---|---|---|
| Fife | 83% | 80%* | 93% | 95% | 85% | 98% | 88% | 90% | 100% |
| Scotland | 86% | 85% | 85% | 80% | 85% | 79% | 82% | 83% | n/k |

**CPE** CRA screening KPI compliance Summary- Commenced from April 2018

**MDRO CRA Patientrack Update**

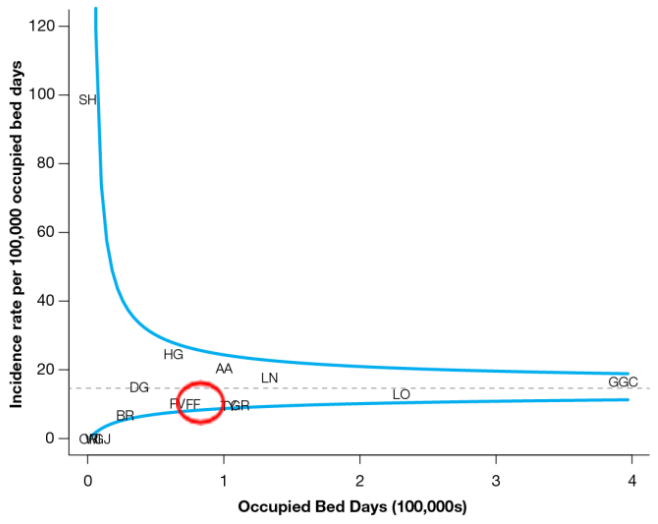
- Following a successful pilot of the electronic MDRO CRA in AU2, Patientrack has now added the CPE and MRSA assessments which were rolled out across the Board in September 2021
- The IPCT available for support to clinical teams
- Ongoing quality assurance will continue through 2021

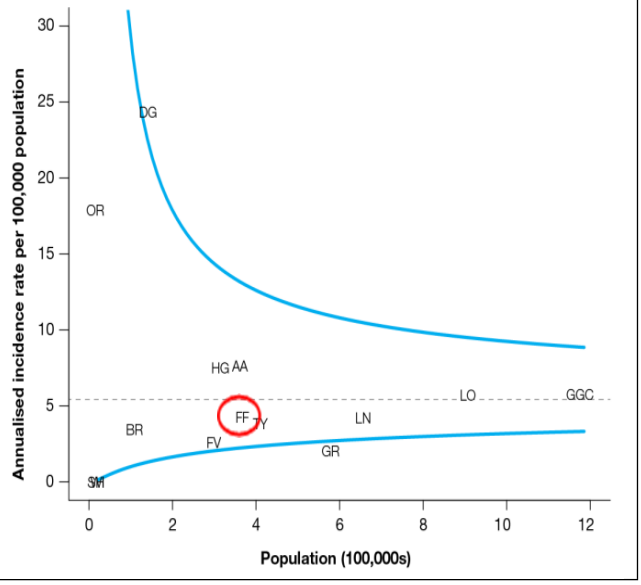
## 3 *Clostridioides difficile* Infection (CDI)

### 3.1 Trends

| ***Clostridioides difficile* Infection (CDI)** | | | | |
|---|---|---|---|---|
| **Local Data: Q3 Jul-Sep 2021 (Q3 2021 HPS National comparison awaited)** | | | | |
| In Q3 2021 NHS Fife had: | 12 CDIs | 8 HCAI/HAI/Unknown<br>4 CAI | This remains the same as | 12 Cases in Q2 2021 |

| **Q2 2021** | | | |
|---|---|---|---|
| With HPS Quarterly epidemiological data Commentary<br>*Please note for HPS reporting- the CDI denominator may vary from locally reported denominators.<br>This is due to some Fife resident Community onset CDIs allocated back to NHS Fife, even though they were treated at other Health boards. | | | |
| **Healthcare associated CDIs** | | Community associated CDIs infection | |
| HCAI CDI rate: **10.0** | **Per 100,000 bed days** | CAI CDIs rate: **4.3** | Per 100,000 Pop |
| No of HCAI CDIs: 8 | | No of CAI CDIs: 4 | |
| This is **BELOW** National rate of 14.6 | | This is **BELOW** National rate of 5.4 | |




| **New standards for reducing all Healthcare Associated CDI by 10% by 2022 (from 2018/2019 baseline)** | | |
|---|---|---|
| **Standards application for Fife:** | **CDI Rate Baseline 2018/2019** | **CDI 10% reduction target by 2022** |
| CDI by rate 100,000 Total bed days | **7.2** per 100,000 TBDs | **6.5** 100,000 TBDs |
| CDI by Number of HCAI cases | **26** | **23** |
| **Current 12 Monthly HCAI CDI rates for Year ending June 2021 (HPS)** | | |
| CDI by rate 100,000 Total bed days | **10.3** per 100,000 TBDs | |
| CDI by Number of HCAI cases | **32** | |

### 3.2 Current CDI initiatives

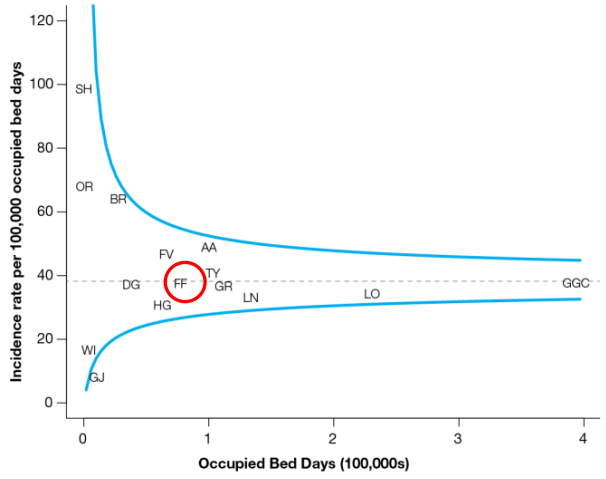
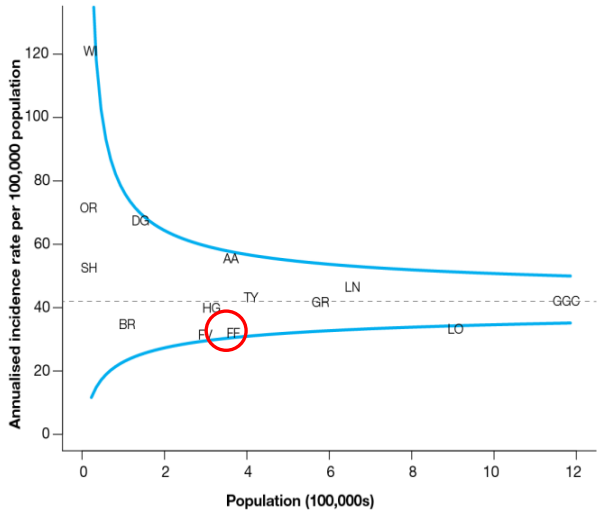
Follow up of all hospital and community cases continues to establish risk factors for CDI

- Monthly CDI reporting to Acute Services & HSCP with summary of all CDI cases
- Enhanced surveillance & HPS trigger tool completion for any triggers/ areas of concerns.
- Dr Venkatesh establishing optimum antimicrobial therapy for multiple recurrence CDI case.
- In 2021 innovative work will be focused on our patients with recurrent CDI.
- From October 2019 each CDI case is assessed for suitability of extended pulsed Fidaxomicin (EPFX) regime aiming to prevent recurrent disease in high risk patients.
- Bezlotoxumab for recurrent CDI currently used in Fife.

## 4.0 *Escherichia coli* Bacteraemias (ECB)

## 4.1 Trends:

| ***Escherichia coli* Bacteraemias (ECB)** | | | | |
|---|---|---|---|---|
| **Local Data: Q3 (Jul-Sep) 2021 (Q3 2021 HPS National comparison awaited)** | | | | |
| In Q3 2021 NHS Fife had: | 85 ECBs | 48 HAI/HCAIs<br>37 CAIs | This is **UP** from | 56 Cases in Q2 2021 |
| **Q3 2021** There were 14 Urinary catheter associated ECBs (4 x HAI & 10 x HCAI)<br>There were no trauma related CAUTIs in Q3 2021. | | | | |

| **Q2 (Apr-Jun) 2021** | | | |
|---|---|---|---|
| **HPS Validated data ECBs with HPS commentary**<br>*Please note for HPS reporting- the ECB denominator may vary from locally reported denominators.<br>Due to some Fife resident Community onset ECB allocated back to NHS Fife, even though they were treated at other Health boards. | | | |
| **Healthcare associated ECBs** | | Community associated ECBs infection | |
| HCAI ECB rate: **37.6** | **Per 100,000 bed days** | CAI ECBs rate: **32.2** | Per 100,000 Pop |
| No of HCAI ECBs: 30 | | No of CAI ECBs: 30 | |
| This is **BELOW** National rate of 38.2 | | This is **BELOW** National rate of 41.9 | |
|  | |  | |
| For HCAI & CAI ECBs: NHS Fife was **WITHIN** the 95% confidence interval in the funnel plot analysis | | | |

Two HCAI reduction standards have been set for ECBs:

| **1) 25% reduction ECBs - 2021/2022** | | |
|---|---|---|
| **New standards for reducing all Healthcare Associated ECB by 25% by 2021/22** (from 2018/2019 baseline) | | |
| **Standards application for Fife:** | **ECB Rate Baseline 2018/2019** | **ECB 25% reduction target by 2022** |
| ECB by rate 100,000 Total bed days | **44.0** per 100,000 TBDs | **33.0** per 100,000 TBDs |
| ECB by Number of HCAI cases | **160** | **120** |
| **Current 12 Monthly HCAI ECB rates for Year ending June 2021 (HPS)** | | |
| ECB by rate 100,000 Total bed days | **38.6** per 100,000 TBDs | |
| ECB by Number of HCAI cases | **120** | |

| **2) 50% Reduction ECBs - 2023/2024** | | |
|---|---|---|
| **New standards for reducing all Healthcare Associated ECB by 50% by 2023/2024** (from 2018/2019 baseline) | | |
| **Standards application for Fife:** | **ECB Rate Baseline 2018/2019** | **ECB 50% reduction target by 2023/4** |
| ECB by rate 100,000 Total bed days | **44.0** per 100,000 TBDs | **22.0** 100,000 TBDs |
| ECB by Number of HCAI cases | **160** | **80** |

**2021-2017 NHS Fife's Urinary catheter Associated ECBs –**
HPS data Q2 data still awaited

**Hospital Acquired Infections (HAI) (Acute & HSCP Hospitals)**
CATHETER Device related *E.coli* Bacteraemia
Count of Device- Catheter over Total Fife **HAI** ECBs

| | NHS Scotland | **NHS Fife** | Rate calculation |
|---|---|---|---|
| 2021 Q3 | TBC | ***20%** | |
| 2021 Q2 | 23.4% | **25%** | * Locally calculated data- TBC by HPS when Q3 data published on Discovery |
| 2021 Q1 | 12.9% | **8.3%** | |
| 2020 TOTAL | 16.4 % | **27.5 %** | |
| 2019 TOTAL | 16.1 % | **24.5 %** | |
| 2018 TOTAL | 14.5 % | **24.2 %** | |
| 2017 -TOTAL | 11.8 % | **10.4 %** | |
| Data from NSS Discovery ARHAI Indicators | | | |

**Healthcare Associated Infections (HCAI)**
CATHETER Device related *E.coli* Bacteraemia
Count of Device- Catheter over Total Fife **HCAI** ECBs

| | NHS Scotland | **NHS Fife** | Rate calculation |
|---|---|---|---|
| 2021 Q3 | TBC | ***35.7%** | |
| 2021 Q2 | 32.5 | **40.9%** | * Locally calculated data- TBC by HPS when Q3 data published on Discovery |
| 2021 Q1 | 27.2% | **40%** | |
| 2020 TOTAL | 24.1 % | **23.0 %** | |
| 2019 TOTAL | 22.8 % | **28.0 %** | |
| 2018 TOTAL | 22.1% | **36.6 %** | |
| 2017 TOTAL | 18.3 % | **35.3 %** | |
| Data from NSS Discovery ARHAI Indicators | | | |

**4.2 Current ECB Initiatives**

**Urinary catheter Group work following raised ECB CAUTI incidence**

The IPC Surveillance team continue to liaise with the Urinary Catheter Improvement Group.
This group aims to minimize urinary catheters to prevent catheter associated healthcare infections & trauma associated with UC insertion/maintenance/ removal & self-removal & to establish Catheter Improvement work in Fife.
The Infection control team continue to work with the Urinary Catheter Improvement group meeting- the next meeting on **19th November 2021.**

Infection control surveillance alert the patients care team Manager by Datix when an ECB is associated with a traumatic catheter insertion, removal or maintenance.

Proposal made through ECB strategy plan for all catheter related ECB to be reportable on Datix & to then undergo a LAER to provide further learning from all ECB CAUTIs. Adverse event activity is ongoing but are being mindful of the pressures in the system.

Monthly ECB reports & graphs are distributed within HSCP & Acute services

Up to 01.11.2021: There have been **TWO** trauma associated CAUTIs in 2021

Catheter insertion/Maintenance bundles now inserted in MORSE for District nurse documentation

Patientrack CAUTI bundles still to be implemented for Acute services/HSCP but in progress with eHealth. There is no fixed timescale but it is hoped this will be installed in 2021.

CAUTI QI projects: Kelty MP- CAUTI QI project ongoing

## 5. Hand Hygiene

- Good hand hygiene by staff, patients and visitors is a key way to prevent the spread of infections.
- NHS Boards monitor hand hygiene and ensure a zero tolerance approach to non-compliance.
- Reporting of Hand Hygiene performance is based on data submitted by each ward via LanQIP
- A minimum of 20 observations are required to be audited per month per ward.
- Hand Hygiene audit results of all staff groups by individual ward, hospital or directorate within both the Acute services & HSCP should be viewed on 'Ward Dashboard'.
- However, form October 2021 it was noted that Ward Dashboard has disappeared as a link on Intranet. This has been reported to eHealth and a response is awaited
  The hand hygiene compliance for the last up to March 2021 only can be found in Section 11.

### 5.1 Trends

- NHS Fife overall results remain consistently ABOVE 98%
- This is ABOVE the Overall target set of 95%

## 6. Cleaning and the Healthcare Environment

- Keeping the healthcare environment clean is essential to prevent the spread of infections.
- NHS Boards monitor the cleanliness of hospitals and there is a national target to maintain compliance with standards above 90%.
- The Overall Cleaning Compliance for NHS Fife for Quarter 2 (Jul-Sep 2021) was **95.7%**.
- The cleaning compliance score for NHS Fife & each acute hospital can be found in Section 11

### 6.1 Trends

- All hospitals and health centres throughout NHS Fife have participated in the *National Monitoring Framework* for *NHS Scotland National Cleaning Services Specification*. Since April 2006, all wards and departments have been regularly monitored with quarterly reports being produced through Health Facilities Scotland (HFS).

- **National Cleaning Services Specification**

| Domestic Location | Q2 Jul-Sep 21 | Q1 Apr-Jun 21 |
|---|---|---|
| Fife | 95.7% ↑ | 95.4% |
| Scotland | 95.5% | 95.3% |

- The National Cleaning Services Specification – quarterly compliance report result for Q2 (Jul-Sep) 2021 shows NHS Fife achieving **GREEN** status.

- **Estates Monitoring**

| Estates Location | Q2 Jul-Sep 21 | Q1 Apr-Jun 21 |
|---|---|---|
| Fife | 96.0↓ | 96.2 |
| Scotland | 96.3 | 96.3 |

- The National Cleaning Services Specification – quarterly compliance report result for Quarter 2 (Jul-Sep) 2021 shows NHS Fife achieving **GREEN** status.

### 6.2 Current Initiatives

· Areas with results below 90% for all Hospital & Healthcare facilities have been identified to relevant managers for action.

## 7.1 Outbreaks

This section gives details on any outbreaks that have taken place in the Board since the last report, or a brief note confirming that none has taken place.

Where there has been an outbreak this states the causative organism, when it was declared, number of patients & staff affected & number of deaths (if any) & how many days the closure lasted.

A summary of all outbreaks since the last report will be within Section 4.1h of the Agenda.

All ward/ bay closures due to Norovirus & Influenza are reported to HPS weekly plus all closures due to an Acute Respiratory Illness (ARI).

All Influenza patients admitted to ICU are also notifiable to HPS

**September – end of October 2021**

**Norovirus**

There has been NO new ward closures due to a Norovirus outbreak since last ICC report

**Weekly national Laboratory reports of Norovirus in Scotland- week 45 2021 (Week ending 14 |November 2021)**

- The provisional total of laboratory reports for norovirus in Scotland up to the end of week 45 of 2021 (week ending 14 November 2021) is 223.
- In comparison, to the end of week 45 in 2020 PHS received 214 laboratory reports of norovirus. The five-year average for the same time period between years 2015 and 2019 was 1086.

**Seasonal Influenza**

There has been NO new closures due to confirmed Influenza since the last reporting period.

**Weekly national seasonal respiratory report-** week **45 2021**

- Influenza activity was at **Baseline** level. There were 10 influenza cases.
- Respiratory syncytial virus (RSV) increased from Baseline to **Low** activity level. The typical RSV season usually peaks between week 49 and week 52. However, in 2021, week on week increases in laboratory-confirmed diagnoses for RSV were reported between week 23 and week 40. Cases have declined over consecutive weeks since the peak in week 40 but a slight increase has been noted for week 45.
- Coronavirus (non-SARS-CoV-2) and rhinovirus were at **Moderate** activity level.
- Human metapneumovirus (HMPV) and parainfluenza were at **Low** activity level.
- Influenza vaccine data are presented and indicate that at least 1,697,724 eligible individuals are estimated to have received their vaccine.

## 7.2 COVID-19 pandemic

NHS Fife is currently managing the pandemic COVID-19 across all of its services.
Please note COVID-19 cases are being reported on the Scottish Government website.

COVID-19 incidents/clusters/outbreaks September – October 2021, there has been 10 new COVID-19 outbreaks/incidents reportable to ARHAI Scotland during this reporting period.

| COVID-19 outbreaks/incidents reported to ARHAI Scotland Sep/Oct 2021 | |
|---|---|
| Hospital | Ward |
| VHK | Ward 23 |
| VHK | AU1 |
| St. Andrews | Ward 1 |
| VHK | Ward 44 |
| VHK | Hospice |
| VHK | Ward 41 |
| VHK | Ward 6 |
| VHK | Ward 42 |
| VHK/QMH | VHK Ward 32/QMH Ward 8 |
| VHK | Ward 53 |

## 8. Surgical Site Infection Surveillance Programme

A letter on 25 March 2020 from the Chief Nursing Officer revised HAI surveillance requirements with temporary changes to routine surveillance:

- All mandatory and voluntary Surgical Site Infection (SSI) surveillance should be paused until further notice

| **8 a) Caesarean section SSI** |
|---|
| **All Caesarean Section surveillance has been postponed due to the COVID19 pandemic until further notice** |

| **8 b) Hip Arthroplasty SSI** |
|---|
| **All Orthopaedic surveillance has been postponed due to the COVID19 pandemic until further notice** |

| **8 c) Hemi arthroplasty SSI** |
|---|
| **All Orthopaedic surveillance has been postponed due to the COVID19 pandemic until further notice** |

| **8 d) Knees SSI** |
|---|
| **All Orthopaedic surveillance has been postponed due to the COVID19 pandemic until further notice** |

| **8 e) Large Bowel SSI** |
|---|
| **All large bowel surveillance has been postponed due to the COVID19 pandemic until further notice** |

## 9. Hospital Inspection Team

There have been no inspections during this reporting period

## 10. Assessment

- **CDIs**: The number of *Clostridioides difficile* cases has risen during 2021 (compared with the previous 2 years). Monitoring will assess if this trend continues. The number of healthcare associated (HAI/HCAI/Unknown) infections need to be reduced to achieve target
- Reducing incidence of recurrence of infections is key to reducing healthcare CDIs
- **SABs**: The Acute Services Division continues to see intermittent blood stream infections related to vascular access device infections
- Interventions to reduce Peripheral Vascular Catheter infections and Dialysis line infections have been effective but remains a challenge & local surveillance continues
- **ECBs**: Healthcare associated (HAI/HCAI) ECBs remain a challenge
- Addressing CAUTI related ECBs through the Urinary Catheter Improvement Group
- Addressing Lower UTI related ECBs
- **SSIs surveillance** currently suspended during COVID pandemic for:
- C-sections,
- Large bowel surgery
- Orthopaedic procedure surgeries
  -Total hip replacements, Knee replacements & Repair fractured neck of femurs
  - Feedback forums to clinical teams for all SSIs is firmly established to address SSI challenges where they occur.

## 11. Healthcare Associated Infection Reporting Template (HAIRT)

The HAIRT template provides CDI, SAB & ECBs information for NHS Fife categorizing by:

- Total NHS Fife
- VHK wards,
- QMH wards (wards 5,6,& 7) &
- Community Hospital wards (QMH 1-4, SH, SACH, GH, LH, CH, AH, RWH, WBH, All Hospices)
- Out of Hospital (Infections that occur in the community/GP or within 48 hours of hospital admission

ECBs, CDIs & SABs are categorized as:

**Healthcare Associated** (HCAI & HAI) or **Community** Onset (Community or Not known).
Please see HPS definition of Healthcare Associated & Community infections in 'References & Links'

The 2019 Scottish Government's new standards aim to reduce the Healthcare Associated Infections.

The information provided is local data, and may differ from the national surveillance reports carried out by Health Protection Scotland. This is due to some Fife residents who are treated at other health boards being allocated back to Fife's data. However, these reports aim to provide more detailed and up to date local information on HAI activities than is possible to provide through the national statistics.

Hand hygiene and cleaning compliances are shown by Total Fife, VHK & QMH.

**Final Report for ICC on 1st December 2021**
**(Validated Data up to October 2021)**

# NHS Fife TOTAL

| | NHS Fife | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | SAB | | | C Diff | | | ECB | | |
| Month | HAI & HCAI | Community / Not Known | SAB Total | HAI/HCAI / UnKnown | Community | CD Total | HAI & HCAI | Community / Not Known | ECB Total |
| Apr-21 | 4 | 2 | 6 | 4 | 0 | 4 | 5 | 5 | 10 |
| May-21 | 0 | 3 | 3 | 3 | 2 | 5 | 12 | 12 | 24 |
| Jun-21 | 1 | 2 | 3 | 1 | 2 | 3 | 13 | 9 | 22 |
| Jul-21 | 3 | 2 | 5 | 3 | 2 | 5 | 13 | 15 | 28 |
| Aug-21 | 5 | 3 | 8 | 3 | 0 | 3 | 13 | 15 | 28 |
| Sep-21 | 6 | 4 | 10 | 2 | 2 | 4 | 21 | 8 | 29 |
| Oct-21 | 3 | 4 | 7 | 1 | 0 | 1 | 10 | 14 | 24 |

| Hand Hygiene Monitoring Compliance (%) TOTAL FIFE | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Dec 20 | Jan 21 | Feb 21 | Mar 21 | Apr 21 | May 21 | June 21 | Jul 21 | Aug 21 | Sep 21 | Oct 21 |
| Overall | 98 | 99 | 99 | 99 | NK | NK | NK | NK | NK | NK | NK |
| AHP | 98 | 98 | 100 | 97 | NK | NK | NK | NK | NK | NK | NK |
| Medical | 97 | 100 | 97 | 99 | NK | NK | NK | NK | NK | NK | NK |
| Nurse | 100 | 100 | 100 | 99 | NK | NK | NK | NK | NK | NK | NK |
| Other | 95 | 100 | 100 | 100 | NK | NK | NK | NK | NK | NK | NK |

Please note: there is currently no access to `Ward Dashboard`.

| Cleaning Compliance (%) TOTAL FIFE | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Dec 20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May 21 | June 21 | July 21 | Aug 21 | Sep 21 | Oct 21 |
| Overall | 96.0 | 95.8 | 95.9 | 95.9 | 95.6 | 94.9 | 95.6 | 95.6 | 96.0 | 95.6 | 95.8 |

| Estates Monitoring Compliance (%) TOTAL FIFE | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Dec 20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May21 | June 21 | July 21 | Aug 21 | Sep 21 | Oct 21 |
| Overall | 96.2 | 95.7 | 96.3 | 96.5 | 96.3 | 95.7 | 96.4 | 95.7 | 96.3 | 96.1 | 96.0 |

**Final Report for ICC on 1st December 2021**
**(Validated Data up to October 2021)**

## Victoria Hospital

| | VHK | | |
|---|---|---|---|
| | SAB >48hrs admx | CDI >48hrs admx | ECB >48hrs admx |
| Month | HAI | HAI | HAI |
| Apr-21 | 2 | 0 | 0 |
| May-21 | 0 | 2 | 3 |
| Jun-21 | 1 | 1 | 4 |
| Jul-21 | 0 | 1 | 3 |
| Aug-21 | 2 | 0 | 5 |
| Sep-21 | 2 | 2 | 7 |
| Oct-21 | 3 | 0 | 4 |

| Cleaning Compliance (%) Victoria Hospital | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Nov 20 | Dec 20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May 21 | Jun 21 | Jul 21 | Aug 21 | Sep 21 | Oct 21 |
| Overall | 95.4 | 95.8 | 95.8 | 95.9 | 96.1 | 95.9 | 95.3 | 95.8 | 95.5 | 96.0 | 95.9 | 95.7 |

| Estates Monitoring Compliance (%) Victoria Hospital | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Nov 20 | Dec 20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May 21 | Jun 21 | Jul 21 | Aug 21 | Sep 21 | Oct 21 |
| Overall | 96 | 96.4 | 95.2 | 96.9 | 95.2 | 96.5 | 96.4 | 97.2 | 96.5 | 96.8 | 96.8 | 96.5 |

## Queen Margaret's Hospital

| | QMH | | |
|---|---|---|---|
| | SAB >48hrs admx | CDI >48hrs admx | ECB >48hrs admx |
| Month | HAI | HAI | HAI |
| Apr-21 | 0 | 0 | 0 |
| May-21 | 0 | 1 | 0 |
| Jun-21 | 0 | 0 | 0 |
| Jul-21 | 1 | 1 | 2 |
| Aug-21 | 0 | 0 | 2 |
| Sep-21 | 1 | 0 | 0 |
| Oct-21 | 0 | 0 | 0 |

| Cleaning Compliance (%) Queen Margaret's hospital | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Nov 20 | Dec 20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May 21 | Jun-21 | Jul 21 | Aug 21 | Sep 21 | Oct 21 |
| Overall | 96.2 | 96.9 | 96.1 | 96.5 | 96.5 | 96.0 | 96.7 | 96.7 | 96.3 | 97.0 | 96.3 | 96.7 |

| Estates Monitoring Compliance (%)Queen Margaret's hospital | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Nov 20 | Dec 20 | Jan - 21 | Feb - 21 | Mar-21 | Apr-21 | May 21 | Jun-21 | July 21 | Aug 21 | Sep 21 | Oct 21 |
| Overall | 96.1 | 97.1 | 96.2 | 95.6 | 97.1 | 95.5 | 94.3 | 95.3 | 94.6 | 95.3 | 95.5 | 95.7 |

**Final Report for ICC on 1st December 2021**
**(Validated Data up to October 2021)**

## Community Hospitals

| | COMMUNITY HOSPITALS | | |
|---|---|---|---|
| | SAB >48hrs admx | CDI >48hrs admx | ECB >48hrs admx |
| Month | HAI | HAI | HAI |
| Apr-21 | 0 | 1 | 0 |
| May-21 | 0 | 0 | 1 |
| Jun-21 | 0 | 0 | 0 |
| Jul-21 | 1 | 0 | 0 |
| Aug-21 | 0 | 0 | 1 |
| Sep-21 | 0 | 0 | 0 |
| Oct-21 | 0 | 0 | 0 |

## Outs of Hospital Infections

| | OUT OF HOSPITAL | | | | | |
|---|---|---|---|---|---|---|
| | SAB <48hrs admx | | CDI <48hrs admx | | ECB <48hrs admx | |
| Month | HCAI | Community / Not Known | HCAI / UnKno | Community | HCAI | Community / Not |
| Apr-21 | 2 | 2 | 3 | 0 | 5 | 5 |
| May-21 | 0 | 3 | 0 | 2 | 8 | 12 |
| Jun-21 | 0 | 2 | 0 | 2 | 9 | 9 |
| Jul-21 | 1 | 2 | 1 | 2 | 8 | 15 |
| Aug-21 | 3 | 3 | 3 | 0 | 5 | 15 |
| Sep-21 | 3 | 4 | 0 | 2 | 14 | 8 |
| Oct-21 | 0 | 4 | 1 | 0 | 6 | 14 |

# Final Report for ICC on 1st December 2021
# (Validated Data up to October 2021)

**References & Links**

**Understanding the Report Cards – Infection Case Numbers**

*Clostridioides difficile infections (CDI)* and *Staphylococcus aureus* bacteraemia *(SAB)* cases are presented for each hospital, broken down by month by Healthcare Associated (HCAI & HAI) & Community (Community/Unknown) onset. More information on these organisms can be found on the NHS24 website:

*Clostridioides difficile*: https://www.hps.scot.nhs.uk/a-to-z-of-topics/clostridioides-difficile-infection/

*Staphylococcus aureus*: https://www.hps.scot.nhs.uk/a-to-z-of-topics/staphylococcus-aureus-bacteraemia-surveillance/

For each hospital, the total number of cases for each month are those, which have been reported as positive from a laboratory report on samples taken more than 48 hours after admission. For the purposes of these reports, positive samples taken from patients within 48 hours of admission will be considered confirmation that the infection was contracted prior to hospital admission and will be shown in the "out of hospital" report card.

**Targets**

There are national targets associated with reductions in C.diff and SABs and from 2019 for e.coli bacteraemias (ECBs). More information on these can be found on the Scotland Performs website:

http://www.scotland.gov.uk/About/Performance/scotPerforms/partnerstories/NHSScotlandperformance

**Understanding the Report Cards – Hand Hygiene Compliance**

Hospitals carry out regular audits of how well their staff are complying with hand hygiene. Each hospital report card presents the combined percentage of hand hygiene compliance with both opportunity taken and technique used.

**Understanding the Report Cards – Cleaning Compliance**

Hospitals strive to keep the care environment as clean as possible. This is monitored through cleaning and estates compliance audits. More information on how hospitals carry out these audits can be found on the Health Facilities Scotland website:
http://www.hfs.scot.nhs.uk/online-services/publications/hai/

**Understanding the Report Cards – *'Out of Hospital Infections'***

*Clostridium difficile infections* and *Staphylococcus aureus bacteraemia* cases can be associated with being treated in hospitals. However, this is not the only place a patient may contract an infection. This total will also include infections from community sources. The final Report Card report in this section covers '*Out of Hospital Infections*' and reports on SAB and CDI cases reported to NHS Fife which are not attributable to a hospital.

**For HPS categories for Healthcare Associated Infections:**
**https://www.hps.scot.nhs.uk/web-resources-container/quarterly-epidemiological-commentary-for-the-surveillance-of-healthcare-associated-infections-in-scotland-methods-caveats/**

Categories of Healthcare & community Infections

| | | Quarterly Epidemiology Commentary category | |
|---|---|---|---|
| | | Healthcare associated infection case | Community associated infection case |
| CDI[1] Enhanced ECB[2] Enhanced SAB[3] surveillance category | Hospital acquired infection (HAI) | X | |
| | Healthcare associated infection (HCAI) | X | |
| | Community infection (CA) | | X |
| | ECB/SAB not known | | X |
| | CDI unknown | X[1] | |

HPS **ECB** & **SAB** definitions for Hospital Acquired, Healthcare Associated, Community or Not known

| | |
|---|---|
| **Hospital Acquired Infection (HAI)**:<br>Positive Blood culture obtained from patient who has been<br>-Hospitalised for >48 hours<br>If the patient was transferred from another hospital the duration of the in-patient stay is calculated from the date of the first hospital admission<br>OR<br>-The patient was discharged from hospital in the 48 hours prior to the positive blood culture being obtained<br>OR<br>-A patient receives regular haemodialysis as an outpatient<br><br>**Community Infection**<br>-Positive Blood culture obtained from a patient with 48 hours of admission to hospital who does not fulfil any of the criteria for the healthcare associated blood stream infections<br><br>**Not known**:<br>-Only to be used if the ECB is not a HAI and unable to determine if community or HCAI | **Healthcare Associated Infection (HCAI):-**<br>Positive blood culture obtained within 48 hours of admission to hospital and fulfils one or more of the following criteria:<br>-Was hospitalised overnight in the 30 days prior to the +ve blood culture being obtained.<br>OR<br>-Resides in a Nursing home, long term facility or residential home<br>OR<br>-IV,IM, Intra-articular or sub cut medication in the 30 days prior to the positive blood culture,<br>but EXCLUDING IV illicit drug use.<br>OR<br>-Underwent venepuncture in the 30 days before +ve BC<br>OR<br>-Underwent medical procedure which broke mucous or skin barrier i.e. biopsies or dental extraction in the 30 days before +ve BC<br>OR<br>-Underwent any care for chronic medical condition or manipulation of medical device by a healthcare worker in the community in the 30 days prior to the +ve BC being obtained i.e. podiatry or dressing of chronic ulcers, catheter change or insertion<br>OR<br>-Has a long term indwelling device (i.e. catheter, central line, drain (excluding a haemodialysis line) |

HPS **CDI** Definition for Hospital Acquired, Healthcare Associated, Unknown or Community onset

**HPS Linkage Origin Definitions**

| CDI Origin | Origin sub category : definitions |
|---|---|
| **Healthcare** | **HAI :** Specimen taken after more than 2 days in hospital (day three or later following admission on day one) |
| | **HCAI** : Specimen taken within 2 or less days in hospital and a discharge from hospital 4 weeks prior to specimen date; or specimen taken in the community and a discharge from hospital within 4 weeks of the specimen date<br><br>**Unknown** : Specimen taken 2 or less days in hospital and a previous discharge from hospital 4-12 weeks prior to specimen date; or specimen taken in the community and a discharge from hospital in 4-12 weeks prior to the specimen date |
| **Community** | **CAI :** Specimen taken 2 or less days in hospital and no hospital discharges in the 12 weeks prior to specimen date; or not in hospital when specimen taken and no hospital discharges in the 12 weeks prior to specimen date. |

**CDI Surveillance Protocol link:** https://www.hps.scot.nhs.uk/web-resources-container/protocol-for-the-scottish-surveillance-programme-for-clostridium-difficile-infection-user-manual/

# NHS FIFE INFECTION CONTROL COMMITTEE
# 1ST DECEMBER 2021 AT 2PM
# VIA MICROSOFT TEAMS

| | |
|---|---|
| **Present** | |
| Janette Owens | Director of Nursing |
| Julia Cook | Infection Control Manager |
| Craig Webster | Deputy Infection Control Manager |
| Margaret Selbie | Lead Infection Prevention and Control Nurse |
| Elizabeth Dunstan | Senior Infection Prevention and Control Nurse |
| Keith Morris | Consultant Microbiologist |
| Stephen Wilson | Consultant Microbiologist |
| Paul Bishop | Head of Estates |
| Catherine Gilvear | Patient Safety Programme Manager |
| Sue Blair | Consultant in Occupational Medicine |
| Pamela Galloway | Clinical Midwifery Manager |
| Pauline Cumming | Risk Manager |
| Lynn Burnett | Nurse Consultant Health Protection/Immunisation Co-Ordinator |
| Norma Beveridge | Head of Nursing |
| **Apologies** | |
| Esther Curnock | |
| Jim Rotheram | |
| Lynn Campbell | |
| Priya Venkatesh | |
| Lynn Barker | |
| Aileen Lawrie | |
| **In Attendance** | |
| Lori Clark | Notes |

| | | |
|---|---|---|
| **1** | **APOLOGIES**<br>Apologies were **noted** as above. | |
| **2** | **MINUTE OF PREVIOUS MEETING – October 2021**<br>Group approved previous minute as accurate reflection | |
| **3** | **ACTION LIST (October 2021)** | **ACTION** |
| | Group talked through each open action and the actions were closed or completed as appropriate.<br><br>Actions 4.1a, 4.1e and 4.7 carried forward to next ICC.<br><br>**Action list updated to reflect.** | |
| **4** | **STANDING ITEMS** | |
| **4.1** | 4.1a HAIRT Report<br><br>ED updated in regards to achievements that during Q2 NHS Fife was below the national rate for HCAI and CAI for SAB, CDI and ECB. In relation to challenges for SABs vascular access devices remain the greatest challenge for hospital acquired SABs and there is ongoing improvement works to reduce these. There has been 67 SABs from Jan-Oct 2021 and for the same timeframe in 2020 there were 61 cases.<br><br>ED added for ECB's UTIs and CAUTIs remain the main source of ECBs so these are the areas being addressed to reduce ECB rates. For ECBs NHS Fife has 85 in Q3 which was up from 56 in Q2. In Q3 there were 14 urinary catheter ECBs. For ECB's NHS Fife is above the target for March 2022. ED added that the UCIG is ongoing with the last a meeting on the 19th Nov, all ECB CAUTIs associated with trauma have been datixed and going forward all CAUTIS will be datixed and an LAER carried out. | |

ED updated that in Q3 NHS Fife has 12 CDI's which is the same as Q2 and we appear to be sitting on the reduction target line for March 2022. In relation to CDI's NHS Fife has seen an increase in cases in 2021 compared to the last 2 years. The HCAI incidence rate must be reduced further to meet targets.

The SSI programme is still paused due to the ongoing pandemic.

ED updated that in Q3 NHS Fife had 23 SABs which is up from 12 cases in Q2 2021 and are on track to achieve the target for March 2022. ED advised the team are still working with addiction services and there is now a PGD for antibiotic prescribing. IPC have also assisted with a training presentation for addiction services on SAB definitions, signs, symptoms and interventions.

ED advised NHS Fife are below the national average at 88% compliance however this may be due to a change-over to electronic MDRO CRA however 100% compliance was achieved for CPE clinical risk assessments. JC added that the MRDO clinical risk assessment went live the end of September for Q3 audit. It seems the 2 sets of questions (MRSA and CPE) come out at different times, therefore working with Excellence in Care and Digital and Information teams to ensure the questions are available for clinical staff at the same time. KM advised the group that the MRSA and CPE surveillance only covers 40 cases per quarter. JC added care dashboard will be reporting 20 cases per ward per month. JO asked if we can run a report to capture all for more assurance, **JC will pick up with Shirley Cowie and Steven Knapman.**

ED updated that for hand hygiene NHS Fife are consistently above 98% compliance which is usually displayed on ward dashboard. Ward dashboard has been removed but we are in talks with digital information to have the dashboard returned.

ED added that for domestic services & estates monitoring compliance in NHS Fife green status..

JC updated that there has been no outbreak of Norovirus during reporting period. Norovirus rates remain significantly lower than in previous years but there seems to be a bit more in community recently.

There has been no closures due to influenza and in week 45 activity remains at baseline level. In week 45, RSV activity increased from baseline to low, coronavirus and rhinovirus were at moderate levels and HMPV and parainfluenza low levels. There was one small outbreak of RSV at Tarvit involving 2 patients in the same room.

JC updated that in September and October there were 10 COVID 19 incidents reportable to ARHAI.

JC updated that there has been no unannounced hospital inspections in the last reporting period. There has however been a DL letter sent out from NES and HIS to say that inspections would be recommending 22nd November. They have different methodology and held a webinar, unfortunately no one form the IPC community were invited to this. The inspections will look at the new respiratory guidance pathways with will be in place in the next few weeks.

Members **noted** the update.

| | | |
|---|---|---|
| | 4.1b HAI LDP Update – SABs Reports<br><br>Reports on agenda for information<br><br>Members **noted** the update. | |
| | 4.1c HAI LDP Update – CDIs Reports<br><br>Reports on agenda for information<br><br>Members **noted** the update. | |
| | 4.1d ECB Surveillance Report<br><br>Reports on agenda for information<br><br>Members **noted** the update. | |
| | 4.1e HAI Update – C Section SSI Reports<br><br>This surveillance has been paused following a CNO letter however is being monitored at a local level.<br><br>Members **noted** the update. | |
| | 4.1f HAI Update – Orthopaedic SSI Reports<br><br>This surveillance has been paused following a CNO letter.<br><br>Members **noted** the update. | |
| | 4.1g Colorectal SSI Surveillance Report<br><br>This surveillance has been paused following a CNO letter.<br><br>Members **noted** the update. | |
| | 4.1h CPE Surveillance Report and MRSA Surveillance<br><br>Covered in HAIRT agenda item<br><br>Members **noted** the update. | |
| | 4.1i Outbreaks, Incidents and Triggers<br><br>Covered in HAIRT agenda item<br><br>Members **noted** the update. | |
| **4.2** | Care Home update<br><br>JC updated that the care home team have been very busy delivering education and training, presenting at grand rounds and manager meetings, completing training on teams and face to face sessions. They have been on supportive walkabouts in care homes following on from the referral process and supporting those homes needing additional assistance. JO added that she has read an article which states that the intervention from boards in the care homes have been very negative and heavy handed, intrusive etc. Fife however got a glowing report and was | |

| | | |
|---|---|---|
| | an exemplar of how the work should be done in a supportive way building relationships with the homes and supporting teams.<br><br>Members **noted** the update. | |
| **4.3** | NHS National Cleaning Services Specification<br><br>Attachment on agenda for noting.<br><br>Members **noted** the update. | |
| **4.4** | Risk Register<br><br>PC updated that there are currently 3 high risks. Risk 612 re offsite services, PC updated that there are quality issues of packs from the decontamination unit at Tayside. NHS Tayside completed an internal audit followed by an external audit that identified a number of issues around training, stacking of trays and the way trays are transported. Risk 2167 is a risk relating to a lack of SLA around the decontamination for robotic surgery. PB updated that there is now an SLA in place with Steris in Motherwell and PB is working on having our own CDU. For risk 1252 regarding flexible PEX hoses in phase 3, PB updated that 50% of the hoses have been replaced and 50 % will be carried out in the next financial year. All augmented care areas have already been covered so no PEX hosed just all copper joints.<br><br>With regards to new possible risk 2213 Orthotic accommodation it seems IPC was not aware of this risk. JO added she has had some discussion with orthotics and they are keen form more space as they are cramped. PB added there is now an accommodation group and now any department requiring space the can go to this group to raise their need which will be considered and when space is found they can be relocated.<br><br>Members **noted** the update | |
| **4.5** | Learning Summaries<br><br>PC advised that if the group had any questions relating to the learning summaries they can contact her.<br><br>Members **noted** the update | |
| **4.6** | National Guidance<br><br>JC updated that the new respiratory guidance has now been published on Monday and the screening table is still being updated potentially this will be published later today. JO added that we do seem to be in a better position with the new guidance than possibly some other boards.<br><br>Members **noted** the update | |
| **4.7** | HEI Inspections<br><br>JC added the DI letter is for the committees awareness regarding the restart of inspections which had been stalled for a few weeks. The letter advises that they will be inspecting against the new guidance which came out on Monday and we have a 2 week implementation period for this guidance. | |

| | | |
|---|---|---|
| | Members **noted** the update. | |
| **4.8** | Quality Improvement Programmes<br>UCIG<br><br>CG advised that this has already been covered and the only thing to add is that there will be another group created and the driver diagram being updated. There will be a lot of work on hydration but work is light touch just now due to the current situation.<br><br>PWID<br><br>JC updated that the last few meetings have been cancelled so unfortunately unable to provide an update.<br><br>Members **noted** the update. | |
| **4.9** | Education<br><br>ED updated that for winter planning processes and documentation has been reviewed. We have delivered weekly education sessions on teams and some face to face sessions with different staff groups and shifts. In 2021 so far the team have trained 981 staff members on various topics which a great achievement with the restrictions that we have had.<br>JO thanked KM for the grand round he done.<br><br>Members **noted** the update. | |
| **4.10** | Infection Prevention & Control Audit Programme<br><br>MS updated that committee that IPC are on track with the audit programme. In the last 2 months there have been 12 environmental audits, 6 re-audits and 6 hand hygiene audits completed. Rosemary Shannon continues to work one day a week with IPC audits and keeping the programme up to date. The substantive IPCN's have very limited capacity due to workload pressures, however we can review in January as the are a number coming up to renewal dates. JO asked if any of the results are concerning, MS advised there is nothing major but follow up on any issues at the time. As a trial at QMH - audit action plans have been broken up and sent to the relating teams estates, domestic, ward etc.<br><br>Members **noted** the update | |
| **4.11** | Prevention and Control of Infection Work Programme 2021-2022 (for noting)<br><br>JC updated that the work programme is for information. The audit programme is up to date however there is a chance of slippage over the coming months. We are trying not to put additional pressure on clinical teams at the moment also.<br><br>Members **noted** the update. | |
| **5.** | **NEW BUSINESS** | |
| **5.1** | COVID-19<br><br>JC updated that she used to get lessons learned weekly but they are less frequent recently. The lessons learned are looking at all the incidents reported to ARHAI and grouping together common themes. JC updated | |

| | | |
|---|---|---|
| | some challenges identified include screening of patients, transfer of patients before known results, challenges around capacity impacting on patient placement, staff attending with mild symptoms, visitors being non-compliant with mask use, visitors coming symptomatic and some PPE breeches. The lessons learned also highlight some good practice points also.<br><br>Members **noted** the update | |
| **5.2** | Excellence in Care<br><br>JC advised EiC MDRO went live in September and showed a drop in compliance for MRSA, however this is potentially due to timing of when the questions are become available. Digital health are already looking into this and we will get some communication out to senior charge nurses. Also explore if a weekly report would provide assurance around compliance with the MDRO.<br><br>Members **noted** the update | |
| **5.3** | Safe and Clean Audit<br><br>ED updated that we provide training sessions every week via teams which have had very good attendance. The audit tool provides assurance within a clinical setting and we have had every ward and the majority of outpatients on this for some time now. Now we can expand this further, we have had staff from occupational health, children's continence services and mental health services attend the training. There seems to be good engagement with the tool and staff seem to find it empowering. NB added she is not convinced that the acute teams have adopted the tool, there has been a lot of issues in the past. It might be something we need to look at in the acute setting. ED asked if this is training or a time factor. NB thinks this is a time factor and due to it being difficult in the beginning it hasn't been picked up again. **ED and NB to pick up a discussion to see how they can move this forward again.**<br><br>Members **noted** the update | |
| **6** | **NHS FIFE INFECTION CONTROL COMMITTEE'S SUB GROUPS** | |
| **6.1** | Infection Prevention & Control Team<br><br>Nothing from this meeting to highlight to group.<br><br>Members **noted** the notes of the meeting | |
| **6.2** | NHS Fife Decontamination Steering Group<br>Nothing from this meeting to highlight to group.<br><br>Members **noted** the notes of the meeting | |
| **6.3** | NHS Fife Antimicrobial Management Team<br>Nothing from this meeting to highlight to group.<br><br>Members **noted** the notes of the meeting. | |
| **6.4** | NHS Fife Water Safety Management Group<br><br>Nothing from this meeting to highlight to group.<br><br>Members **noted** the notes of the meeting. | |

| | | |
|---|---|---|
| **6.5** | HAI SCRIBES<br><br>HAI-SCRIBE works ongoing. MS added that the team keep a record of all SCRIBEs they are involved in.<br><br>JO raised that the independent review of the Queen Elizabeth University Hospital has been published. The review has 63 recommendations and 21 of these recommendations were highlighted as being relevant to wards. Of the 21 recommendations most were in relations to new build design and construction, ventilation etc. JO has shared with JC and KM and exploring developing a permanent HAI SCRIBE post.<br><br>To look at the governance round the orthopaedic centre. The orthopaedic centre team should be assuring the ICC that everything has been done around ventilation and equipment etc.<br>**JO to liaise with Ben Johnston to bring a report to the next ICC around this review**.<br><br>KM added that as an IPC team we haven't always had project leads coming to the team to advise of upcoming work. Now with NHS Assure there will be much more scrutiny. Also for larger projects such as the orthopaedic centre there is a need for a IPCT representative to be at all the meetings for attention to detail. PB added that he has had a conversation with Neil McCormick to have IPCT representation for HAI SCRIBE to ensure involvement in all SCRIBE.<br><br>MS added that she has arranged for HFS to provide training and updates early next year, everyone is welcome including estates.<br><br>JO added that another point from the report is that there was no records, PB agreed that we need to make sure there is an audit trail. SW reiterated the importance of good record keeping and keeping good documentation in a central place in case any information is needed at a later date. SW thanked MS for keeping up to date with all SCRIBE and ensuring IPC are involved in all these projects from the start.<br><br>Members **noted** the notes of the meeting | |
| **6.6** | Quality Reports<br>Quality reports attached to agenda for information.<br><br>Reports are for **noting** only | |
| **7** | **ANY OTHER BUSINESS**<br><br>JC updated that the communications plans is included for awareness and updated that the team are working with communications team to get some new branding for IPC to be more in line with the rest of NHS Fife.<br><br>JC updated that the ICC ToR has the suggested changes and requires approval. JO advised she may have something to add so can send that to JC then can virtually get agreement before the next meeting.<br><br>KM asked if there is a requirement in the agenda for points 4.1a to 4.1i. These are covered in the HAIRT and if there is something else we can comment at the time monthly reports not required. JO content with HAIRT report then reporting by exception. Group agreed.<br><br>JC updated that at the national meeting yesterday they were informed | |

| | | |
|---|---|---|
| | that the UK IPC Cell were having an extraordinary meeting today regarding the Omicron variant. At a local level we have been asked that if we have one of these cases we should isolate at this time and there is some direction for public health around contacts and contact tracing. SB added that isolation includes isolation for household members which might have implication for staff as many staff use the HCW exemptions to come back to work if they are contacts. Omicron requires 10 days isolation of all contacts. The issue might be with identifying omicron as these need to be done through the reference lab. This will be discussed at STAC on Friday but it is a concern.<br><br>Members **noted** updates. | |
| **8** | **DATE OF NEXT MEETING**<br>The next meeting of the Committee will be held 2nd February 2022 at 10am via Microsoft Teams. | |

NHS Fife

| | |
|---|---|
| **Meeting:** | **Clinical Governance Committee** |
| **Meeting date:** | **13 January 2022** |
| **Title:** | **Organisational Duty of Candour Annual Report (Interim)** |
| **Responsible Executive:** | **Dr Chris McKenna, Medical Director** |
| **Report Author:** | **Gemma Couser, Head of Quality and Clinical Governance** |

## 1 Purpose

**This is presented to the Clinical Governance Committee for:**

- Assurance
- Decision
- Discussion

**This report relates to a:**

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

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

- Safe
- Effective
- Person Centred

## 2 Report summary

### 2.1 Situation

Annually there is a requirement for Health Boards to publish an Annual Duty of Candour (DoC) Report. Incidents which trigger DoC are typically identified through the adverse event review process. Due to the pandemic there have been delays in the timely conclusion of adverse event reviews meaning that the annual report for 2020/2021 is currently not able to present a conclusive picture of all incidents where DoC has applied.

## 2.2 Background

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

NHS Fife monitor compliance with the Regulations across the following domains:

- Providing an apology
- Patient and or relative were notified and informed of the adverse event
- A review was undertaken
- The opportunity for the patient or relative was given to ask any questions
- The review findings were shared
- An offer of a meeting, which is arranged if required
- Giving consideration to support and assistance for the relevant person/ and or staff

Review of reports for 2018/2019 and 2019/2020 indicated the requirement for the report to include a look back at previous years to ensure completeness. In previous years DoC applied to cases which concluded review after the submission of respective annual submissions and as such these were not represented in the annual report.

## 2.3 Assessment

In November an interim DoC annual report was presented to the NHS Fife Clinical Governance Committee. In view of the delays in completing adverse event reviews and the commitment to providing a comprehensive annual report it was agreed by the committee that a further report should be presented at the January 2022 meeting. The updated interim annual report is set out in appendix 1. This report shows that since November there has been an additional 7 incidents where DoC applied, taking the total number of DoC incidents to 22.

In order to conclude the 2020/2021 annual report the following remain outstanding:

Compliance

- Completion of 7 audit forms to assess compliance with DoC Regulations
- Confirmation of the primary outcome for 2 incidents

Adverse Events

- 13 Significant Adverse Event Reviews awaiting submission of final report
- 4 Adverse Event Review Oversight Meetings planned
- 1 Adverse Event review meeting to be rescheduled
- 21 Local Adverse Event Reviews pending

The Clinical Governance Team are working with services to support completion of the outstanding compliance feedback and to conclude adverse event reviews.

### 2.3.1 Quality/ Patient Care

The learning from adverse event and DoC incidents continues to be a priority. Development of this will be supported through the Clinical Governance Framework.

### 2.3.2 Workforce

N/A

### 2.3.3 Financial

N/A

### 2.3.4 Risk Assessment/Management

As above, support is in place from the Clinical Governance Team to conclude outstanding compliance feedback and adverse event reviews.

### 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

This report has been discussed with Dr Chris McKenna, Medical Director.

### 2.3.8 Route to the Meeting

An earlier version of the Interim Annual Duty of Candour Report (2020/2021) was presented at the Clinical Governance Committee in November 2021.

## 2.4 Recommendation

The Clinical Governance Committee are recommended to:

- Note the interim report and;
- Support the submission of a final report at the March committee thereby allowing the outstanding matters above to progress and allow for a more comprehensive report.

## 3 List of appendices

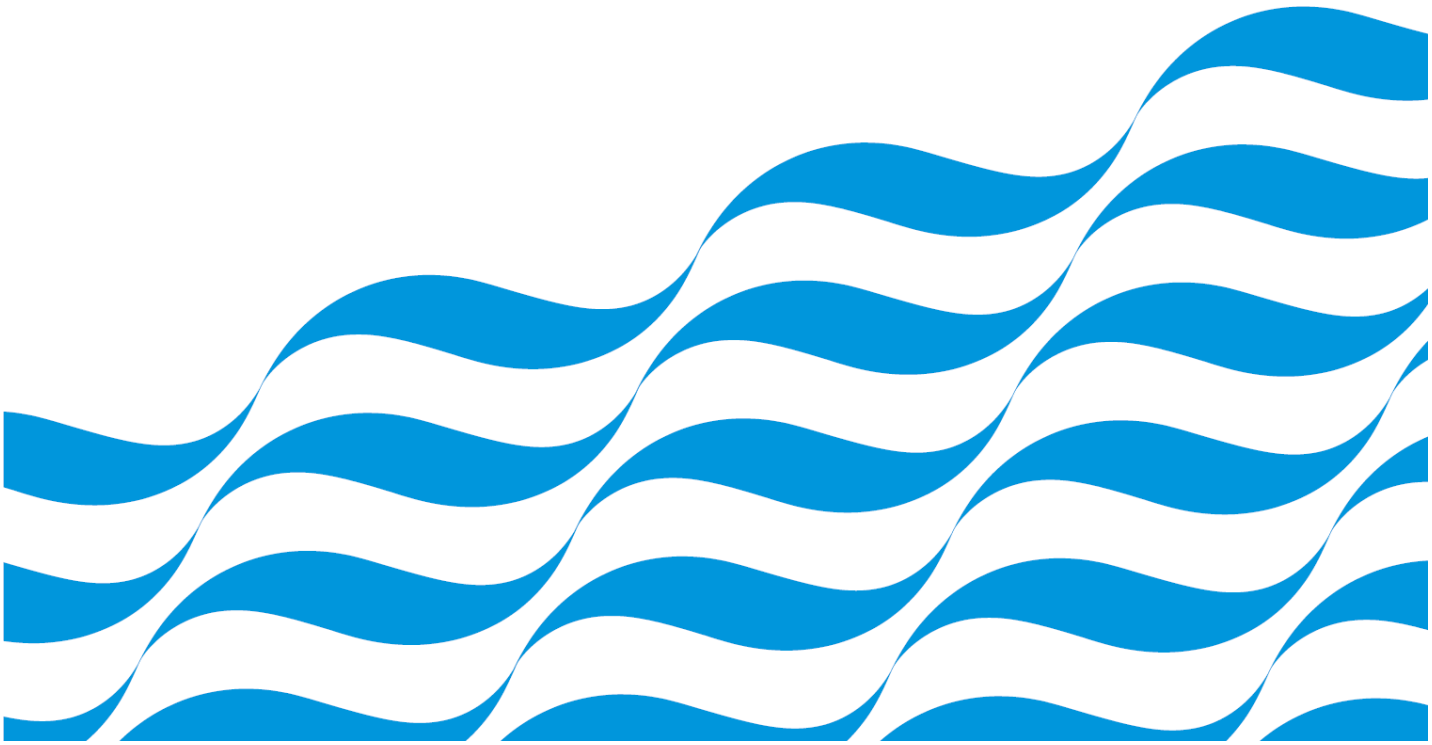
The following appendices are included with this report:

- Appendix 1: Interim Annual Duty of Candour Report, 2020/2021

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

# Interim Annual Organisational Duty of Candour Report

2020-2021



# Contents

# 1. Introduction and background

## NHS Fife

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

## Content of Report

This report describes how NHS Fife has implemented the organisational Duty of Candour (Doc) Regulations -during the period 1 April 2020 to 31 March 2021 (2020/2021). NHS Fife identified these events mostly through its adverse event management processes. The organisation adopts a consistent approach to the identification, reporting and review of all adverse events. This is reflected through the local NHS Fife Adverse Events policy and which is aligned with a national framework[3].

This report is being issued on an interim basis due to the ongoing response required by NHS Fife to the Covid-19 pandemic. This has resulted in a delay to the completion of adverse event reviews. This is reviewed regularly with processes in place to ensure reviews are progressed and completed. Consequently there are a number of events reported during this period which are currently under review and which may be reported as activating organisational DoC. It is therefore possible that the number of reported DoC events may be higher than stated in this report. Only those events with a confirmed decision have been included in this report. An updated annual report for 2020/2021 will be issued in March 2022.

A look back at year 1 (2018/2019) and year 2 (2019/2020) is also included in this report. Previous years are included for completeness as DoC applied to cases which concluded review after the submission of respective annual reports. Also contained in appendix 1-4 reports from the four health board managed general practices in NHS Fife.

## Organisational Duty of Candour

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

The Organisational Duty of Candour guidance[2] outlines the procedure which must be a

followed as soon as reasonably practicable after an organisation becomes aware that:

- an individual who has received health care has been the subject of an unintended or unexpected incident and
- in the reasonable opinion of a registered health professional not involved in the incident:
  - **(a)** the incident appears to have resulted in or could result in any of the outcomes below (see Table 1).
  - **(b)** the outcome relates directly to the incident rather than to the natural course of the person's illness or underlying condition.

This means if a patient suffers from an unintended or unexpected harm as a result of an adverse event then the following should happen:

- The patient or relative is notified and an apology is offered.
- An investigation is undertaken.
- The patient/relative is given the opportunity to raise questions they wish to be considered and answered as part of the investigation.

NHS Fife has an embedded process for the decision making for activating organisational duty of candour and ensuring all necessary actions are undertaken in accordance with national guidance. On review, any event which is considered to activate duty of candour is escalated to the Board Medical Director for ratification and confirmation of decision.

[1] NHS Fife Strategic Framework. 2015.

[2] Organisational Duty of Candour guidance. The Scottish Government. March 2018

[3] Learning from adverse events through reporting and review: A national framework for Scotland, revised July2018, NHS Fife review all adverse events.

- On completion of the investigation the findings and report are offered to be shared with the patient or relative.
- A meeting is offered.
- Throughout the review and investigation support is to be offered to the people affected which may include staff members involved.

The outcome for organisations is to learn from the investigation and make changes identified as part of the review.

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

Between 1 April 2020 and 31 March 2021, there were 22 adverse events where the duty of candour applied. The main categories of event which activated DoC during this period were:

- Other clinical events
- Patient fall
- Tissue viability

Table 1 details the outcomes which were reported across NHS Fife after 1 April 2020 to 31 March 2021.

## Table 1

| Duty of Candour outcome arising from an unexpected or unintended incident | Number of times this occurred |
|---|---|
| The death of the person | <5 |
| Permanent lessening of bodily, sensory, motor, physiologic or intellectual functions | 0 |
| An increase in the person's treatment | 6 |
| Changes to the structure of the person's body | 0 |
| The shortening of the life expectancy of the person | <5 |
| An impairment to the sensory, motor or intellectual functions of the person which has lasted, or is likely to last, for a continuous period of at least 28 days | 0 |
| The person experiencing pain or psychological harm which has been, or is likely to be, experienced by the person for a continuous period of at least 28 days | <5 |
| The person requiring treatment by a registered health professional in order to prevent:<br>• the death of the person, or<br>• any injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned above | <5 |

The most common outcome which these events have resulted in is an increase in the person's treatment. This can range from additional antibiotics required to additional nightsstay in hospital.

**Summary of Years 1-3**

Table 2 sets out the events where DoC applied in 2018/2019, 2019/2020 and 2020/2021. This additional information is being included for completeness as DoC was applicable to events which concluded review after respective annual reports were submitted.

The number of events where DoC applied in year 1 is higher than the subsequent years. This can be attributed to the development of learning and assessment in the application of DoC Regulations. Table 3 sets out the DoC outcomes for the three year period. Across this period the most common outcome is an increase in the person's treatment.

## Table 2

| | Year 1 18/19 | Year 2 19/20 | Year 3 20/21 |
|---|---|---|---|
| Number of events where DoC applied and where included in respective annual report | 46 | 28 | 22 |
| Number of events where DoC applied and where not included in annual report | 10 | 10 | To be determined |
| Total number of events where DoC applied | 56 | 38 | To be determined |

## Table 3

| Duty of Candour outcome arising from an unexpected orunintended incident | Number of times this occurred | | |
|---|---|---|---|
| | Year 1 18/19 | Year 2 19/20 | Year 3 20/21 |
| The death of the person | <5 | <5 | <5 |
| Permanent lessening of bodily, sensory, motor, physiologic or intellectual functions | <5 | <5 | 0 |
| An increase in the person's treatment | 34 | 22 | 6 |
| Changes to the structure of the person's body | <5 | 0 | 0 |
| The shortening of the life expectancy of the person | <5 | <5 | <5 |
| An impairment to the sensory, motor or intellectual functions of the person which has lasted, or is likely to last, for a continuous period of at least 28 days | <5 | 0 | 0 |

| | | | |
|---|---|---|---|
| The person experiencing pain or psychological harm which has been, or is likely to be, experienced by the person for a continuousperiod of at least 28 days | 8 | <5 | <5 |
| The person requiring treatment by a registered health professionalin order to prevent:<br>• the death of the person, or<br>• any injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned above | <5 | 7 | <5 |

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

Of the 22 identified cases, each one was reviewed to assess for compliance with the procedure on the following elements:

- Providing an apology
- Patient and or relative were notified and informed of the adverse event
- A review was undertaken
- The opportunity for the patient or relative was given to ask any questions
- The review findings were shared
- An offer of a meeting, which is arranged if required
- Giving consideration to support and assistance for the relevant person/ and or staff

Overall NHS Fife has carried out the procedure in each case. A number of areas of strength have been identified. These are:

- notifying the person and providing details of the incident
- provision of an apology, and
- Reviewing all cases.

Areas for improvement which are attributable to the pressures as a result of the pandemic include:

- Arranging the meeting following offer to meet
- Providing the patient with a written apology

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

# 4. Information about our policies and procedures

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

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

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

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

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

# 5. What has changed as a result?

Further to reviews of DoC events in 2020/2021 the following changes have been implemented:

- Improvement work to increase compliance with the pressure ulcer risk assessment (PURA) including training, education and introduction of a PURA sticker on admission to increase compliance
- Updates to wound care guidance supported by clear escalation plans
- Daily input from off site Plastic Consultant team inputting into multi speciality reviews
- Identification of additional ward Falls Champions to lead improvement work to reduce patient falls
- Review of the pathway for paediatric patients requiring rapid review
- Development of a standard operating procedure to support clinical teams with Warfarin prescribing, monitoring and follow up which includes communications with GPs.

Given the delays described in this report it is anticipated that more changes will be implemented following conclusion of events which are still under review. These will be captured in the March 2022 updated report.

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

**Board Medical Director Office**
NHS Fife
Hayfield House
Hayfield Road
Victoria Hospital
Kirkcaldy
KY2 5AH
Telephone: 01592 648077

# Appendix 1: Linburn Road Health Centre

**Linburn Road Health Centre**
124 Nith Street
Dunfermline, KY11 4LT
Tel: 01383 733490
Fax: 01383 748758
Email: Fife-UHB.F20502LinburnRoad@nhs.net

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

**Duty of Candour Report**

**Report period:** 1 April 2020 to 31 March 2021

**Completed by:** Sharon Duncan, Practice Manager (Job Share)

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

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

| Type of unexpected or unintended incident (not related to the natural course of someone's illness or underlying condition) | Number of times this happened (between 1 April 2020 and 31 March 2021) |
|---|---|
| A person died | 0 |
| A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions | 0 |
| A person's treatment increased | 0 |
| The structure of a person's body changed | 0 |
| A person's life expectancy shortened | 0 |
| A person's sensory, motor or intellectual functions was impaired for 28 days or more | 0 |
| A person experienced pain or psychological harm for 28 days or more | 0 |
| A person needed health treatment in order to prevent them dying | 0 |
| A person needing health treatment in order to prevent other injuries as listed above | 0 |
| **Total** | **0** |

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

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

| | |
|---|---|
| **What has changed as a result?** | N/A |

| | |
|---|---|
| **Other Information** | N/A |

# Appendix 2: Kinghorn Medical Practice

**Kinghorn Medical Practice**
Rossland Place
Kinghorn
Fife
KY3 9RT
Tel: 01592 890217

**Duty of Candour Report**

**Report period:** 1 October 2020 to 31 March 2021

**Completed by:** Fay Paterson, Practice Manager

Kinghorn Medical Practice provides general medical services to around 3360 registered patients residing within the practice boundary which encompasses Burntisland, Kinghorn and the bottom part of Kirkcaldy and some surrounding rural areas. Our mission is to provide a personal quality service making the best use of available resources.

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

| Type of unexpected or unintended incident (not related to the natural course of someone's illness or underlying condition) | Number of times this happened (between 1 October 2020 and 31 March 2021) |
|---|---|
| A person died | 0 |
| A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions | 0 |
| A person's treatment increased | 0 |
| The structure of a person's body changed | 0 |
| A person's life expectancy shortened | 0 |
| A person's sensory, motor or intellectual functions was impaired for 28 days or more | 0 |
| A person experienced pain or psychological harm for 28 days or more | 0 |
| A person needed health treatment in order to prevent them dying | 0 |
| A person needing health treatment in order to prevent other injuries as listed above | 0 |
| **Total** | **0** |

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

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

| | |
|---|---|
| **What has changed as a result?** | N/A |

| | |
|---|---|
| **Other Information** | N/A |

# Appendix 3: The Links Practice

**The Links Practice**
Masterton Health Centre
74 Somerville Street
Burntisland
Fife, KY3 9DF

Tel: 01592 873321

**Dr J Yule**
M.B.,Ch.B.,D.C.H., M.R.C.G.P.

**Dr C Fleming**
M.B., Ch.B., M.R.C.G.P.


This short report describes how our care service has operated the duty of candour during the time between 1st April 2020 to 31st March 2021. We hope you find this report useful.

Our Practice serves a population of 1947 patients within the Burntisland, Kinghorn, Aberdour area.

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

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

**Information about our policies and procedures.**

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

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

**The Links Practice**
**Masterton Health Centre**
**74 Somerville Street**
**Burntisland**
**Fife**
**KY3 9JD**

**Tel: 01592 873321**
**Email: Fife.F20184LinksPractice@nhs.scot**

# Appendix 4: Valleyfield Medical Practice

**Valleyfield Medical Practice**
Chapel Street, High Valleyfield
Fife, KY12 8SJ
Tel: 01383 880511
Email: Fife-UHB.F20729valleyfield@nhs.net

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

**Duty of Candour Report**

**Report period:** 1 April 2020 to 31 March 2021

**Completed by:** Michelle Parker, Practice Manager

Valleyfield Medical Practice provides Health Care to patients within the High Valleyfield, Low Valleyfield, Culross, Torryburn, Newmills, Cairneyhill and Crossford. The Health Centre's aim is to provide high quality care for every person who uses our services.

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

| **Type of unexpected or unintended incident (not related to the natural course of someone's illness or underlying condition)** | **Number of times this happened (between 1 April 2020 and 31 March 2021)** |
|---|---|
| A person died | 0 |
| A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions | 0 |
| A person's treatment increased | 0 |
| The structure of a person's body changed | 0 |
| A person's life expectancy shortened | 0 |
| A person's sensory, motor or intellectual functions was impaired for 28 days or more | 0 |
| A person experienced pain or psychological harm for 28 days or more | 0 |
| A person needed health treatment in order to prevent them dying | 0 |
| A person needing health treatment in order to prevent other injuries as listed above | 0 |
| **Total** | **0** |

| | |
|---|---|
| **To what extent did Valleyfield Medical Practice follow the duty of candour procedure?** | All Staff are aware of the NHS Fife Complaints and Significant Event procedures and will report any incidents to the Practice Managers or Senior Members of Staff. Incidents falling into the category of Duty of Candour will be the responsibility of the Practice Manager to ensure that the correct procedures are followed. The Practice |

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

| | |
|---|---|
| **What has changed as a result?** | N/A |

| | |
|---|---|
| **Other Information** | N/A |

**NHS Fife provides accessible communication in a variety of formats including for people who are speakers of community languages, who require Easy Read versions, who speak BSL, read Braille or use Audio formats.**

NHS Fife SMS text service number 07805800005 is available for people who have a hearing or speech impairment.

To find out more about accessible formats contact:
fife-UHB.EqualityandHumanRights@nhs.net or phone 01592 729130

**NHS Fife**
Hayfield House
Hayfield Road
Kirkcaldy, KY2 5AH

**www.nhsfife.org**

facebook.com/nhsfife
@nhsfife
youtube.com/nhsfife
@nhsfife

# NHS Fife

| | |
|---|---|
| **Meeting:** | **Clinical Governance Committee** |
| **Meeting date:** | **13 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 Clinical Governance 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

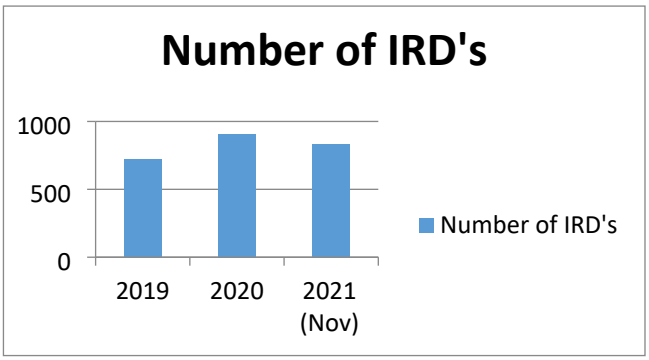
Concerns regarding possible hidden harm were raised due to an initial drop in IRDs and forensic medicals over late spring and early summer of 2020. However, by the end of December 2020 IRD trends were on a trajectory towards pre COVID levels and data presented in this report illustrates sustained levelling 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.

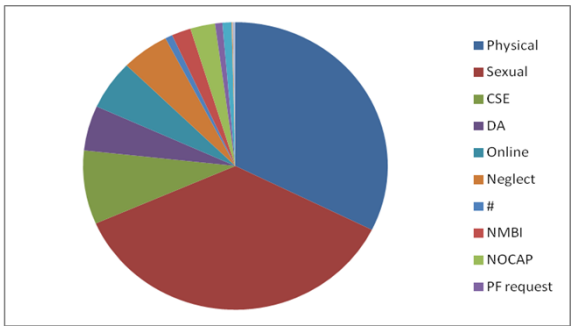
## 2.3 Assessment

### 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.



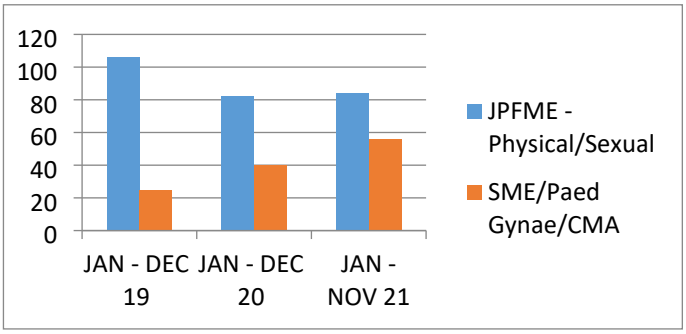

**Nature of concern**




(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

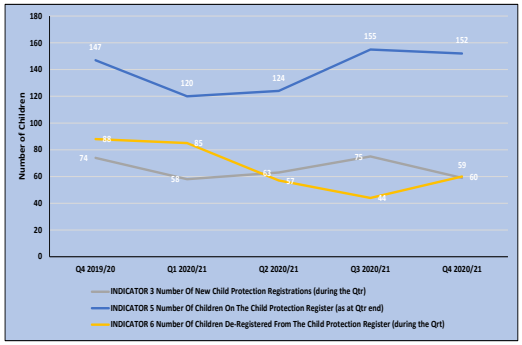



a JPFME. Due to an uplift of consultant paediatricians, including two with CP as their special interest, we have had more regular input from paediatricians in IRDs of cases where medicals may be required. This is likely to have strengthened decision making, including need for medicals, resulting in a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

### 2.3.iii CPC data – Main concern recorded at registration

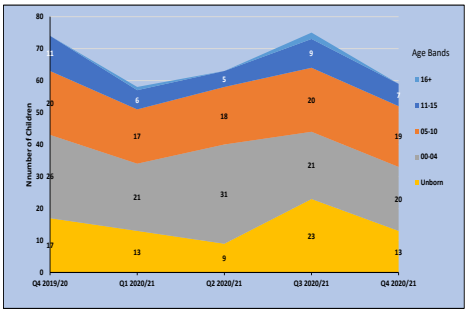
Further insight can be gained by reviewing thematic features of children placed on the Child Protection Register, as well as prevalence. Domestic abuse, emotional abuse and [parental] mental health were the most common concerns identified in Q2, which have remained the same over the past reporting year. 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 | |



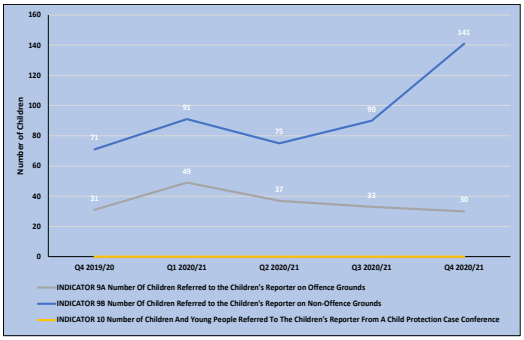

New registration of C&YP is on a downward trend (grey line). Given there have been less children subject to case conference and the conversion rate has gone down this is consistent with the number of newly registered decreasing also. The reason for this is currently being examined through a Multi-agency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

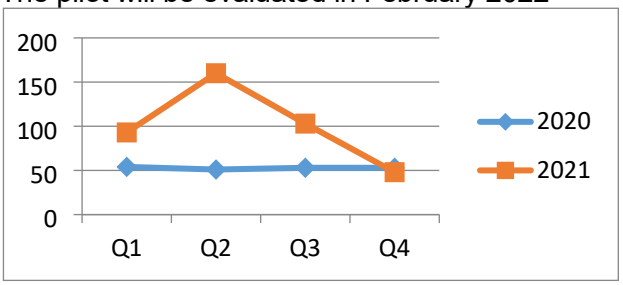
The CP Core training Framework has been refreshed and endorsed by Janette Owens, Nurse Director and Executive Lead for Child Protection. After a void due to the staffing implications of the pandemic, members Child Protection Health Steering Group are again committed to provide annual returns of staff 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.

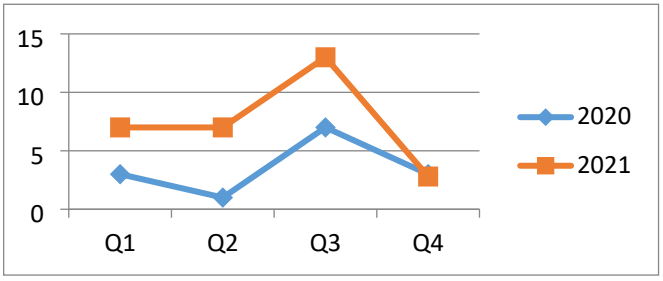
Unfortunately the CPC Learning and Development post has not been recruited to as yet, hence multi-agency training remains unavailable. That said, monthly CP peer review is available via Teams in collaboration with NHS Lothian, and the quarterly local peer review with police and social work colleagues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



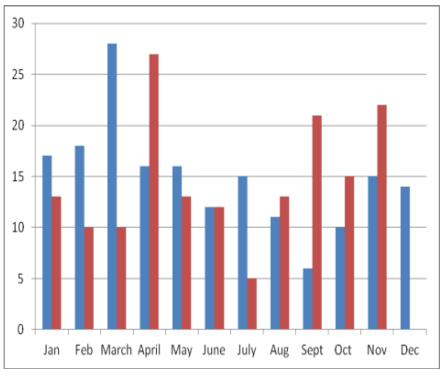

**Number of staff attending group supervision**




**Number of one to one supervision sessions**

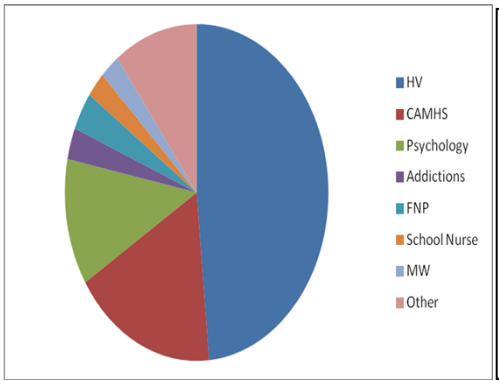
**2.3.2. iii Advice & support**
There is often blurring between staff receiving supervision, and those seeking advice and support. Sometimes the only difference is the child protection nurse advisors do not have access to records, although many calls are also about adults (parents), often unnamed. It 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**




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

**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

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)

**Report Contact**
Author Name: Cicilie Rainey

Author's Job Title: Lead Nurse Child Protection
Email: Cicilie.rainey@nhs.scot

# NHS Fife

| | |
|---|---|
| **Meeting:** | **Clinical Governance Committee** |
| **Meeting date:** | **13 January 2022** |
| **Title:** | **Adult Support and Protection Biennial Report 2018 – 2020** |
| **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 Clinical Governance 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

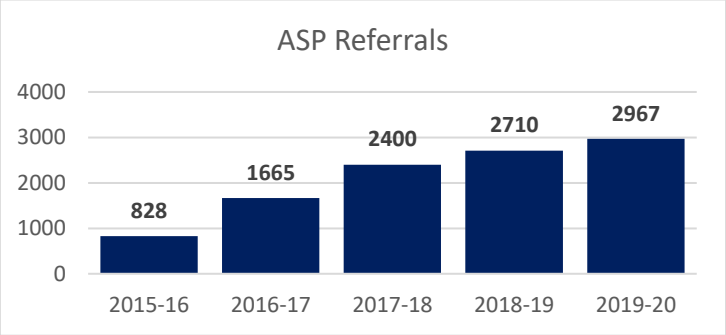
For the past two years the Committee has been provided with detailed statistical summary reports following the submission of the Scottish Government data return. Reports provide trend analysis, information on types of harm being investigated, demographic details of adults at risk and has helped to inform 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.

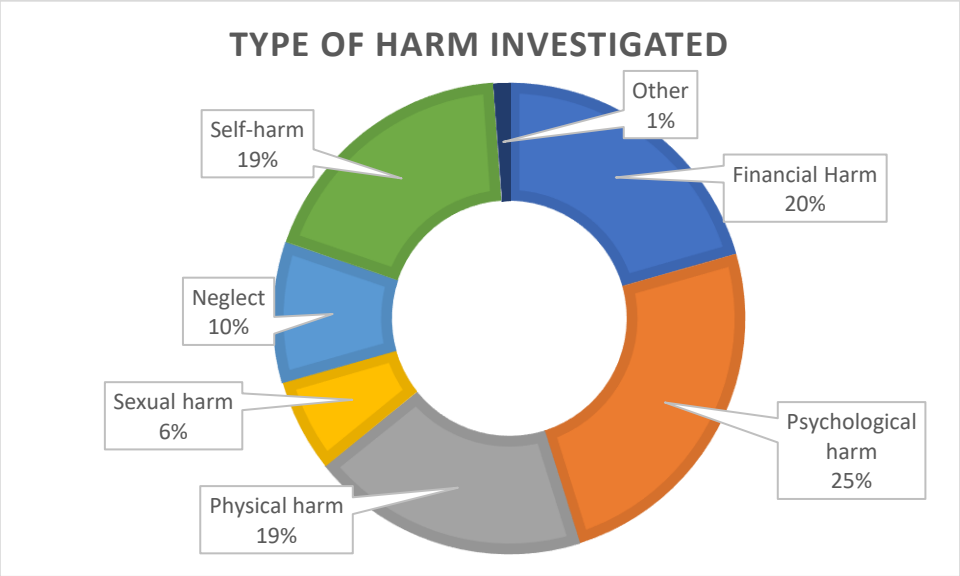
More than one in every four investigations (27.7%) relate to an adult with a physical disability. There has been a significant drop in investigations where the adult is recorded as having 'dementia' although this may be due to a change in reporting practices. The committee is exploring this further and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

NHS Fife Clinical Governance Committee
January 2022

Agenda item no

| | |
|---|---|
| Title of Group/Sub-committee | ACUTE SERVICES DIVISION CLINICAL GOVERNANCE COMMITTEE |
| Date of Group/Sub-committee Meeting: | WEDNESDAY 10th NOVEMBER 2021 AT 2.00PM |
| Release: draft/final minutes | UNCONFIRMED |
| Author/Accountable Person: | Ms Lynn Campbell/Professor Morwenna Wood |

| Summarise the items of significance from the minutes and the important points you want to raise to the attention of the committee? |
|---|
| The committee noted that the accreditation process for labs has continued in the background throughout the pandemic and is as robust as it always is. The Laboratories are accredited and are assessed on an annual basis and this includes the COVID testing which Fife was the first laboratory in Scotland to get accreditation for. The positive feedback and comments from the assessors was acknowledged. |
| **What are the concerns/issues/risks you want to bring to the attention of the committee?** |
| As noted previously, workforce remains under review as the demand on services remains high. A focus on areas where incidents are noted to have increased is in place through Directorate teams to provide support on activity for improvement. |

**A NOTE OF THE ACUTE SERVICES DIVISION CLINICAL GOVERNANCE COMMITTEE HELD ON WEDNESDAY 10th NOVEMBER 2021 AT 2.00PM VIA MS TEAMS**

| **Present** | **Designation** |
|---|---|
| Mrs Jane Anderson | Radiology Manager / Professional Head of Service - Radiography |
| Dr Annette Alfonzo | Clinical Director – Emergency Care Directorate (until 15.15 – Item 7.3) |
| Mrs Norma Beveridge | Head of Nursing – Emergency Care Directorate |
| Mrs Lynn Campbell | Associate Director of Nursing – ASD (CHAIR) |
| Mrs Donna Galloway | General Manager – WCCS Directorate |
| Mrs Pamela Galloway | Inpatient Midwifery Manager |
| Mrs Karen Gray | Head of Therapies & Rehab |
| Ms Aileen Lawrie | Associate Director of Midwifery |
| Mrs Elizabeth Muir | Clinical Effectiveness Co-ordinator |
| Dr Sally McCormack | Clinical Director – Emergency Care Directorate (from 14.25 – Item 6) |
| Mrs Gillian Ogden | Head of Nursing – Planned Care Directorate |
| Ms Marie Paterson | Head of Nursing - Acute |
| Mrs Miriam Watts | General Manager – Emergency Care Directorate (until 1530 - end Item 8.4) |
| Prof. Morwenna Wood | Interim Associate Medical Director/Director of Medical Education |
| Mr Satheesh Yalamarthi | Clinical Director – Planned Care Directorate (from 15.35 – Item 9) |

| **Apologies** | **Designation** |
|---|---|
| Mr Ben Hannan | Chief Pharmacist – Acute Services Division |

**In Attendance:**

| | |
|---|---|
| Mrs Margaret Dodds | Senior Nurse – Quality & Risk – Emergency Care Directorate |
| Miss Lynn Godsell | PA to the Interim Associate Medical Director & Associate Director of Nursing (minutes) |
| Ms Andrea Smith | Pharmacist (rep Ben Hannan) |

**ACTION**

**1 Welcome and Introductions**

Mrs Campbell welcomed everyone to the meeting and advised that the Echo Pen was being used for assisting with the note taking process.

Mrs Campbell welcomed Professor Wood to the Committee and advised that Professor Wood would be co-chairing the meetings in her role as Interim Associate Medical Director.

**2 Apologies for Absence**

Apologies for absence were noted.

**3 Unconfirmed Minute of ASDCGC Meeting held on 15th September 2021**

Mrs Campbell referred to the notes of the meeting held in September 2021 and asked members for any comments. There were no comments, hence the minutes were approved as an accurate record.

**4 Matters Arising**

**4.1 Action List**

Action 334 – Penicillin Business Case – Mrs Beveridge was unable to provide an update but will pick up with Dr Alfonzo and carry forward to the January 2022 meeting. Mrs Campbell asked about the timescale for this as it seems to have been ongoing for some time. Mrs Beveridge said that this was something that had been implemented as a trial and required some measures being tightened up. Mrs Campbell noted the action and suggested that Dr Alfonzo prepare a brief for the January 2022 meeting in order that the action can be closed off. **AA**

Action 335 - Botox Migraine – Agenda Item.

Action 354 - Dermatology – Mrs Beveridge said that Dr McCormack would need to update on this subject. Mrs Campbell suggested that if the lead person is not in attendance at the meeting then a paper should be submitted in advance. c/f to January 2022. **SMcC/LG**

Action 355 – Dermatology – No update available – c/f to January 2022. **LG**

Action 367 – AWI Audit Report – Mrs Campbell noted this was in relation to Helen Skinner setting up a Short Life Working Group (SLWG). Mrs Campbell will pursue this action to ensure this is underway. **LC**

Action 370 – PCD Cyclodiode – Mrs Ogden said that the audit findings are to be submitted within the first year. Mrs Ogden said that it has been entered onto the main register for Interventional Procedures but that she needed to check with Ms Saunderson if this has been replicated onto the Planned Care register. Mrs Campbell asked that PCD confirm the date the audit will come back with Miss Godsell so she can add to the workplan. **GO LG**

Action 373 - Clinical Services Report – It was noted that Dr Cargill had not shared the report as planned. Mrs Anderson said that significant progress has been made so the action could be closed off. Regard as complete.

Action 374 - ECD Directorate Report – Mrs Campbell said this was around sharing information re the national research on multi-organ failure and pressure damage. Mrs Beveridge advised the information was shared at the time and is being monitored as this was a process with multi-organ failure and proning, end of life and the impact on tissue. No update has been received on the research. Mrs Campbell suggested that this be closed off and an update be brought back when available. Add to workplan. **ECD LG**

Action 375 – ECD Directorate Report – Mrs Campbell said she was aware of discussions that had taken place around supporting staff to be supported in being involved in the SAER process. Mrs Muir said that both herself and Gemma Couser had met with Mrs Beveridge, Mrs Dodds & Dr McCormack but was unsure of the current situation if there had been any engagement with clinicians. Mrs Dodds said that the people that had concerns have taken on Lead Reviewer roles and this seems to be going smoothly at the moment. Mrs Dodds said that they will watch this closely and identify if there are any other issues. Regard as complete.

Action 377 – ECD Directorate Report – Mrs Campbell said there had been a spike

in the Pressure UIcer development figures within ICU and Mrs Campbell confirmed that she had discussed with Mrs Beveridge and there were a number of things happening. This was in direct relation to patients being nursed in a prone position and there are new mattresses now within ICU that will hopefully mitigate the problem as much as possible. Mrs Beveridge said that while there are patients still in Level 3 care being proned, it will be about how we manage this. Regard as complete.

Action 379 – Clinical Services Report – Mrs D Galloway advised that it was not directly linked to the number of samples, but it is linked to how busy areas are. The errors increase when the laboratories are really busy. Mrs Campbell asked if there was anything further that needs to be done? Mrs D Galloway said that it is being constantly monitored and they target the areas that have higher rates. Mrs Dodds said that ED is one of the high areas and Dr Roy has taken this on as a project and meets with staff that make the errors for education/supportive learning. Mrs Campbell suggested that it be removed from the action list as an open action but continue to be kept under review. If there is something in the model hat Dr Roy is working with that proves to have a good outcome and a positive learning experience, then that initiative then perhaps needs to be replicated. Mrs D Galloway said this is audited throughout the year so would be addressed as it happens. Regard as complete.

Action 380 – Complaints - Neonates Cooling – Mrs P Galloway said that Dr Morrice has completed the paperwork and has been submitted. Mrs Campbell said that it has not been to the Committee, so the report needs to be submitted to ASD CGC. Ms Lawrie added that two reviews have been done on the same subset of babies and was submitted to Dr McKenna. Ms Lawrie said that she will take an action to follow up with Dr McKenna for his view on the report and will submit through the Clinical Governance system. **AL/PG**

Action 381 – Complaints – Mrs P Galloway advised that Claire Fulton is doing a piece of work as a result of a Datix. This is almost complete and will be submitted in due course. Regard as complete.

Action 382 – SAER LEARN Summaries – Mrs Ogden said that this related to Psychology pain notes which went missing and Dr Cargill had asked about the option of digital record keeping rather than paper copies. Mrs Ogden to obtain an update from Ms Saunderson. It was noted that the cabinet was still unaccounted for. c/f to January 2022. **GO**

Action 383 – Cyclodiode Procedure – Mrs Ogden said this was similar to Action 370. Mrs Ogden to double check re Directorate register. Regard as complete.

Action 384 – Robotics Assisted Surgery – Mrs Campbell suggested that in future this needs an SBAR to accompany this as it is helpful to have narrative to support the numbers. **PCD**

Mrs Campbell thanked members for the updates and added that the aim is to keep the action list as succinct as possible and transfer items to the workplan or report issues via the Directorate reports.

**5 Hospital/Board or Population Level Reports:**

**Scheduled Governance Items:**

- **Mortality Report**

Professor Wood referred to the Mortality report and advised that the crude mortality rates are recorded weekly for acute adult inpatients and reviewed as a clinical governance measure for hospital clinical services. Professor Wood added that there were peaks of deaths in March 2020 and January 2021 which were attributable to COVID-19.

The report was noted.

- **Integrated Performance & Quality Report (IPQR)**

Mrs Campbell advised that the IPQR report was included for information and expected that any areas of concern were highlighted through the Directorate reports. Mrs Campbell noted that it was a useful report to see the organisational wide position.

The report was noted.

- **Deteriorating Patient Report (Dr G Simpson) – b/f from September 2021**

Mrs Muir spoke to the update prepared by Dr Simpson. The update provided an overview of the role and remit of the group and the group now has representation from across NHS Fife. The group was re-established this year and the Terms of Reference were recently signed off. This group will also support the SPSP Acute collaborative and discussions around the partnership agreement are ongoing. Mrs Muir added that the first submission for the Acute Adult Collaborative for the Deteriorating Patient is currently being drawn up and is due to be returned imminently.

Mrs Campbell noted there are couple of distinct differences is that this is now a Fife wide approach and not just Acute and the formal reporting structure is through the Clinical Governance Oversight Group, but it is beneficial this Committee is sighted in a timely fashion.

Mrs Muir advised that the Clinical Governance team have re-started from October carrying out live audits on the wards, these audits are focussing on HACP/DNACPR and Scottish Structured Response (SSR). These reports will go to the Directorates who will in turn feed into this Committee.

The update was noted.

- **Waiting Times Audit – N/A - c/f to January 2022**
- **End of Life Audit Annual Report – N/A - c/f to March 2022**
- **Cardiac Arrest/Peri-Arrest Reports Q1 – N/A – c/f to January 2022**

## 6 Emergency Care Directorate

### 6.1 Specialty National Reports

There were no specialty reports.

**6.2 Directorate Level Outcomes Data:**

- **Clinical Audit**

There was nothing to report under Clinical Audit.

- **SAER LEARN Summaries**

This item was included within the Directorate report.

**6.3 Directorate Report**

Mrs Dodds presented the Directorate report.

**Incidents**
There were 609 incidents reported between 1 August 2021 and 30 September 2021.

The percentage of Datix recorded with harm was 31%, an increase from 26% on the previous reporting period.

There were no extreme incidents reported but major and moderate both saw an increase in numbers during September.

The top 5 reported incidents by category continue to be: Patient Falls, Tissue Viability, Other Clinical Events, Medication incidents and Infrastructure (staffing/accommodation).

Mrs Dodds advised that there have been no extreme incidents reported for some time now, however there were 23 major incidents. These incidents related to:
Cardiac Arrests – 7, 4 of these have been reviewed at the Emergency Bleep Group (EBG) and closed off, 3 will be submitted to an EBM meeting for investigations.
The other 16 major incidents related to:
Hospital Acquired pressure ulcers, Patient falls, failure to follow policy/protocol, delay in treatment, medication incident, Indwelling device associated infections and a serious adverse reaction to blood transfusion (TACO). Mrs Dodds advise that this is the first serious adverse reaction to blood transfusion for a very long time and LAER has been commissioned with support from Laboratories.

**SAERs & LAERs**
Mrs Dodds advised that there are 39 LAERs and 19 SAERs ongoing currently.
It was noted that 10 of the LAERs are outstanding and the SAERs are at different stages within the process and the Directorate are working through these.

**Patient Falls**
There have been 165 patient falls during the reporting period which sees an increase from 122. This includes the number of falls with harm and coincides with the reduction in staffing levels due to absence/vacancies within the clinical wards which the Directorate has been able to evidence. The falls were categorised as 2 major harm and 19 minor harm, with no moderate harm being reported.

Mrs Dodds said that since June the number of falls has increased as has the harm

caused by the falls. It was noted that both Admissions Unit 1 and the Emergency Department have seen an ongoing increase in the number of falls within their respective areas – this could be attributed to the capacity and busyness of the departments.

Mrs Dodds added that the Directorate has seen an increase in falls happening overnight, these are more evident when staffing levels are reduced and also when patients require supervision procedures staff are having to risk assess the situations as well as trying to provide care for the other patients which is challenging.

**Tissue Viability**
There has been an increase in Hospital acquired Tissue Viability incidents. This reporting period has also seen a significant increase in grade 2 and suspected deep tissue injury. The report notes that on ward developed incidents account for 30% of all Tissue Viability incidents reported. Mrs Dodds informed members that:

- All critical care areas had seen an increase – noting there has been a higher number of acutely unwell patients.
- ITU has an increase in numbers but also an increase in prone patients, this tends to be around the tracheostomy area. Mrs Dodds added that all interventions are in place and actions have been taken to reduce this but because patients are being proned for a longer period, this is a high-risk area. Mrs Campbell asked if these incidents were device related? Mrs Dodds responded that in the main, they were tracheostomy device related.
- Both Ward 43 and Ward 9 have shown an increase, so these wards are being monitored. The Senior Charge Nurses in these wards are putting education processes in place.

**Other Clinical Events**
Mrs Dodds advised there had been an increase in reporting of this category with it now being the 3rd top reported incident which equates to 11% of harm reported by the Directorate.

The sub-categories which have increased are:

- failure to follow policy, procedure and guidelines and this cover a multitude of circumstances where protocols have not been fully followed resulting in mistakes being made. Mrs Dodds said that this is resulting in going back to staff and re-iterating the awareness that they are busy, but guidelines are in place for a reason and take more care and the Clinical Nurse Managers were supporting the ward with this.
- Unexpected deterioration of the condition of a patient
- Unexpected complication following procedure
- Failure to act on a clinically abnormal result – this tends to be picked up with cancers where clinics have been cancelled or delayed mainly due to COVID. Mrs Dodds noted that a few cases have progressed to SAERs and learning has been put in place.

**Medication Incidents**
There remains a high number of medication incidents although this reporting period showed a slight decrease. The main themes remain prescribing and administration.

**Infrastructure**
There has been an increase in reported infrastructure incidents accounting for 25% of reported harms with the main category being staffing in clinical areas. Mrs

Dodds advised that staffing has also been documented in several other Datixes as a contributing factor – e.g., Pressure Ulcers & Falls.

**Healthcare Associated Infections (HAI)**
Mrs Dodds advised that there has been an increase in HAI which tends to be with COVID swabbing and COVID positive patients, Mrs Dodds said that due to capacity issues and organisational demands patients are being moved to downstream beds or other care providers too quickly as the swab results have not yet been returned. Mrs Dodds said patients have ended up in Amber areas and have had HAI on COVID patients and also one death which is being reviewed at the moment. Mrs Dodds added that overnight patients are also being moved to Ward 6 when they are not within the proper timescale after being swabbed. The majority of these moves happen either overnight or at the weekend when the staffing cohort is lower.

**SABs**
There have been 2 SABs. These were in Ward 21 – no further action required and Ward 22 – LAER requested as learning has been identified.

**Complaints**
Mrs Dodds said there was an ongoing increase in both stage 1 and stage 2 complaints. Many of the stage 1 complaints are progressing to stage 2 as people are not satisfied with the outcome/response. Mrs Dodds said that a change in language had been noticed in the complaints recently – these include patient neglect and failure of duty. Mrs Dodds said there were several sad and complex complaints being received at the moment which take a lot of investigation. There was also an increase in the number of multi-directorate complaints which causes delay in responding within the target time.

**Risk Register**
The risk register is updated regularly. There were no new risks added during this reporting period but there may be 2 new risks but will update at the next meeting.

**SPSO**
Mrs Dodds said again there has been an increase as the complainants are unhappy with the responses or outcomes received. Mrs Dodds added that sometimes we do not fully agree with the SPSO but unfortunately when the outcome is received there is no opportunity to go back to the SPO to challenge any decision which is often difficult for colleagues, so a lot of support is needed.

Mrs Campbell thanked Mrs Dodds for the report and asked members if there were any questions.

Professor Wood asked why Ward 32 has a high profile of various different incidents and harms and did not think this ward was different to any of the other Medicine of the Elderly (MOE) wards? Mrs Beveridge responded that the Directorate has looked at Ward 32 and agreed that it wasn't just pressure damage and falls but also infrastructure and staffing. Mrs Beveridge said she thought there was a very low threshold for Datix reporting in the ward and the culture was slightly different than in the other MOE wards. Ward 32 has a lot of side rooms and is more reliant on falls alarms whereas Ward 41 the culture tends to be allowing the patients to be up and wandering which is the right thing to do. Mrs Beveridge said there is work to be done taking the best of both wards and making one good one. Mrs Dodds added that instead of the ward staff speaking with people they tend to rely on Datix as their means of communications and have done this for a number of years.

Mrs Campbell said it was an important point and is stark reading as a comparator with other wards with similar profiles of patients and the ongoing conversations will be helpful in bringing some consistency to this.

Mrs Beveridge added a couple of observations and noted that the unexpected deterioration in conditions that we have seen an increase in, Mrs Beveridge advised that she would like to do some work around observations on time and will pick this up with Ms Paterson as we know from Patientrak that this has deteriorated. **NB**

Mrs Beveridge acknowledged the COVID swabbing situation which Mrs Dodds spoke about and noted that lots of operational discussions take place about this subject, Mrs Beveridge added that it is very difficult to prove that it is the timing of the swabs as there are lots of other factors such as staff, visitors and community transmission and Microbiology colleagues are reluctant to say that this is directly associated to swabbing. Mrs Beveridge advised that for re-assurance the handover SBAR has been revised between wards to include COVID status which details information around dates of swabs/ isolation period and swabs due. This was an improvement action.

Mrs Campbell noted that there appeared to be a clearer correlation between staffing challenges, harms and supplementary staffing and while we see that it is difficult to make a direct link between these, but it is helpful to see this in the report where it has been sighted as part of the Datix. Mrs Campbell noted that she did not have the answer to this added that the staffing situation was unlikely to change in the short term. Mrs Ogden said that Planned Care are experiencing the same difficulties and has noticed that comfort rounds are not being carried out due to the staffing situation, so the Directorate are trialling an extra Band 2 on the floor in Orthopaedics at night try and mitigate some of the issues.

Mrs Campbell noted it was challenge for everyone to maintain standards and noted that some of the bundle audits with missing aspects or not completed across all areas and again are a symptom of non-core team but needs to be monitored.

**6.4 Specialty/departmental audit & assurance data (incl. guidance)**

**Update re Action 335 – Botox Migraine**

Dr McCormack spoke to the Botox Migraine update and advised this was introduced as an Interventional treatment in May and the team was asked to report back with the outcomes after 20 cases or 6 months.

Dr McCormack advised that 20 patients have been treated up to October 2021. The report noted that:

- 3 patients have had 3 cycles. One of these now stopped treatment due to poor response and two have had more than a 60% reduction in headache.
- 8 patients have had 2 cycles, 6 of these have had more than a 60% reduction in headache and 2 have had more than a 40% reduction in headache.
- 9 Patients have had 1 cycle for review in 3 months.

There have been no adverse events and have had a positive outcome as expected as this was a known treatment which was already being carried out for NHS Fife in

another Health Board.

This will be reviewed continually and hopefully by December the first full 20 patients will be reported on.

Professor Wood commented on the standard of the report as there is no indication of who wrote the report, when it was written, and the Committee should ask for clarity. Dr McCormack advised that the report was written last month by the nurse who runs the clinic and Dr McCormack omitted to notice that her name was not on the report. Dr McCormack apologised for this oversight.

Professor Wood said that Miss Godsell should ask for clarity for reports going forward. Miss Godsell to share the standard template. **LG**

Mrs Campbell asked if there was anything else to raise by the Emergency Care team?

Dr McCormack advised that she had a number of medical specialty reports but there was nothing exceptional to raise from these and any issues had been covered within the SAERs and LAERs and staffing concerns have already been raised. Mrs Campbell wished to note for the minutes that Dr McCormack has been reviewing Directorate specialty reports internally and there is nothing to escalate to the Committee. Dr McCormack confirmed that the specialities are reporting albeit the full reports are not being submitted to the Committee, only the highlights or exceptions.

Mrs Campbell thanked the Emergency Care team for their contribution to the meeting.

**6.5 New Interventional Procedures**

- **Update re Interventional Procedures Register**

There was nothing to report on the Interventional Procedures Register.

**6.6 SPSO Recommendations**

This was covered under Item 6.3.

**7 Women, Children & Clinical Services Directorate**

**7.1 Directorate Governance – Specialty National Reports**

**7.2 Directorate Level outcomes data:**

- **Clinical Audit**

There was nothing to report for Clinical Audit.

- **SAER LEARN Summaries**

This was included within the Directorate reports.

**7.3 Departmental Report/s**

- **Clinical Services Report**

Mrs D Galloway spoke to the Clinical Services report.

**Incidents**
Laboratories reported 54 incidents, this was a slight increase on the previous period There were no major/extreme incidents and 5 moderate incidents were reported.

Radiology reported 38 incidents with no major and of the 7 radiation incidents, none of these were reportable to IRMER.

The main theme for the Laboratories incidents remains consistently as incorrectly labelled samples. Mrs D Galloway noted there was a significant increase during this reporting period and this is likely due to increased workload and the department being busier resulting in more errors.

Mrs Anderson spoke to the Radiology incidents and noted that the department is also seeing an increase in errors with the Trak referral process. There was only 1 radiation incident but also 11 near misses, one of these was reportable but it was later downgraded after a discussion with the Inspectorate. Mrs Anderson added that in context there was 12600 images/examinations carried out that use ionising radiation and one error from this number.

Mrs Anderson noted that the Communicator system was working well and the Directorates have processes in place which work satisfactorily for them. Mrs Anderson added that there was a recent clinical incident as the mailbox was full and not generating emails. This was rectified by Digital & Information. Mrs Campbell asked if there was a trigger or notification about this mailbox being full? Mrs Anderson advised that the department has an audit process in place that provides notifications when an item has been delivered and this is checked daily and were able to identify the issue. Mrs Campbell noted that was reassuring.

**Falls**
Nothing to report

**SAERs & LAERs**
Nothing to report.

**Complaints**
Laboratories – no complaints.
Radiology – 1 complaint which is cross Directorate and remains outstanding.
Therapies & Rehab – 3 complaints – these related to Occupational Therapy and Physiotherapy with the issues being discharge and communication.

**SPSO**
Laboratories are heavily involved in enquiries around SPSO but have not been the subject of any of them but are frequently asked for information so record this for completeness.

**Risk Register**
Mrs D Galloway advised Laboratories have 17 active risks (2 high and 15 medium). No new risks have been added and 1 risk has been closed. The high risks relate to Clinical Systems Interface Issues – all the pieces of kit throughout the hospital does

not link up with the Laboratories system and results do not reach the correct place and QPulse upgrade which is the document quality management system and requires an upgrade but as the organisation is discussing Quality Management systems as a whole, this has been put on hold meantime but are in discussion with Digital and Information.
Radiology has 5 active risks (1 high and 4 medium).
Therapies and Rehab have 2 active risks with one new risk being added.

**Laboratory Services Accreditation**
Mrs D Galloway advised the work towards the accreditation process continually goes on in the background and is as robust as it always is. Mrs D Galloway said it was for reassurance as she had received a few queries about when accreditation would begin again, when in fact it has not stopped. The Laboratories are still accredited and are assessed on an annual basis. Mrs D Galloway added that this includes the COVID testing which Fife was the first laboratory in Scotland to get accreditation for their COVID testing so the Directorate are proud of that achievement.

Mrs Campbell commented that it was nice to see the positive feedback and comments from the assessors.

Mrs D Galloway referred to the national shortage of blood tubes which resulted in some good discussions around when to take blood and when it does not add value. The shortage seems to have abated for the moment but are aware that with winter approaching the demand for the blood tubes may increase again. Mrs D Galloway said that the situation is being monitored closely.

Mrs D Galloway noted there was a similar situation in Radiology with a shortage of contract medium used for CT Imaging. Mrs Anderson added that it was an ongoing issue but was being managed.

**Radiology – issues for escalation**
Mrs D Galloway advised members that a Short Life Working Group (SLWG) was being established to consider the scope of practice for non-medical referrers across NHS Fife. This would enable practice to be monitored due to the IRMER regulations.

Mrs Anderson noted that Dr McKenna has delegated responsibility for Radiation Protection, and this was taken to the IRMER board in August and had a discussion about increasing the non-medical referrers and their scopes. Dr McKenna was supportive providing this was done within the Clinical Governance framework so the best option was to form at SLWG to ascertain where the gaps are and what support the teams require to meet the governance. Mrs Campbell said that sounded a sensible controlled approach.

Professor Wood commented that she had been asked to sign forms for individuals as their responsible clinician and when questioned about what training had taken place the response was that no training had been given or received. Professor Wood asked if the SLWG would include a basic training requirement and to be specified so whoever is signing off the forms can be assured that suitable training has been undertaken? Mrs Anderson said that this documentation and process is already in place and can share if required.

Mrs Campbell commented that Dr Cargill had been enthusiastic about the learning

from the blood bottle shortage and noted that it would be good to maintain the learning and not revert back to taking unnecessary blood tests.

Mrs Anderson highlighted that there has been an increase in the number of undeclared implants on MRI safety checklists. Dr Cargill had been very supportive earlier in the year and circulated a cross Directorate communication to raise the importance. Mrs Anderson would appreciate this being done again. Mrs Campbell said that she would support if Mrs Anderson could provide the forms of words to be circulated. **JA/LC**

Ms Paterson advised that a SLWG is still in place looking at butterfly usage and trying to reduce the usage which decrease the haemolysed sample rates and also prevent some level of patients being re-bled. Ms Paterson said this work is ongoing in various wards. Mrs D Galloway said this was welcome.

- **Women & Children**

Mrs Lawrie spoke to the Women & Children report.

**Paediatrics**
There were no major or extreme events noted.

**Neonates**
There was 1 major incident reported which related to the death of an infant following a complicated delivery for a breech presentation.

There were a total of 32 incidents during this reporting period. 21 were no harm, 5 minor, 5 moderate and 1 major as noted.

**Obstetric/Maternity**
Maternity have had 3 ante-natal stillbirths – these were discussed at the obstetric risk management meeting at the end of October.
There are 2 ongoing LAERS and awaiting the reports for another 2 incidents.
Mrs Lawrie advised that a cluster review had taken place around the Neonates who were cooled.

Mrs Lawrie noted that the breakdown in themes, one of which has been escalated via Senior Leadership Team (SLT) is the long delays in care and children being seen. Medication incidents and medication errors is linked to the acuity and complexity and the staffing situation. Mrs Lawrie added that further investment has been put into Paediatric staffing.

Obstetrics incidents remain consistently the same in that it is Post-Partum Haemorrhage (PPH) is the biggest incidence.

Mrs Lawrie advised that Gynaecology has now caught up with the historical Datix which was an outstanding issue for the team.

**SAERs & LAERs**
Gynaecology has 4 ongoing LAERs and the draft reports are being finalised by the review teams. It was noted there are no ongoing SAERs and one new SAER is in the process of being arranged.

**Neonatal**

1 SAER was closed at the oversight meeting.
1 SAER review complete and report in progress.
2 LAERs reviews completed and reports in progress.

There were 3 LEARN summaries issues during the reporting period (1 Neonates & 2 Gynaecology).

**Patient Falls**
There was 1 patient fall in the Gynaecology ward in relation to the use of a triage bed. The learning was shared with the Gynaecology nursing team to mitigate and future issues.

**Complaints**
Mrs Lawrie highlighted that the complaints are becoming more complex and there has been a rise in general in complaints as well as cross Directorate complaints. The Directorate continue to respond to these as quickly as possible.

**SPSO**
There we no SPSO issues to report.

**Risk Register**
Mrs Lawrie wished to highlight some of the risks within the Women & Children Directorate.

Risk 2087 which was categorised as high was around insufficient anti-ligature points in the children's ward. Mrs Lawrie added that the Directorate are trying to expedite some work on this but given the nature of the current climate with COVID/restrictions and isolation etc there are more children with mental health challenge and more suicidal ideation. Mrs Lawrie also noted staffing challenges in the ward. Ms Holloway is trying to push this forward but Mrs Lawrie asked if there were any other avenues to expedite this request? Mrs Campbell asked if this had been presented to SLT? Mrs Lawrie responded that it had been through SLT and had been signed off and was now with Engie. Mrs D Galloway added that she thought all the equipment for this had been purchased it was a case of obtaining the permission to have the equipment rather than purchasing it again. Mrs Lawrie and Mrs D Galloway to take forward. **AL/DG**

Mrs Lawrie also noted Risk 2084 around extravasation in Paediatric pumps was causing concern. Mrs Lawrie said that Paediatrics were not on the initial tranche for new pumps and these need to be able to be titrated slightly differently to avoid any extravasation incidents. This has previously been mitigated by staff who were able to monitor more closely but given the acuity in the area and challenges with staff absence and set and if this could also be expedited. Mrs Campbell asked if there had been agreement to purchase these pumps? Mrs Lawrie advised that Ms Holloway was trying to progress this but there are competing priorities on the equipment list. Mrs Campbell suggested a conversation outwith the meeting and involve Medical Physics. Mrs Campbell asked Ms Paterson if she was aware of any of these pumps? Ms Paterson said it may be the BBraun ones and was sure that Lynette McKenzie & Ms Holloway had been involved in the discussions. Ms Paterson said that herself and Mrs P Galloway would catch up in the first instance to sense check what is already in the system and feedback to Ms Holloway. **MP/PG**

**Specialty Reports**

Mrs Lawrie informed the Committee about the specialty reports which had been included.

- Cluster review of the babies who required hypothermic treatment
- Scottish Government child death review – working alongside Gemma Couser and the Clinical Governance team on this review
- Adverse events review for Scotland
- The most MBBRACE report has been received so the Directorate will undertake a gap analysis report.
- PPH work group remains ongoing
- Gynaecology – work is ongoing with Planned Care relating to the care of women requiring complex pelvic surgery. A multi-directorate group will take this this work forward and once complete will be submitted via this Committee.

Mrs Campbell said it will be good to hear the outcomes of the multi-directorate group as this work has been spoken about for some time now.

Mrs Campbell said it was impressive that the Directorate were on top of the SAERs and LAERs and noted they would be the envy of the other Directorates. Mrs Campbell also noted that Mrs Muir picked up that one of the LEARN summaries contained identifiable information and this was to be redacted. Miss Godsell was asked not to submit the minutes to the full Committee until this was sorted out. **WCCS LG**

Mrs Campbell asked the Committee for any questions or comments for Mrs Lawrie. Mrs Muir advised that she had spoken to Lynette McKenzie regarding one of the LEAN summaries being too detailed and this has been fedback to the group.

Mrs Campbell thanked the Women, Children and Clinical Services Directorate team.

**7.4 Specialty/departmental audit & assurance data (incl. guidance)**

- **Clinical Quality Indicators**

- **Update re Interventional Procedures Register**

There were no new updates to report.

**7.5 New Interventional Procedures**

There were no new procedures.

**7.6 SPSO Recommendations**

There were no issues from SPSO.

**8 Planned Care Directorate**

**8.1 Directorate Governance – Speciality National Reports**

There were no Specialty reports submitted.

**8.2 Directorate Level Outcomes Data**

- **Clinical Audit**

- **SAER Learn Summaries**

Mrs Ogden referred to the LEARN summary to note. This concerned a patient being referred to the Procurator Fiscal and because of a subsequent delay this resulted in a delay in the body being released to the family.

**8.3 Directorate Report**

- **PCD Clinical Governance Report**

**Incidents**
There were 265 incidents during the reporting period. There were 14 major incidents and these related to:

Ophthalmology – Endophthalmitis infections caused during intra-vitrial injections. A PAG was held and Infection Control suggested that the increase may be related to mask wearing during the procedure and for 5 days thereafter. This practice has stopped now and there have been no further cases.

Tissue Viability – 3 major pressure damage incidents within Orthopaedics relating to plaster casts. Mr Ballantyne and one of the Clinical Nurse Managers are doing some work around this and Mrs Ogden will report back if there are any common findings.

**SAERs & LAERs**
There are a few ongoing and these are being progressed.

**Outstanding Actions**
Mrs Ogden advised that there are a number of outstanding actions arising from SAER and LAER investigations and work continues by the Heads of Nursing in an attempt to finalise these actions.

**Patient Falls**
There were 36 falls reported during August and September. 17% (6) of these falls sustained harm – 3 moderate and 3 major. Mrs Ogden advised that 3 of these falls resulted in fractured neck of femurs (#NOF), these were in different areas and are subject to LAERs. Mrs Ogden will feedback any common themes or factors from the LAERs but did note that the comfort rounds are not being carried out at the correct time. Ward 31 has the highest number of falls and this relates to the frailty of the patients within this ward. The staff of the ward did raise a concern over the staffing levels in the ward and an additional B2 is now supporting the ward.

**Medication Related Incidents**
There were 35 medication related incidents and this included 1 major regarding missing controlled drugs from one of the wards. This is subject to an LAER. Ward 52 saw an increase in medication incidents and this was directly related to staffing as the ward had staff from other areas and supplementary staff who were unfamiliar with the ward.

**Tissue Viability**

It was reported there were 17 related incidents. Some of the common themes are long lies at home and patients refusing to change position. Mrs Ogden highlighted that Ward 52 had an increase and this related to the knowledge and education of the staff on pressure care. This has been addressed by the Senior Charge Nurse.

**Incident Themes**
These range from Endoscopy incidents to blood glucose levels. These have all been reviewed appropriately.

**Risk Register**
The Directorate risk register is regularly reviewed and no new risks have been added.

**SABs**
No device related SABs were recorded.

**Complaints**
The Directorate have noticed a significant increase in the number of complaints. A lot of these are about delays to treatment due to COVID and Mrs Ogden said that staff are trying hard to work through these and close off where possible.

**SPSO & Legal Claims**
There have been no new SPSO cases, outcomes or decisions.
There have been no legal claims during this reporting period.

**President's Commendation**
Dr John Donnelly has received an award from the Royal College of Anaesthetists for his contribution.

**Care Opinion**
The Care Opinion always tend to be positive stories and any negative tend to be around waits for appointments/clinics. There have been a couple around attitude and behaviour of staff which are investigated accordingly.

**8.4 Specialty/departmental audit & assurance data (incl. guidance)**

- **Early Cancer Diagnostic Centre Update Paper**

Mrs Ogden provided an update regarding the ECDC paper.

The report notes that Fife is one of three pilot sites in Scotland to successfully roll out a Scottish Government funded Early Cancer Diagnosis Centre service. £297,394 was awarded to support the project for one year and this is to be extended for a further year. This is one of the four flagship areas in the publication Recovery and Redesign: An Action Plan for Cancer Services, December 2020. A pathway for patients with vague but concerning symptoms who do not meet tumour specific Scottish Referral Guidelines has been developed with the aim of seeing, assessing and referring on/discharging as appropriate within 21 days.

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

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

Mrs Ogden added that the pilot went live in June 2021 and since then there have been 234 referrals received with 30 cancers being diagnosed. The most common diagnosis is lung cancer.

The ECDC is fully appointed and added that a Patient Navigator has been appointed and commenced in post on 21st October. Arrangements are being finalised to support cover for the service during absences.

The update was noted by the Committee.

- **Update re Interventional Procedures Register**

The register was noted.

- **Update re Robotics Assisted Surgery (Urology/Colorectal)**

Mrs Ogden apologised about the format of the report and noted that it was not the standard expected for the Committee.

Mrs Ogden provide a verbal update and the following points were noted:

- There have been 18 procedure and of these there were no conversions to open or other types of surgery.
- The proctorship is now finished and this worked very well for all 3 Surgeons who are doing the Robotic surgery. They have all now been signed off for Independent practice.
- There was 1 complication which related to an Anastomotic leak but no other major
- The outcome data is being collected and this will be fedback to the Committee.

Mrs Ogden advised the report will be submitted in the correct format in future.

Mrs Campbell noted that would be helpful as this is of interest to the NHS Fife Clinical Governance Committee and in terms of providing assurance as it is new to Fife, people are intrigued by it.

Mrs Campbell acknowledged the recognition for Dr Donnelly on the recent award from the Royal College of Anaesthetists.

Mrs Campbell also noted about closing actions from SAERs acts as a permanent reminder to everyone that it does not finish when the report is signed off and these need to be followed through and acted upon. Mrs Campbell added that the responsibility for the actions does not just lie with nursing but is for all members of the multi-disciplinary team and the Directorate should support and ensure this is shared.

Mrs Campbell asked if the risks were discussed as part of a Directorate or team meeting? Mrs Ogden advised that herself, Ms Saunderson and Mr Yalamarthi go

through these and update accordingly.

Mrs Campbell asked for any other questions.

Professor Wood thanked Mrs Ogden for a comprehensive report and then asked about the learning from the Procurator Fiscal case. Professor Wood asked if this Committee should ask the Procurator Fiscal to provide guidance on reporting deaths or if that had already been asked. Mrs Ogden was unsure but agreed to find out and report back. **GO**

Mrs Campbell suggested that Mrs Ogden link in with Mrs D Galloway too regarding management of the mortuary. Mrs D Galloway advised that there is guidance and the patient had been in the mortuary for 2 weeks so this would not have triggered the procedure as this happens at 3 weeks or more. Any patients in the mortuary for more than 3 weeks are Datixed so there is a record. Mrs D Galloway suggested that Mrs Ogden link directly with Derek Selbie who is the Service Manager for the mortuary.

**8.5 New Interventional Procedures**

There were no new procedures submitted.

**8.6 SPSO recommendations**

There was nothing to report.

**9 Divisional Risk Register – Active Risks**

ED Dept – risk around social distancing. Mrs Dodds asked if this was on the Corporate register? This was confirmed Mrs Dodds to find out the risk number and move forward as there is a similar risk on the ECD risk register. Mrs Campbell said that it would be good to reconcile and remove from the Corporate register. **MD**

Cancer Waiting Times – Mrs Campbell said this was historical risk siting with Cancer Services under Acute and should now move as Cancer is under the remit of Dr McKenna and Ms Couser. Mrs Campbell to find out if this should be transferred to another risk owner. **LC**

Mr Yalamarthi wished to highlight a potential problem with Cancer waiting times treatment. Mr Yalamarthi noted that the 31-day target seems to be fine but the 62-day target is an issue – there are delays to treatments for Fife patients being treated in Lothian as one of the surgeons has resigned, this will become more of a problem whilst the recruitment process takes place.

Mr Yalamarthi added that the axis of the robot is a concern as this is carried out regionally and it has been a struggle to achieve target times so Prosthetic services will need to be relooked at as the appropriate care is not being given in a timely fashion. Mr Yalamarthi wished the governance team to note this as solutions will need to be found to address this. Mrs Campbell questioned where this risk sits as she was unsure with some of the changes in structure around Cancer if this was under Planned Care ownership? Mrs Campbell suggested an offline discussion within Planned Care and additionally Mrs Campbell would discuss with Ms Couser who historically held this risk in Acute. Mrs Campbell said that it may well need split if there are different aspects to it. **SY** **LC**

Dermatology – Dr McCormack said this was a longstanding risk around the condition of the Dermatology department. There is no ventilation which is a risk to both staff and patients. The department was looking to get some portable suction machines but is unsure of the progress with this. Dr McCormack added the refurbishment of the department has been put on hold as there is a possibility the department will be moving. Dr McCormack also noted that a surgical suite should not be a dual-purpose suite which happens in the Dermatology dept. The department has been condemned by Health & Safety and Infection Control but that is longstanding and outwith the Directorates control until there is a clearer future plan.

Mrs Campbell asked where this risk best sits and suggested that a conversation takes place prior to the next meeting to ensure the ownership is accurate. Mrs Campbell was not keen to leave risks on the register for lengthy periods of time. Dr McCormack said it belonged under the Corporate register as this is part of the NHS Fife accommodation strategy not the Directorate. **LC/SMcC**

Medical Staffing – Mrs Campbell said that Dr Cargill owned this risk about Medical Locums operate equipment or machinery they are unfamiliar with. Mrs Campbell suggested that herself and Professor Wood discuss outwith the meeting. Professor Wood said that it could be extended to a greater risk of any doctor, particularly junior medial staff handling equipment they are not familiar with. Professor Wood expanded on her suggestion and advised there had been a death in the South of England that has resulted in communication from the General Medical Council (GMC) about junior doctors accessing a central line and this is not part of their normal training. Professor Wood noted that she is in dialogue with the Medical Education team regarding this training and asked Mrs Campbell for her input.

Professor Wood suggested that she discuss offline but was not comfortable removing from the register meantime. **MW/LC**

Mrs Campbell thanked members for their input to the active risks.

Mr Yalamarthi referred to Locums and noted that no induction was provided for equipment usage and this was something that should be looked at. Mrs Campbell agreed and suggested that it be opened up to other professions for a refocus. **SY**

**10 Items for information only:**

**10.1 NHS Fife Activity Tracker**

The Activity Tracker was noted.

**10.2 SIGN Guidance**

The SIGN Guidance was noted.

**10.3 ASD CGC Workplan 2021/2022**

The workplan for 2021/2022 was noted. Mrs Campbell asked that any new reports were planned into to annual workplan via Miss Godsell.

**10.4 Infection Control Committee Minutes of 4th August 2021**

The Infection Control Committee minutes were noted.

**10.5 HAIRT Report – October 2021**

The HAIRT report was noted.

**10.6 NHS Fife CP&PAG Minute of 23rd August 2021**

The NHSF CP&PAG minutes were noted.

**10.7 Resuscitation Minutes of 13th October 2021**

N/A - c/f to January 2022

**10.8 HTC Minutes of 29th October 2021**

N/A – c/f to January 2022

**10.9 Review of Terms of Reference – For Info (no changes)**

The Terms of Reference were noted.

**11 Meeting dates for 2022/2023**

Mrs Campbell asked members to note the dates for the meeting dates for 2022/2023. Miss Godsell would send out the invites within the next few days. **LG**

**12 AOCB**

Mrs Campbell thanked members for good discussions and succinct reports.

Ms Smith thanked Mrs Campbell for chairing and wished to note the reports are very comprehensive and the content is quite difficult, there is more complaints, more incidents and activity and acknowledged the Leadership team and their teams for reporting on these issues and dealing with this on a day to day basis. Ms Smith noted and acknowledged the pressure everyone is under and said it is good to share the learning.

Mrs Campbell thanked Ms Smith for the acknowledgment.

**13 Date of Next Meeting/s:**

Wednesday 26th January 2022 at 2.00pm via MS Teams

Unconfirmed

**MINUTES OF THE NHS FIFE AREA CLINICAL FORUM HELD ON THURSDAY 7 OCTOBER 2021 AT 2PM VIA MS TEAMS**

**Present:**
A Lawrie, Associate Director of Midwifery (Chair)
L Campbell, Associate Director of Nursing *(agenda items 5 – 6)*
D Galloway, Women Children & Community Services General Manager (Healthcare Scientists Forum) *(agenda items 1 – 6)*
S Garden, Director of Pharmacy & Medicine
B Hannan, Deputy Director of Pharmacy & Medicines (Chair of Fife Area Pharmaceutical Committee)
A MacKay, Speech and Language Therapy SLT Operational Lead (Chair – Allied Health Professional Clinical Area Forum)
Dr C McKenna, Medical Director
E O'Keefe, Consultant in Dental Public Health
J Owens, Director of Nursing

**In Attendance:**
S Fraser, Associate Director of Planning & Performance *(agenda item 5)*
Dr J Tomlinson, Director of Public Health *(agenda item 6)*
H Thomson, Board Committee Support Officer (Minutes)

**1. Apologies for Absence**

The Chair welcomed everyone to the meeting.

Lynn Campbell, Associate Director of Nursing has joined the Area Clinical Forum in the interim to represent the Nursing, Midwifery and Allied Health Professionals Council.

Apologies were received from S Bailey (Consultant Clinical Psychologist), J Hornal (Pharmacist), P Madill (Consultant in Public Health), and D Platt (Area Optical Committee Chair).

**2. Declarations of Members Interests**

There were no declarations of interest from those present.

**3. Minutes of the Previous Meeting held on 10 June 2021**

The Minutes from the previous meeting were **agreed** as an accurate record.

**4. Matters Arising and Action List**

The Forum noted the action on hold, and it was advised L Campbell, Associate Director of Nursing has joined the Area Clinical Forum (ACF) in the interim until a notice of interest to join the ACF has been circulated.

**5. REMOBILISATION PLAN (RMP4)**

The Associate Director of Planning & Performance presented on the final Remobilisation Plan (RMP4) and advised it has been submitted, in draft form, to the Scottish Government. Once agreement has been made, and has been through the Board, the Remobilisation Plan will be circulated. It was noted the RMP4 is a six month document.

**Action: Associate Director of Planning & Performance**

Background was provided on the Remobilisation Plan and it was advised it has been through consultation. It was also advised the format has changed due to a change in guidelines from the Scottish Government, and a delivery action plan, activity templates and a heatmap have been added. An overview of the heatmap was provided and it was advised further work is required. In terms of activity, templates have been submitted, and it was noted assurance was provided to the Board on performance and activity.

An overview of what was included in the narrative was provided: assumptions around Covid and non-Covid activity, current position on Covid, high level risks (mainly around workforce), impact of significant changes within the organisation, reflection of the last six months, winter plan (which was previously a separate document and now incorporated into the Remobilisation Plan), national care programmes & NHS recovery plans, funding around mental health wellbeing, staff health & wellbeing and digital information.

It was advised the next plan will be a three year plan which will focus more on a strategic direction, and will be submitted in early 2022. Guidance will available by the end of November 2021, and the Associate Director of Planning & Performance agreed to bring the guidance to a future Area Clinical Forum for input, and for the ongoing iteration of the planning.

**Action: Associate Director of Planning & Performance**

Following a question, it was advised the recovery plan forms part of the Remobilisation Plan. It was noted there are challenges around elective activity and improving the elective position; discussions around improvements are ongoing.

It was reported the Clinicians in Fife are working on the projects for the centre for sustainability delivery (CFSD) work, and are linking in with the Scheduled Care Group who meet on a weekly basis. It was advised a Planned Board is being established, and the CFSD work will form part of their remit and scope. It was also advised the CFSD work is generally around planned care delivery and acute delivery. The Associate Director of Planning & Performance agreed to provide a list of activity and specific pieces of the CFSD work.

**Action: Associate Director of Planning & Performance**

The action plan was outlined, and it was advised this will be updated on a monthly basis, and reported by exception to the Board. It was noted priorities are agreed by the Executive Directors' Group, and plans will be flexible. It was advised updates on actions are provided and discussed at the Remobilisation Forum which meet every two months, and they report into the Governance Committees, by exception.

It was reported the Clinical Strategy (up to the end of 2021) is in the process of being replaced by the Population Health & Wellbeing Strategy, and input from the Area Clinical Forum was welcomed. The Associate Director of Planning & Performance will join the next meeting to provide an update.

**Action: Associate Director of Planning & Performance**

The Associate Director of Planning & Performance was thanked for presenting on the Remobilisation Plan (RMP4).

## 6. ANCHOR INSTITUTIONS

The Director of Public Health presented on the Anchor Institutions. The presentation will be shared with the Area Clinical Forum.

**Action: Director of Public Health**

The role of the Area Clinical Forum in Anchor Institutions was raised, and it was advised clinical roles will form part of a signposting role for Anchor Institutions. Another aspect of Anchor Institutions is around making use of buildings and estates and the links with third sector organisations who can assist. Identifying gaps, and where help is required, to allow clinical staff to signpost was welcomed.

Lack of awareness in the differences between medical models of health and social models of health was highlighted, and it was questioned how we can have a better understanding.

Communication, linking in with other areas/groups, and Key Performance Indicators were highlighted. It was advised deprivations are in the early stages of conversations, and a process of self-assessment and scoring will support in monitoring progress in this area. The Director of Public Health agreed to keep the Area Clinical Forum informed of discussions that require a clinical voice and the monitoring of progress.

**Action: Director of Public Health**

It was noted elements of the Anchor Institutions Framework will be carefully considered in taking forward.

As an Anchor Institution, it was questioned what input into environmental sustainability is required. It was advised a NHS Fife Environmental Strategy Framework will be developed around sustainable development, and is an implicit part of managing our estates and buildings. It was noted a discussions around the clinical contributions in terms of Net Zero work would be beneficial; The Deputy Director of Pharmacy & Medicines agreed to take this action forward.

**Action: Deputy Director of Pharmacy & Medicines**

The Director of Public Health was thanked for presenting on the Anchor Institutions.

## 7. STAFF WELLBEING

The Director of Nursing advised the Fife Health Charity Sub-Committee held on 6 October 2021 discussed support for the charity, and this will go to the next Board of Trustees meeting.

It was noted coffee/tea has been provided to all areas in each directorate, and communication will go out to staff to advise.

## 8. DIGITAL INFORMATION

The Director of Pharmacy & Medicines advised discussions had taken place on challenges and issues with the electronic immediate discharge documents; It was advised this will be replaced by Hospital Electronic Prescribing and Medicines Administration (HEMPA) programme when it is rolled out in 2022. Work around training materials and procedures has been carried out, and it was also advised necessary investigations will be carried out from the Problem Assessments Group.

It was advised the Area Clinical Forum would discuss ways to improve the education on the use of systems within the clinical teams under the Digital Information standing agenda item. It was also agreed under this agenda item that meaningful discussions with others regarding Digital Information would be beneficial and to link in with other groups to avoid duplication of discussions. The Chair and Deputy Director of Pharmacy & Medicines agreed to take forward.

**Action: Chair/Deputy Director of Pharmacy & Medicines**

It was agreed to invite a colleague to present on Digital Information at a future ACF meeting. The Medical Director agreed to take this forward.

**Action: Medical Director**

## 9. BOARD FEEDBACK

The Chair advised a Public Health & Wellbeing Committee (PH&WC) has been established, and representation on the PH&WC requires consideration.

## 10. ACF CHAIR'S FEEDBACK

There was no feedback to update at this meeting.

## 11. POSITIONS TO BE AGREED

### 11.1 ACF Representative on Fife Elective Orthopaedic Centre

The Deputy Director of Pharmacy & Medicines was agreed as the ACF Representative on Fife Elective Orthopaedic Centre.

### 11.2 Representative for ACF from Nursing, Midwifery and Allied Health Professionals Council

The Associate Director of Nursing has joined the ACF in the interim until a notice of interest to join the ACF has been circulated.

**11.3 ACF Deputy Chair**

The Deputy Director of Pharmacy & Medicines was agreed as the ACF Deputy Chair.

**12. Subcommittee Minutes**

The Forum noted the following subcommittee minutes.

**12.1 Allied Health Professionals Clinical Advisory Forum**

Confirmed dated 2 June 2021 and Unconfirmed dated 4 August 2021.

**12.2 Area Medical Committee**

Unconfirmed dated 10 August 2021.

**12.3 General Practitioners Sub-Committee**

Confirmed dated 15 June 2021 and Unconfirmed dated 10 August 2021.

**13. ANY OTHER BUSINESS**

**13.1 Complaints**

It was advised the complaints management will be available in due course.

**13.2 High Risk Pain Medicines and Safety Programme**

It was reported the High Risk Pain Medicines and Safety Programme will reach across all areas of the organisation. The programme is for three years and funding has been provided. It was noted it would be beneficial for the ACF to support and shape the programme, and it was agreed to add this to the agenda in early 2022.

**Action: Director of Pharmacy & Medicine**

**14. DATE OF NEXT MEETING**

The next meeting will take place on Thursday 9 December 2021 at 2pm.

**Fife NHS Board**

**MINUTE OF THE NHS FIFE AREA CLINICAL FORUM HELD ON THURSDAY 9 DECEMBER 2021 AT 2PM VIA MS TEAMS**

**BEN HANNAN**
Chair

**Present:**

B Hannan, Deputy Director of Pharmacy & Medicines (Chair)
S Bailey, Consultant Clinical Psychologist
D Galloway, Women Children & Community Services General Manager
S Garden, Director of Pharmacy & Medicines
J Owens, Director of Nursing
D Platt, Optometrist

**In Attendance:**

G Couser, Head of Quality & Clinical Governance *(agenda items 6 & 7)*
S Fraser, Associate Director of Planning & Performance *(agenda item 9)*
N McCormick, Director of Property & Asset Management *(agenda item 5)*
S McNamee, Programme Manager
P King, Corporate Governance Support Officer (Minutes)

## 1. APOLOGIES FOR ABSENCE

Apologies were received from A Lawrie, Associate Director of Midwifery, A MacKay, Speech and Language Therapy SLT Operational Lead and Dr C McKenna, Medical Director.

## 2. DECLARATION OF MEMBERS' INTERESTS

There were no declarations of interest from those present.

## 3. MINUTE OF THE PREVIOUS MEETING HELD ON 7 OCTOBER 2021

The minute of the previous meeting was **agreed** as an accurate record.

## 4. MATTERS ARISING AND ACTION LIST

The Forum **noted** the action list which would be updated accordingly.

## 5. NHS FIFE'S PROPERTY & ASSET MANAGEMENT STRATEGY

It was noted that the Property & Asset Management Strategy (PAMS) is an annual return submitted to Scottish Government to help shape the State of the NHS Scotland Assets and Facilities Report (SAFR) which helps to provide an understanding of what the NHS Estate in Scotland looks like. The 2021 PAMS has been published on the NHS Fife website as part of the NHS Fife Board meeting papers of 30 November 2021.

The Director of Property & Asset Management gave a presentation on NHS Fife's Property & Asset Management Strategy providing an overview of the national context in terms of property and asset management, the estate, capital programme and backlog maintenance and compliance. In this year's report, the team has worked to make the prescriptive document more relevant to NHS Fife and to support the development of the Public Health & Wellbeing Strategy to be completed by end March 2022. The report focuses on the Anchor Institution Work, Environmental Sustainability and Zero Carbon issues, and Green Space and Bio-Diversity. The document also provides context for future business cases and makes mention of the Mental Health Strategy, Fife Elective Orthopaedic Centre and the Kincardine and Lochgelly Health & Wellbeing hubs which are a blueprint for the modern way to deliver care in a primary care setting in local communities.

Discussion took place on how the ACF could best engage with the team across the broad estates and facilities portfolio particularly in relation to service changes and prioritisation. Questions were also asked around accommodation and clinic space and the impact of agile working with many staff based at home, noting that this could influence future use of the estate. The Director of Property & Asset Management acknowledged the desire to have a 5 – 10 year plan and work was underway, initially looking at medical equipment and backlog maintenance. A Primary Care Services Review is also being undertaken and this will be reported back to the NHS Fife Board in due course.

The Chair thanked the Director of Property & Asset Management for his interesting presentation, and he confirmed that the Area Clinical Forum was keen to engage where it could in order to provide a clinical viewpoint.

## 6. CANCER STRATEGIC FRAMEWORK

The Head of Quality & Clinical Governance presented on the development of the Cancer Strategic Framework for NHS Fife. Considerable work has been undertaken to raise the profile of cancer in Fife with the establishment of a Core Cancer Team to drive work forward under the leadership of the Medical Director and a new governance structure put in place. A full systems approach has been taken to build the Framework focusing on the patient pathway and putting patients at the heart of the Framework. The new Cancer Strategic Framework is also feeding into the Public Health & Wellbeing Strategy and references the 68 actions contained within the Scottish Government Cancer Recovery Plan.

The timeline for approval of the Cancer Strategic Framework was set out. Once drafted and endorsed by the organisation, the Framework will be supported by an Annual Delivery Plan with oversight through the Cancer Strategic & Governance Group and via the Clinical Governance Committee.

The Chair welcomed the opportunity to see how work is progressing and for the wide consultation that has already taken place.

## 7. CLINICAL GOVERNANCE FRAMEWORK

The Head of Quality & Clinical Governance presented on the development of the Clinical Governance Framework, a document which underpins many of the fundamentals about what we do across our healthcare setting. The Framework will include a clearly defined overview of the governance structures in place and show how our governance assurance flows from the point of care delivery to Health Board level. Quality improvement has been a focus over the past few years to embed a system whereby the organisation is actively learning and evaluating any changes made and the need to foster a culture whereby openness, transparency and staff support is clear to allow people to discuss concerns and feel supported to make changes was emphasised.

The Clinical Governance Framework has been broken down into four key primary drivers and the table showed the supporting programmes of work being pushed forward to deliver the primary aims. An organisational learning group has been established to bring together all the information relating to clinical governance and triangulate it in a way to begin to understand the organisational themes and hotspots and consider how these can be addressed at a strategic level. The next steps were also outlined.

The Chair thanked the Head of Quality & Clinical Governance for the presentations, which would be circulated following the meeting, and looked forward to having the ACF playing into the work of the organisational learning group in future.

**Action: P King**

## 8. NHS FIFE POPULATION HEALTH & WELLBEING STRATEGY UPDATE

The Associate Director of Planning & Performance provided an update on progress on the NHS Fife Population Health & Wellbeing Strategy which is due to be submitted to the Board at the end of March 2022. Reference was made to the public and staff surveys that launched on 6 December 2021 to understand the thoughts, motivations and health and wellbeing experiences of people in Fife. Around 300-400 forms had been received to date and analysis is being undertaken by an external company which will report mid-January to EDG and onto the Board. Susan Fraser was happy to share these results with the ACF if requested. Finally, the extant Clinical Strategy was also being reviewed. This was being done differently from before largely due to the pressures and restrictions of Covid-19 and there had been good clinical and managerial engagement to date.

Discussion took place about some of the changes and challenges going forward recognising the impact of Covid-19 over the course of the next year at a minimum, and then moving into a recovery position. Views were expressed around staff wellbeing and the need for authenticity and clear messaging, being mindful of the longer term impact of Covid-19 on areas such as children's development and mental health and retaining some of the positive working that has been realised during the pandemic in terms of being able to change things quickly and being more ambitious.

## 9. REMOBILISATION PLAN (RMP4)

The Associate Director of Planning & Performance provided an update on the Remobilisation Plan (RMP4) and advised that following submission to Scottish Government in September, a progress report will be submitted to the committees in January 2022. Scottish Government has requested a progress update at the end of Quarter 3 (January) and Quarter 4 (April).

In terms of planning going forward, Scottish Government has put back the deadline for submission of next year's Annual Delivery Plan to July 2022 in recognition of the pressure in the system at the current time. However, it was important to know what the service will be delivering in 2022 so it is planned to have that information available to submit to the Board in March 2022.

The Strategic Planning & Resource Allocation process is underway to ask all services about their plans for the forthcoming year and for the next five years and almost all submissions have been received and will be presented to EDG next week and onward to the committees in January 2022.

The Associate Director of Planning & Performance was thanked for presenting on the Remobilisation Plan (RMP4) and NHS Fife Population Health & Wellbeing Strategy.

## 10. SUB COMMITTEE MINUTES

The Forum **noted** the following sub-committee minutes:

10.1. Area Medical Committee dated 12 October 2021 (unconfirmed)
10.2. GP Subcommittee dated 21 September 2021 (confirmed)
10.3. GP Subcommittee dated 19 October 2021 (unconfirmed)

## 11. MEETING DATES 2022/23

The Forum **noted** the meeting dates 2022/23.

## 12. ANY OTHER BUSINESS

None.

## 13. DATE OF NEXT MEETING

The next meeting will take place on Thursday **3 February 2022 at 2pm** via MS Teams.

**UNCONFIRMED Minutes of the Health & Safety Sub Committee held on Friday 10th December 2021 at 12:30 within Microsoft Teams**

**Present:**

Neil McCormick (NM) Director of Property & Asset Management
Conn Gillespie (CG) Staff Side Representative
Linda Douglas (LD) Director of Workforce
Paul Bishop

**In attendance**

Anne-Marie Marshall (AMM) Acting Health and Safety Advisor
David Young (DY) Minute Taker

**1. Chairperson's Welcome and Opening Remarks**

NM Welcomed everyone to the meeting and introduced Anne-Marie Marshall to the group.

**2. Apologies for absence**

Dr Chris McKenna (CM) Medical Director

**3. Minutes of previous meeting** Action

**3.1. APPROVAL OF PREVIOUS MINUTES**

The minutes of the previous meeting were reviewed by the group and agreed as accurate.

**3.2. Matters Arising**

**3.2.1. Dates for Meetings in 2022**

NM informed the group that the dates for next year's meetings have been arranged. The next meeting will be held on Friday 11 March 2022

**4. COVID 19**

**4.1. Discussion around H&S issues relating to COVID-19 response and ongoing management.**

NM talked about the potential impact of the new variant and commented that Carol Potter had recently issued new information to the organisation based around advice from Public Health Scotland. NM noted that the First Minister will be discussing the current situation later today which may bring further information to bear on what Scotland's approach to Omicron will be.

NM added that, up until this point, the organisation has been operating with the rules, guidance and practice that have been set up around COVID and staff are working incredibly hard to make sure that hospitals and important health and social care services continue running during the pandemic. This new variant presents a major threat to us continuing to run an organisation through a difficult winter period.

NM asked AMM if she was aware of any Health & Safety Related COVID 19 issues in Fife recently, AMM stated that there were no issues at present.

LD said that she was thoughtful about the organisation's state of readiness and preparedness to adapt to any changes to existing COVID rules made by the government.

CG raised his concerns regarding the morale of the Staff at present and is cautious about giving too much information to staff as it may cause confusion and worry

NM agreed that it is a very difficult time for staff and said that any information that brings clarity to current situation regarding this new variant should be shared as soon as possible.

**5. Governance Arrangements**

**5.1. Discussion around H&S arrangements for 2021-2022 (and beyond)**

NM explained that temporary measures are in place for the violence and aggression team and manual handling team. Meetings have been held with NHS Tayside and other partners including the

Fife Council and they have all offered their support should we need it. At the moment, we are managing to run the department on a reasonably sensible basis and will be looking to recruit more formally some of the positions.

PB provided an update regarding recruitment within the Health & Safety Services Team.

- A VMF has been submitted today for the position of Health & Safety Manager.
- He intends to recruit a Manual Handling Team Leader as manual handling provision throughout NHS Fife has been challenging and getting a team leader involved will help.
- An agreement has been made with Fife Council to set up some of their manual handling trainers on the bank system should we require additional help delivering training.
- Vacant positions within the team which have not been filled due to COVID will be filled.
- PB hopes that, by the end of this financial year, he will have a team which is more reminiscent of what it used to be, rather than what it is now.

**6. NHS Fife Enforcement Activity**

NM informed the group that the organisation has received formal notice indicating that the Enforcement Notice has been closed.

No other activity at present.

AMM informed the group that the HSE have launched a campaign focusing directly on stress. They have formulated some tool box talks and guidance on how we can evidence that we are supporting of staff through that. AMM has carried out research so that we can get Stress Risk Assessments in place before any HSE visit. The group discussed whether other departments such as Occupational Health should be involved with this work. LD suggested that AMM should contact Rhona Waugh for help. AMM

**7. Policies & Procedure**

**7.1. Health and Safety Policy review**

The group discussed the Spreadsheet submitted by CW at the last meeting. The spreadsheet shows information regarding the current status of all the policies relating to Health & Safety. DY

There some discussion regarding how redundant polices should retired, what policies should be included in the list and the ownership of policies.

NM stated that Hazel Thomson holds a master register of all the policies and procedures and suggested that list could be used to identify what policies need to be included in the H&S Policies Spreadsheet

NM asked DY to update the status and circulated around the group in due course

**8. Other business**

**8.1. Staff Governance Standards**

LD discussed the Staff Governance Standard focusing on “provide with continuously improving and safe working environment, promoting health and wellbeing of staff, patients and the wider community”. LD suggested looking at the work plan to make sure that the standard is appropriately accounted for, asked the group to be thoughtful in terms of items that are not currently on our agenda that should be on there and also looking through the lens of the staff governance standard is there other matters relevant to that remit and that purpose that either needs to go as well as clinical governance committee to staff Governance committee, or are unique to their remit or viewpoint.

NM stated that he had spoken with Rhona it has been agreed that that we should give an update to staff governance on a six monthly basis starting in February/March next year, depending on the agendas.

NM suggested that we give a presentation to explain what activities were undertaken, what the issues were, some points for discussion and anything that we think would be of interest to the Staff Governance Committee. And then they can help shape what comes to future meeting hopefully that and that will begin to address that point.

**8.2. Alternate Mask Supply Issues s**

CG told the group that some staff who have who had issues with face masks and have been advised to wear an alternate mask by Occupational Health, have then had difficulties obtaining the alternate AMM/CG

mask from the HUB. AMM and CG have agreed to investigate and resolve the issue. LD suggested that AMM contacts Occupational Health for help.

**9. FOR INFORMATION/ NOTING**

Committee Minutes

CW reported that there were no other committee minutes to review at present.

**10. Next Meeting**

Next meeting will take place on Friday 11th March 2022 @ 12:30 on Teams

**NHS FIFE INFECTION CONTROL COMMITTEE**
**1ST DECEMBER 2021 AT 2PM**
**VIA MICROSOFT TEAMS**

| | |
|---|---|
| **Present** | |
| Janette Owens | Director of Nursing |
| Julia Cook | Infection Control Manager |
| Craig Webster | Deputy Infection Control Manager |
| Margaret Selbie | Lead Infection Prevention and Control Nurse |
| Elizabeth Dunstan | Senior Infection Prevention and Control Nurse |
| Keith Morris | Consultant Microbiologist |
| Stephen Wilson | Consultant Microbiologist |
| Paul Bishop | Head of Estates |
| Catherine Gilvear | Patient Safety Programme Manager |
| Sue Blair | Consultant in Occupational Medicine |
| Pamela Galloway | Clinical Midwifery Manager |
| Pauline Cumming | Risk Manager |
| Lynn Burnett | Nurse Consultant Health Protection/Immunisation Co-Ordinator |
| Norma Beveridge | Head of Nursing |
| **Apologies** | |
| Esther Curnock | |
| Jim Rotheram | |
| Lynn Campbell | |
| Priya Venkatesh | |
| Lynn Barker | |
| Aileen Lawrie | |
| **In Attendance** | |
| Lori Clark | Notes |

| | | |
|---|---|---|
| **1** | **APOLOGIES**<br>Apologies were **noted** as above. | |
| **2** | **MINUTE OF PREVIOUS MEETING – October 2021**<br>Group approved previous minute as accurate reflection | |
| **3** | **ACTION LIST (October 2021)** | **ACTION** |
| | Group talked through each open action and the actions were closed or completed as appropriate.<br><br>Actions 4.1a, 4.1e and 4.7 carried forward to next ICC.<br><br>**Action list updated to reflect.** | |
| **4** | **STANDING ITEMS** | |
| **4.1** | 4.1a HAIRT Report<br><br>ED updated in regards to achievements that during Q2 NHS Fife was below the national rate for HCAI and CAI for SAB, CDI and ECB. In relation to challenges for SABs vascular access devices remain the greatest challenge for hospital acquired SABs and there is ongoing improvement works to reduce these. There has been 67 SABs from Jan-Oct 2021 and for the same timeframe in 2020 there were 61 cases.<br><br>ED added for ECB's UTIs and CAUTIs remain the main source of ECBs so these are the areas being addressed to reduce ECB rates. For ECBs NHS Fife has 85 in Q3 which was up from 56 in Q2. In Q3 there were 14 urinary catheter ECBs. For ECB's NHS Fife is above the target for March 2022. ED added that the UCIG is ongoing with the last a meeting on the 19th Nov, all ECB CAUTIs associated with trauma have been datixed and going forward all CAUTIS will be datixed and an LAER carried out. | |

ED updated that in Q3 NHS Fife has 12 CDI's which is the same as Q2 and we appear to be sitting on the reduction target line for March 2022. In relation to CDI's NHS Fife has seen an increase in cases in 2021 compared to the last 2 years. The HCAI incidence rate must be reduced further to meet targets.

The SSI programme is still paused due to the ongoing pandemic.

ED updated that in Q3 NHS Fife had 23 SABs which is up from 12 cases in Q2 2021 and are on track to achieve the target for March 2022. ED advised the team are still working with addiction services and there is now a PGD for antibiotic prescribing. IPC have also assisted with a training presentation for addiction services on SAB definitions, signs, symptoms and interventions.

ED advised NHS Fife are below the national average at 88% compliance however this may be due to a change-over to electronic MDRO CRA however 100% compliance was achieved for CPE clinical risk assessments. JC added that the MRDO clinical risk assessment went live the end of September for Q3 audit. It seems the 2 sets of questions (MRSA and CPE) come out at different times, therefore working with Excellence in Care and Digital and Information teams to ensure the questions are available for clinical staff at the same time. KM advised the group that the MRSA and CPE surveillance only covers 40 cases per quarter. JC added care dashboard will be reporting 20 cases per ward per month. JO asked if we can run a report to capture all for more assurance, **JC will pick up with Shirley Cowie and Steven Knapman.**

ED updated that for hand hygiene NHS Fife are consistently above 98% compliance which is usually displayed on ward dashboard. Ward dashboard has been removed but we are in talks with digital information to have the dashboard returned.

ED added that for domestic services & estates monitoring compliance in NHS Fife green status..

JC updated that there has been no outbreak of Norovirus during reporting period. Norovirus rates remain significantly lower than in previous years but there seems to be a bit more in community recently.

There has been no closures due to influenza and in week 45 activity remains at baseline level. In week 45, RSV activity increased from baseline to low, coronavirus and rhinovirus were at moderate levels and HMPV and parainfluenza low levels. There was one small outbreak of RSV at Tarvit involving 2 patients in the same room.

JC updated that in September and October there were 10 COVID 19 incidents reportable to ARHAI.

JC updated that there has been no unannounced hospital inspections in the last reporting period. There has however been a DL letter sent out from NES and HIS to say that inspections would be recommending 22nd November. They have different methodology and held a webinar, unfortunately no one form the IPC community were invited to this. The inspections will look at the new respiratory guidance pathways with will be in place in the next few weeks.

Members **noted** the update.

| | | |
|---|---|---|
| | 4.1b HAI LDP Update – SABs Reports<br><br>Reports on agenda for information<br><br>Members **noted** the update. | |
| | 4.1c HAI LDP Update – CDIs Reports<br><br>Reports on agenda for information<br><br>Members **noted** the update. | |
| | 4.1d ECB Surveillance Report<br><br>Reports on agenda for information<br><br>Members **noted** the update. | |
| | 4.1e HAI Update – C Section SSI Reports<br><br>This surveillance has been paused following a CNO letter however is being monitored at a local level.<br><br>Members **noted** the update. | |
| | 4.1f HAI Update – Orthopaedic SSI Reports<br><br>This surveillance has been paused following a CNO letter.<br><br>Members **noted** the update. | |
| | 4.1g Colorectal SSI Surveillance Report<br><br>This surveillance has been paused following a CNO letter.<br><br>Members **noted** the update. | |
| | 4.1h CPE Surveillance Report and MRSA Surveillance<br><br>Covered in HAIRT agenda item<br><br>Members **noted** the update. | |
| | 4.1i Outbreaks, Incidents and Triggers<br><br>Covered in HAIRT agenda item<br><br>Members **noted** the update. | |
| **4.2** | Care Home update<br><br>JC updated that the care home team have been very busy delivering education and training, presenting at grand rounds and manager meetings, completing training on teams and face to face sessions. They have been on supportive walkabouts in care homes following on from the referral process and supporting those homes needing additional assistance. JO added that she has read an article which states that the intervention from boards in the care homes have been very negative and heavy handed, intrusive etc. Fife however got a glowing report and was | |

| | | |
|---|---|---|
| | an exemplar of how the work should be done in a supportive way building relationships with the homes and supporting teams.<br><br>Members **noted** the update. | |
| **4.3** | NHS National Cleaning Services Specification<br><br>Attachment on agenda for noting.<br><br>Members **noted** the update. | |
| **4.4** | Risk Register<br><br>PC updated that there are currently 3 high risks. Risk 612 re offsite services, PC updated that there are quality issues of packs from the decontamination unit at Tayside. NHS Tayside completed an internal audit followed by an external audit that identified a number of issues around training, stacking of trays and the way trays are transported. Risk 2167 is a risk relating to a lack of SLA around the decontamination for robotic surgery. PB updated that there is now an SLA in place with Steris in Motherwell and PB is working on having our own CDU. For risk 1252 regarding flexible PEX hoses in phase 3, PB updated that 50% of the hoses have been replaced and 50 % will be carried out in the next financial year. All augmented care areas have already been covered so no PEX hosed just all copper joints.<br><br>With regards to new possible risk 2213 Orthotic accommodation it seems IPC was not aware of this risk. JO added she has had some discussion with orthotics and they are keen form more space as they are cramped. PB added there is now an accommodation group and now any department requiring space the can go to this group to raise their need which will be considered and when space is found they can be relocated.<br><br>Members **noted** the update | |
| **4.5** | Learning Summaries<br><br>PC advised that if the group had any questions relating to the learning summaries they can contact her.<br><br>Members **noted** the update | |
| **4.6** | National Guidance<br><br>JC updated that the new respiratory guidance has now been published on Monday and the screening table is still being updated potentially this will be published later today. JO added that we do seem to be in a better position with the new guidance than possibly some other boards.<br><br>Members **noted** the update | |
| **4.7** | HEI Inspections<br><br>JC added the DI letter is for the committees awareness regarding the restart of inspections which had been stalled for a few weeks. The letter advises that they will be inspecting against the new guidance which came out on Monday and we have a 2 week implementation period for this guidance. | |

| | | |
|---|---|---|
| | Members **noted** the update. | |
| **4.8** | Quality Improvement Programmes<br>UCIG<br><br>CG advised that this has already been covered and the only thing to add is that there will be another group created and the driver diagram being updated. There will be a lot of work on hydration but work is light touch just now due to the current situation.<br><br>PWID<br><br>JC updated that the last few meetings have been cancelled so unfortunately unable to provide an update.<br><br>Members **noted** the update. | |
| **4.9** | Education<br><br>ED updated that for winter planning processes and documentation has been reviewed. We have delivered weekly education sessions on teams and some face to face sessions with different staff groups and shifts. In 2021 so far the team have trained 981 staff members on various topics which a great achievement with the restrictions that we have had.<br>JO thanked KM for the grand round he done.<br><br>Members **noted** the update. | |
| **4.10** | Infection Prevention & Control Audit Programme<br><br>MS updated that committee that IPC are on track with the audit programme. In the last 2 months there have been 12 environmental audits, 6 re-audits and 6 hand hygiene audits completed. Rosemary Shannon continues to work one day a week with IPC audits and keeping the programme up to date. The substantive IPCN's have very limited capacity due to workload pressures, however we can review in January as the are a number coming up to renewal dates. JO asked if any of the results are concerning, MS advised there is nothing major but follow up on any issues at the time. As a trial at QMH - audit action plans have been broken up and sent to the relating teams estates, domestic, ward etc.<br><br>Members **noted** the update | |
| **4.11** | Prevention and Control of Infection Work Programme 2021-2022 (for noting)<br><br>JC updated that the work programme is for information. The audit programme is up to date however there is a chance of slippage over the coming months. We are trying not to put additional pressure on clinical teams at the moment also.<br><br>Members **noted** the update. | |
| **5.** | **NEW BUSINESS** | |
| **5.1** | COVID-19<br><br>JC updated that she used to get lessons learned weekly but they are less frequent recently. The lessons learned are looking at all the incidents reported to ARHAI and grouping together common themes. JC updated | |

| | | |
|---|---|---|
| | some challenges identified include screening of patients, transfer of patients before known results, challenges around capacity impacting on patient placement, staff attending with mild symptoms, visitors being non-compliant with mask use, visitors coming symptomatic and some PPE breeches. The lessons learned also highlight some good practice points also.<br><br>Members **noted** the update | |
| **5.2** | Excellence in Care<br><br>JC advised EiC MDRO went live in September and showed a drop in compliance for MRSA, however this is potentially due to timing of when the questions are become available. Digital health are already looking into this and we will get some communication out to senior charge nurses. Also explore if a weekly report would provide assurance around compliance with the MDRO.<br><br>Members **noted** the update | |
| **5.3** | Safe and Clean Audit<br><br>ED updated that we provide training sessions every week via teams which have had very good attendance. The audit tool provides assurance within a clinical setting and we have had every ward and the majority of outpatients on this for some time now. Now we can expand this further, we have had staff from occupational health, children's continence services and mental health services attend the training. There seems to be good engagement with the tool and staff seem to find it empowering. NB added she is not convinced that the acute teams have adopted the tool, there has been a lot of issues in the past. It might be something we need to look at in the acute setting. ED asked if this is training or a time factor. NB thinks this is a time factor and due to it being difficult in the beginning it hasn't been picked up again. **ED and NB to pick up a discussion to see how they can move this forward again.**<br><br>Members **noted** the update | |
| **6** | **NHS FIFE INFECTION CONTROL COMMITTEE'S SUB GROUPS** | |
| **6.1** | Infection Prevention & Control Team<br><br>Nothing from this meeting to highlight to group.<br><br>Members **noted** the notes of the meeting | |
| **6.2** | NHS Fife Decontamination Steering Group<br>Nothing from this meeting to highlight to group.<br><br>Members **noted** the notes of the meeting | |
| **6.3** | NHS Fife Antimicrobial Management Team<br>Nothing from this meeting to highlight to group.<br><br>Members **noted** the notes of the meeting. | |
| **6.4** | NHS Fife Water Safety Management Group<br><br>Nothing from this meeting to highlight to group.<br><br>Members **noted** the notes of the meeting. | |

| | | |
|---|---|---|
| **6.5** | HAI SCRIBES<br><br>HAI-SCRIBE works ongoing. MS added that the team keep a record of all SCRIBEs they are involved in.<br><br>JO raised that the independent review of the Queen Elizabeth University Hospital has been published. The review has 63 recommendations and 21 of these recommendations were highlighted as being relevant to wards. Of the 21 recommendations most were in relations to new build design and construction, ventilation etc. JO has shared with JC and KM and exploring developing a permanent HAI SCRIBE post.<br><br>To look at the governance round the orthopaedic centre. The orthopaedic centre team should be assuring the ICC that everything has been done around ventilation and equipment etc.<br>**JO to liaise with Ben Johnston to bring a report to the next ICC around this review**.<br><br>KM added that as an IPC team we haven't always had project leads coming to the team to advise of upcoming work. Now with NHS Assure there will be much more scrutiny. Also for larger projects such as the orthopaedic centre there is a need for a IPCT representative to be at all the meetings for attention to detail. PB added that he has had a conversation with Neil McCormick to have IPCT representation for HAI SCRIBE to ensure involvement in all SCRIBE.<br><br>MS added that she has arranged for HFS to provide training and updates early next year, everyone is welcome including estates.<br><br>JO added that another point from the report is that there was no records, PB agreed that we need to make sure there is an audit trail. SW reiterated the importance of good record keeping and keeping good documentation in a central place in case any information is needed at a later date. SW thanked MS for keeping up to date with all SCRIBE and ensuring IPC are involved in all these projects from the start.<br><br>Members **noted** the notes of the meeting | |
| **6.6** | Quality Reports<br>Quality reports attached to agenda for information.<br><br>Reports are for **noting** only | |
| **7** | **ANY OTHER BUSINESS**<br><br>JC updated that the communications plans is included for awareness and updated that the team are working with communications team to get some new branding for IPC to be more in line with the rest of NHS Fife.<br><br>JC updated that the ICC ToR has the suggested changes and requires approval. JO advised she may have something to add so can send that to JC then can virtually get agreement before the next meeting.<br><br>KM asked if there is a requirement in the agenda for points 4.1a to 4.1i. These are covered in the HAIRT and if there is something else we can comment at the time monthly reports not required. JO content with HAIRT report then reporting by exception. Group agreed.<br><br>JC updated that at the national meeting yesterday they were informed | |

| | | |
|---|---|---|
| | that the UK IPC Cell were having an extraordinary meeting today regarding the Omicron variant. At a local level we have been asked that if we have one of these cases we should isolate at this time and there is some direction for public health around contacts and contact tracing. SB added that isolation includes isolation for household members which might have implication for staff as many staff use the HCW exemptions to come back to work if they are contacts. Omicron requires 10 days isolation of all contacts. The issue might be with identifying omicron as these need to be done through the reference lab. This will be discussed at STAC on Friday but it is a concern.<br><br>Members **noted** updates. | |
| **8** | **DATE OF NEXT MEETING**<br>The next meeting of the Committee will be held 2nd February 2022 at 10am via Microsoft Teams. | |

**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.

NHS Fife

**NOTE OF MEETING OF THE AREA MEDICAL COMMITTEE (AMC) HELD ON TUESDAY 12 OCTOBER 2021 AT 2PM VIA MS TEAMS**

**Present:**

| | |
|---|---|
| Dr Phil Duthie | Chair |
| Dr Chris McKenna | Medical Director |
| Dr Fiona Henderson | General Practitioner |
| Dr Sally McCormack | Clinical Director Emergency Care |
| Professor Morwenna Wood | AMD for Surgery, Medicine and Diagnostics |
| Mr Satheesh Yalamarthi | Clinical Director Planned Care |

**In Attendance:**

| | |
|---|---|
| Catriona Dziech (Notes) | |
| Susan Fraser | Associate Director of Planning |
| Allan Young | Head of Digital Operations |

**1 APOLOGIES FOR ABSENCE**

Dr Marie Boilson, Dr Helen Hellewell, Dr John Kennedy, Dr John Morrice.

**2 DECLARATIONS OF MEMBERS' INTERESTS**

There were no declarations of interest.

**3 MINUTES OF PREVIOUS MEETING HELD ON 10 AUGUST 2021**

The notes of the meeting held on 10 August were approved.

**4 MATTERS ARISING**

**i) Revised Constitution – Requirements for AMC in Statute**

Dr McKenna advised Fay Richmond had looked at the websites of other Boards. The exercise had revealed not many Boards across the country had a well-functioning AMC serving the purpose they were originally set up for. It was agreed there are other mechanisms in place to get the clinical voice across the organisation but this Committee and the Area Medical Committees are Statutory Committees.

**5 STANDING ITEMS**

**i) Financial Position – Including (IPQR considered at Clinical Governance Committee 17 September 2021)**

Dr McKenna advised there was no specific update other than there is a lot of long-term uncertainty regarding funding.

Dr Duthie advised there is a push to SGHD to fund MOU2 properly.

**ii) Medicines**

There was no update at this time.

**iii) Adverse Events**

Activity around adverse events has been slowed down due to the current clinical pressures within the system.

**iv) Medical Staff Committee**

Dr McKenna advised despite follow up there was no update at this time.

**v) Update from GP Sub Committee**

Dr Henderson advised still trying to move forward GP access to CT Heads. Dr McCormack said the delay was due to a technical hold up but Radioloy have done all their criteria and cleared with Neurology who are now happy to move forward.

A meeting has been arranged with Mr Robertson to discuss Bariatric Surgery.

There remains an issue with secondary care work being passed to General Practice. Dr McCormack advised there is a clear SOP in place and would be happy to follow up any issues with individuals if required.

**vi) Realistic Medicine**

Work remains ongoing. Dr McKenna advised the value improvement fund bids which had been recently submitted by NHS Fife and Lanarkshire had not been considered by SGHD and funding had been distributed to other Health Boards. Dr McKenna wrote to Gregor Smith expressing his disappointment and it has been agreed NHS Fife will submit double the number of bids in the next round.

**vii) Medical Workforce**

Dr McKenna advised there has been several good appointments recently. Interviews will take place shortly for Community Paediatricians which will help this at-risk service. There are areas across Acute which are a challenge mostly in Emergency Care. Planned Care are in a good place. An Acute Physician has been appointed to undertake stroke. Areas of concern are Microbiology and Haematology along with Diagnostics.

It was suggested lessons could be learned from Planned Care around recruitment. Professor Wood advised Planned Care Women and Child have senior trainees who rotate out which enables them to influence senior trainee decision making when applying for jobs in Fife. In Emergency Care this only applies to ITU and ED and does

not apply to the areas of medical specialties or laboratories where there are constantly gaps. Professor Wood said she felt there is a cohesive culture in Planned care which is attractive and promotes the feeling of a team which is maybe not as clear in Emergency Care.

Professor Wood suggested that GPST and F2 training needs to be encouraged in Primary Care. Kim Steel is liaising with Fife GPs regarding F2 training to look at increasing Foundation Doctors within Fife. If these places are not taken up with Fife GPs, the trainees will be sent to Lothian practices. Although understanding of the pressures within Primary Care and the difficulty of taking on trainees Professor Wood expressed a concern that it is a way of influencing future recruitment. Dr Henderson advised she thought it would be helpful to have a recap of what is expected of the different stages for GP Training to allow practices to consider if they could take on GP Registrars or F2s.

**viii) Education & Training**

There was no update at this time other that what is covered above.

**ix) LAER/SAERs – Report from Adverse Events/DoC**

No update as meetings on 10 August & 5 October 2021 were cancelled

**6 STRATEGIC ITEMS**

**i) Health & Care Services Transformation**

Covered in update from Susan Fraser.

It was agreed there should be good clinical input to the four sections; Scheduled Care, Planned Care, Proactive/ Preventative Care and Place and Wellbeing. Professor Wood advised she has reiterated this point to Susan Fraser in a previous meeting.

**ii) GMS Implementation**

Issues remain with SGHD now wishing to move the contract from the NHS to the IJB.

**iii) COVID & Remobilisation**

It has been tough in Secondary since September with another wave of Covid with numbers remaining persistent which puts pressure elsewhere on the system. ITU has settled within the last ten days and we retracted back to 1 ITU but the situation remains precarious. Attendances to A&E are the highest they have ever been with ambulance waits of four hours which is unacceptable. As we prepare for winter, we need to consider plans for preparing the staff and system for the coming months.

**7 Transformation / Strategic Plans for NHS Fife – Susan Fraser**

Susan Fraser advised the new Strategy was in progress. The previous Strategy was for 2016 – 2021. Planning is underway by looking at the previous strategy and the overall recommendations as well as the workstream recommendations and what has progressed over the past five years. What has not been progressed will be looked at and if we need to keep continuing with the recommendations that have not been completed and what is on the horizon in terms of moving forward. Susan Fraser advised she has spoken Dr McKenna and will be in touch with Professor Wood and Sally McCormack and other clinicians to seek their views on progressing this work.

The next Strategy will be called the Public Health and Wellbeing Strategy and will cover the delivery of clinical services as well as population and wellbeing aspects to healthcare. The Strategy will be moulded around the four National Care Programmes; Scheduled Care, Planned Care, Proactive/ Preventative Care and Place and Wellbeing.

Susan Fraser advised a Public and Staff Survey is currently being developed which will be issued mid / late November to gather views on health and wellbeing and the clinical services we provide. This information will then be incorporated into high level Strategy. The timescale for this is Q1, Q2 in 2022. Work has not progressed as far as hoped but is ongoing to ensure this next Strategy is correct.

Alignment with other strategic pieces of work has been ongoing. The RMP4 has just been submitted which sets out plans for services up to March 2022. Although this may not be the correct time for remobilisation given the position within the hospital and primary care and services in general. The SGHD have asked that after March 2022 a three-year delivery and strategic plan is prepared for the next three years. Alongside this there is Strategic Planning and Resource Allocation which looks at the 2022/23 Operational Plan and the objectives for each area. These pieces of work all need to align with each other to ensure there is no duplication of work.

In taking comments it was noted on the back on the new contract this is an opportunity for us consider Primary / Secondary care as a single unit for the patient journey from start to finish. There is a move towards the community, which is good, but consideration should be given to the lack of capacity in general practice. Both sides of the equation need to be integrated from the MOU2 work and from secondary care into the community.

Dr Duthie thanked Susan Fraser for her update.

**8 Update on Digital Strategy – Allan Young**

Allan Young shared the top ten items which summaries the strategic aims in Digital.

| | | | | | |
|---|---|---|---|---|---|
| 1 | Maintain Internal SLA and Core Infrastructure availability | Focus on continuous improvement and innovative ways to protect the production environment | Head of Digital Operations | 75% | Ongoing |
| 2 | Continue to progress towards maximum Cyber Resilience | Continue working towards compliance with NIS Directive and best practice. | Head of Digital Operations | 69% | Ongoing |
| 3 | Complete the GP Estate IM&T Improvements | Complete the workstreams that deliver GP equipment improvements | Head of Digital Operations | 95% | Paused |
| 4 | Continue to more the organisation towards paperlite | Scanning solution for Health Records in order to reduce paper (forward scanning) | Head of Strategy & Programmes | 90% | Completing |
| 5 | Introduce a robust and layered Service Catalogue | Improve understanding and engagement with stakeholders and services | Head of Digital Operations | 5% | Starting |
| 6 | Implement the O365 Business Transformation Programme | Business transformation for O365 to maximise the investment and improve productivity | Head of Strategy & Programmes | 30% | Ongoing |
| 7 | Maintain a standardised and within 5 year lifecycle endpoint estate | Upgrade all endpoints to Windows 10 | Head of Digital Operations | 80% | Ongoing |
| 8 | Morse Community System Rollout | Replace MiDIS community system with Morse and onboard new services previously paper based. | Head of Strategy & Programmes | 85% | Ongoing |

| | | | | | |
|---|---|---|---|---|---|
| 9 | Clinical Portal (H&SC Portal | Development of Clinical Portal, horizontal expansion | Head of Strategy & Programmes | 25% | Ongoing |
| 10 | HEPMA (Hospital Electronic Prescribing & Medicines Administration | Business Case approved – progress programme resourcing and inception | Head of Strategy & Programmes | 5% | Starting |

In taking comment it was noted from a clinical perspective it does not feel paperlite is moving towards completion. There are various components to paperlite, and solutions will have to be worked through before planning delivery can begin. Paperlite will remain an active conversation.

Consideration is being given to moving to mobile Trak which will allow the use of Trakcare on iPads etc.

In terms of safety from a digital perspective Dr McKenna has asked the team to look at the conversion to News2 on PatientTrak from the current Fuse system. This work will begin next year. Results Reconciliation is another area which will be look at. Both items will need project management and investment as well as a Business Case to support the work.

Mr Yalamarthi asked that the pace of the changes be more rapid. He also highlighted a SLWG had been formed to identify software to support digital pre assessment but were facing delays with digital input to buy in to the system the clinicians were supporting. This was considered key transformation going forward and asked how this could be addressed. Dr McKenna advised it was recognised there are various levels of priorities within the organisational but ultimately it comes down to resource and projects that take precedent tend to be organisational wide. These projects also take up a huge amount of resource and workforce from a Digital perspective. How you influence priorities is an issue for the Management Teams and decisions taken at the D&I Board.

Any specific areas of investment we wish to prioritise for the organisation could perhaps be included in our SPRA process for the next financial year so any available funding can be prioritised by Finance colleagues.

Dr McKenna and Mr Yalamarthi agreed to discuss further offline.

**Action: CMcK/SY**

**9 ITEMS FOR INFORMATION**

**i) Notes of the GP Sub Committee held on 15 June & 17 August 2021**

Noted.

**ii) Notes of the Adverse Events / Duty of Candor meeting held on 8 June 2021 (Unconfirmed)**
Noted.

**10 AOCB**

**Follow up Chest x-ray per vetting outcome letter / electronic requesting of interval imaging through Trakcare**

There was a plea from the GP Sub Committee that the appropriate Consultant or Junior may wish to make the request themselves rather than asking GPs. To request.

**11 PROPOSED DATES FOR 2022**

Tuesday 8 February 2022
Tuesday 12 April 2022
Tuesday 14 June 2022
Tuesday 9 August 2022
Tuesday 11 October 2022
Tuesday 13 December 2022
(all meetings will commence at 2pm) – Teams invites will be circulated.

**12 DATE OF NEXT MEETING**

**Tuesday 14 December 2021 at 2pm via MS Teams**