NHS Fife Clinical Governance Committee

Fri 03 November 2023, 10:00 - 12:50

MS Teams

Agenda

10:00 - 10:00
0 min

1. Apologies for Absence

Arlene Wood

10:00 - 10:00
0 min

2. Declaration of Members' Interests

Arlene Wood

10:00 - 10:00
0 min

3. Minutes of Previous Meeting held on Friday 8 September 2023

Enclosed *Arlene Wood*

Item 3 - Clinical Governance Committee Minutes (unconfirmed) 20230908.pdf (11 pages)

10:00 - 10:10
10 min

4. Matters Arising / Action List

Enclosed *Arlene Wood*

Item 4 - Clinical Governance Committee Action List - 20231108.pdf (2 pages)

4.1. Computerised Tomography Scanner

Enclosed *Claire Dobson*

Item 4.1 - SBAR Computerised Tomography Scanner.pdf (4 pages)

10:10 - 10:25
15 min

5. Patient Story - Urology Care

Presentation *Janette Keenan*

10:25 - 10:35
10 min

6. ACTIVE OR EMERGING ISSUES

6.1. Letter to Cabinet Secretary re. Countess of Chester Hospital Inquiry

Enclosed *Chris McKenna*

Item 6.1 - SBAR Letter to Cabinet Secretary re. Countess of Chester Hospital Inquiry.pdf (3 pages)
Item 6.1 - Appendix 1 Letter from Cabinet Secretary to Board Chairs and Chief Executives 20230826.pdf (2 pages)
Item 6.1 - Appendix 2 NHS Fife response to the Cabinet Secretary 20230913.pdf (5 pages)

6.2. Letter from Chief Medical Officer re. Report of the Transvaginal Mesh Case Record Review

Enclosed *Dr Chris McKenna*

Item 6.2 - Letter from CMO re. Report of the Transvaginal Mesh Case Record Review.pdf (2 pages)

10:35 - 10:55
20 min

7. GOVERNANCE MATTERS

7.1. Corporate Risks Aligned to Clinical Governance Committee, including Deep Dive: Digital & Information

Enclosed *Dr Chris McKenna / Alistair Graham*

Item 7.1 - SBAR Corporate Risks Aligned to Clinical Governance Committee.pdf (7 pages)
Item 7.1 - Appendix 1 Corporate Risks aligned to the Clinical Governance Committee.pdf (6 pages)
Item 7.1 - Appendix 2 SBAR Deep Dive - Digital & Information.pdf (6 pages)
Item 7.1 - Appendix 3 Assurance Principles.pdf (1 pages)
Item 7.1 - Appendix 4 Risk Matrix.pdf (2 pages)

7.2. Clinical Governance Oversight Group Assurance Summary from August 2023 Meeting

Enclosed *Dr Shirley-Anne Savage*

Item 7.2 - SBAR Clinical Governance Oversight Group Assurance Summary from August 2023 Meeting.pdf (2 pages)
Item 7.2 - Appendix 1 Assurance Summary Clinical Governance Oversight Group 22 August 2023.pdf (6 pages)

7.3. Delivery of Annual Workplan 2023/24

Enclosed *Dr Shirley-Anne Savage*

Item 7.3 - Delivery of Annual Workplan.pdf (8 pages)

10:55 - 11:35
40 min

8. STRATEGY / PLANNING

8.1. Annual Delivery Plan Quarter 2 Performance 2023/24

Enclosed *Margo McGurk*

Item 8.1 - SBAR Annual Delivery Plan Quarter 2 Performance 2023-24.pdf (6 pages)
Item 8.1 - Appendix 1 Annual Deliver Plan 2023-24 Q2 Update.pdf (7 pages)

8.2. Cancer Strategic Framework Delivery Plan 2023/24

Enclosed *Dr Chris McKenna*

Item 8.2 - SBAR Cancer Strategic Framework Delivery Plan 2023-24.pdf (5 pages)
Item 8.2 - Appendix 1 Cancer Framework Annual Delivery Plan Year 2 2023-24.pdf (13 pages)

8.3. Alignment of NHS Fife Cancer Framework and the National Cancer Strategy 2023-2033 and Cancer Action Plan for Scotland 2023-2026

Enclosed *Dr Chris McKenna*

Item 8.3 - SBAR Alignment of NHS Fife Cancer Framework....pdf (6 pages)
Item 8.3 - Appendix 1 National Cancer Strategy 2023-2033.pdf (68 pages)
Item 8.3 - Appendix 2 Cancer Action Plan Scotland 2023-2026.pdf (30 pages)
Item 8.3 - Appendix 3 NHS Fife Cancer Framework 2022-2025.pdf (70 pages)

8.4. Clinical Governance & Strategic Framework Delivery Plan 2023/24 –Mid-Year Report

Enclosed *Dr Shirley-Anne Savage*

Item 8.4 - SBAR Clinical Strategic Framework Delivery Plan 2023-24.pdf (3 pages)
Item 8.4 - Appendix 1 Clinical Governance Strategic Framework Delivery Plan 2023-24 Mid-Year Update.pdf (6 pages)

8.5. Incident Management Framework

Enclosed *Dr Joy Tomlinson*

- Item 8.5 - SBAR Incident Management Framework.pdf (3 pages)
- Item 8.5 - Appendix 1 Incident Management Framework.pdf (100 pages)

11:35 - 12:00
25 min

9. QUALITY / PERFORMANCE

9.1. Integrated Performance & Quality Report, including in depth review on In-Patient Falls

Enclosed *Dr Chris McKenna / Janette Keenan*

- Item 9.1 - SBAR Integrated Performance & Quality Report.pdf (4 pages)
- Item 9.1 - Appendix 1 Integrated Performance & Quality Report.pdf (16 pages)
- Item 9.1 - SBAR Deep Dive In-Patient Falls.pdf (12 pages)
- Item 9.1 - Appendix 1 SPSP Acute Adult Programme Falls Reduction Change Package and measurement plan.pdf (27 pages)
- Item 9.1 - Appendix 2 Draft version of NHS Fife HSCP Falls Toolkit.pdf (5 pages)
- Item 9.1 - Appendix 3 Revised patient information leaflet.pdf (8 pages)
- Item 9.1 - Appendix 4 Deconditioning poster NHS Fife.pdf (1 pages)

9.2. Medicines Safety Review and Improvement Report

Enclosed *Ben Hannan*

- Item 9.2 - SBAR Medicines Safety in NHS Fife Review and Improvement.pdf (4 pages)
- Item 9.2 - Appendix 1 Medicines Safety in NHS Fife Review and Improvement.pdf (39 pages)

9.3. Healthcare Associated Infection Report (HAIRT)

Enclosed *Janette Keenan*

- Item 9.3 - SBAR Healthcare Associated Infection Report (HAIRT).pdf (6 pages)
- Item 9.3 - Appendix 1 HAIRT Report.pdf (28 pages)

12:00 - 12:10
10 min

10. DIGITAL / INFORMATION

10.1. Digital and Information Strategy 2019-24 Update

Enclosed *Alistair Graham*

- Item 10.1 SBAR Digital and Information Strategy 2019-24 Update + appendices.pdf (13 pages)

12:10 - 12:20
10 min

11. PERSON CENTRED CARE / PARTICIPATION / ENGAGEMENT

11.1. Patient Experience & Feedback Report

Enclosed *Janette Keenan*

- Item 11.1 - SBAR Patient Experience & Feedback Report.pdf (6 pages)
- Item 11.1 - Appendix 1 Improvement Plan.pdf (5 pages)

12:20 - 12:45
25 min

12. ANNUAL REPORTS / OTHER REPORTS

12.1. Mid-Year Resilience Assurance Report

Enclosed *Dr Joy Tomlinson*

- Item 12.1 - Mid-Year Resilience Assurance Report.pdf (7 pages)
- Item 12.1 - Appendix 1 NHS Fife Incident Management Framework.pdf (83 pages)

12.2. Hospital Standardised Mortality Ratio Update Report

Enclosed *Dr Chris McKenna*

- Item 12.2 - SBAR Hospital Standardised Mortality Ratio Update Report.pdf (4 pages)

12.3. Infection, Prevention & Control Annual Report

Enclosed *Janette Keenan*

- Item 12.3 - SBAR Infection, Prevention & Control Annual Report.pdf (6 pages)
- Item 12.3 - Appendix 1 Infection, Prevention & Control Annual Report 2022-23.pdf (46 pages)

12.4. Volunteering Annual Report 2022/23

Enclosed *Janette Keenan*

- Item 12.4 - SBAR Volunteering Annual Report 2022-23.pdf (3 pages)
- Item 12.4 - Appendix 1 Volunteering Annual Report 2022-23.pdf (11 pages)

12:45 - 12:50
5 min

13. LINKED COMMITTEE MINUTES

13.1. Area Clinical Forum held on 5 October 2023 (unconfirmed)

Enclosed

- Item 13.1 - Minute Cover Paper.pdf (1 pages)
- Item 13.1 - Area Clinical Forum Minutes (unconfirmed) 20231005.pdf (4 pages)

13.2. Area Medical Committee held on 8 August 2023 (unconfirmed)

Enclosed

- Item 13.2 - Minute Cover Paper.pdf (1 pages)
- Item 13.2 - Area Medical Committee Minutes (unconfirmed) 20230808.pdf (7 pages)

13.3. Area Radiation Protection Committee held on 10 May 2023 (unconfirmed)

Enclosed

- Item 13.3 - Minute Cover Paper.pdf (1 pages)
- Item 13.3 - Area Radiation Protection Committee Minutes (unconfirmed) 20230510.pdf (3 pages)

13.4. Cancer Governance & Strategy Group held on 17 August 2023 (unconfirmed)

Enclosed

- Item 13.4 - Minute Cover Paper.pdf (1 pages)
- Item 13.4 - Cancer Governance & Strategy Group (unconfirmed) 20230817.pdf (15 pages)

13.5. Clinical Governance Oversight Group held on 22 August 2023 (confirmed)

Enclosed

- Item 13.5 - Minute Cover Paper.pdf (1 pages)

13.6. Fife Area Drugs & Therapeutic Committee held on 16 August 2023 (unconfirmed)

Enclosed

- Item 13.6 - Minute Cover Paper.pdf (1 pages)
- Item 13.6 - Fife Area Drugs & Therapeutic Committee Minutes (unconfirmed) 20230816.pdf (8 pages)

13.7. Fife IJB Quality & Communities Committee held on 30 June 2023 (confirmed) & 7 September 2023 (unconfirmed)

Enclosed

- Item 13.7i - Minute Cover Paper.pdf (1 pages)
- Item 13.7i - Fife IJB Quality & Communities Committee Minutes (confirmed) 20230630.pdf (11 pages)
- Item 13.7ii - Minute Cover Paper.pdf (1 pages)
- Item 13.7ii - Fife IJB Quality & Communities Committee Minutes (unconfirmed) 20230907.pdf (10 pages)

13.8. Health & Safety Subcommittee held on 8 September 2023 (unconfirmed)

Enclosed

- Item 13.8 - Minute Cover Paper.pdf (1 pages)
- Item 13.8 - Health & Safety Subcommittee Minutes (unconfirmed) 20230908.pdf (9 pages)

13.9. Infection Control Committee held on 9 August 2023 (confirmed) & 4 October 2023 (unconfirmed)

Enclosed

- Item 13.9i - Minute Cover Paper.pdf (1 pages)
- Item 13.9i - Infection Control Committee Minutes (confirmed) 20230908.pdf (4 pages)
- Item 13.9ii - Minute Cover Paper.pdf (1 pages)
- Item 13.9ii - Infection Control Committee Minutes (unconfirmed) 20231004.pdf (5 pages)

13.10. Medical Devices Group held on 13 September 2023 (unconfirmed)

Enclosed

- Item 13.10 - Minute Cover Paper.pdf (1 pages)
- Item 13.10 - Medical Devices Group Minutes (unconfirmed) 20230913.pdf (6 pages)

13.11. Research, Innovation & Knowledge Oversight Group held on 3 October 2023 (unconfirmed)

Enclosed

- Item 13.11 - Minute Cover Paper.pdf (1 pages)
- Item 13.11 - Research, Innovation & Knowledge Oversight Group Minutes (unconfirmed) 20231003.pdf (7 pages)

12:50 - 12:50
0 min

14. ESCALATION OF ISSUES TO NHS FIFE BOARD

14.1. To the Board in the IPQR Summary

Verbal *Arlene Wood*

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

Verbal *Arlene Wood*

12:50 - 12:50
0 min

15. ANY OTHER BUSINESS

12:50 - 12:50
0 min

16. DATE OF NEXT MEETING - FRIDAY 12 JANUARY 2024 FROM 10AM - 1PM VIA MS TEAMS

Fife NHS Board

Unconfirmed

MINUTE OF THE NHS FIFE CLINICAL GOVERNANCE COMMITTEE MEETING HELD ON FRIDAY 8 SEPTEMBER 2023 AT 10AM VIA MS TEAMS

Present:
Arlene Wood, Non-Executive Member (Chair)
Sinead Braiden, Non-Executive Member
Colin Grieve, Non-Executive Member
Anne Haston, Non-Executive Member
Janette Keenan, Director of Nursing
Carol Potter, Chief Executive

In Attendance:
Lynn Barker, Associate Director of Nursing
Nicky Connor, Director of Health & Social Care
Claire Dobson, Director of Acute Services
Susan Fraser, Associate Director of Planning & Performance
Alistair Graham, Associate Director of Digital & Information
Ben Hannan, Director of Pharmacy & Medicines
Helen Hellewell, Deputy Medical Director, Health & Social Care Partnership
Iain MacLeod, Deputy Medical Director, Acute Services Division
Gillian MacIntosh, Head of Corporate Governance & Board Secretary
Neil McCormick, Director of Property & Asset Management
John Morrice, Consultant Paediatrician
Elizabeth Muir, Clinical Effectiveness Manager
Sue Ponton, Interim Head of Service for Occupational Health Service *(item 10.6 only)*
Nicola Robertson, Associate Director of Nursing
Shirley-Anne Savage, Associate Director of Quality & Clinical Governance
Hazel Thomson, Board Committee Support Officer (Minutes)

Chair's Opening Remarks

The Chair welcomed everyone to the meeting.

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

1. Apologies for Absence

Apologies were received from members Simon Fevre (Area Partnership Forum Representative), Aileen Lawrie (Area Clinical Forum Representative), Kirstie MacDonald, (Non-Executive Whistleblowing Champion), Chris McKenna (Medical Director), Joy Tomlinson (Director of Public Health) and attendee Margo McGurk (Director of Finance & Strategy).

2. Declaration of Members' Interests

There were no declarations of interest made by members.

3. Minutes of the Previous Meeting held on 7 July 2023

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

4. Matters Arising / Action List

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

It was agreed the Optimal Clinical Outcomes Development Session be arranged for diaries as a priority.

Action: Board Committee Support Officer

4.1 Central Sterilisation Decontamination Units Update

The Director of Property & Asset Management noted that this update would be covered under agenda item 6.1.

5. ACTIVE OR EMERGING ISSUES

5.1 Health Improvement Scotland (HIS) Inspection Update

The Director of Nursing provided positive feedback on the recent Mental Welfare Commission visit, which took place on 7 September 2023 in Ward 1 at Queen Margaret Hospital. She highlighted that the Lead Inspector had commented on the extent of efforts made by staff in relation to environmental improvements within the ward. The Committee thanked all the team involved for all their hard work.

The Director of Nursing provided an overview, in advance of formal receipt of the HIS written report, on the recent safe delivery of care inspection by HIS in the Victoria Hospital between 31 July 2023 and 2 August 2023. It was noted that an action plan will be developed following receipt of the report, which is expected to be published on 19 October 2023. Following a query from the Chair, it was advised that there had been some escalation issues, which will be fully captured within the HIS report.

The Director of Property & Asset Management provided an update on the issues within Ward 5 and advised that preventative work is ongoing within the teams. It was noted that there is a quarterly reporting tool, in terms of all the proactive and reactive maintenance that has not been carried out, which is received by the Sector Estates Managers. The Director of Acute Services provided assurance and updated the Committee on the services that have been moved to other areas and she also advised that a Phase One Oversight Group has been established for the refurbishment of Ward 5. Some of the Non-Executive membership visited the ward the previous week to see directly the ward environment and to hear of the refurbishments being planned.

The Chief Executive praised and acknowledged the efforts of the Acute Leadership and ward teams in responding to the inspection, which was a very challenging and difficult time for all involved.

Whilst assured by the actions underway as to why some of the issues were not picked up as part of environmental audits / monitoring in the clinical area, the Committee

noted the information provided in relation to the inspection, with a further update to be received on receipt of the draft HIS report.

The Committee also took **assurance** that immediate remedial work has taken place and a review of issues highlighted by the inspection of Ward 5 is being taken forward.

5.2 Computerised Tomography (CT) Scanner Update and Next Steps

The Deputy Medical Director provided a verbal update and explained the recent issue affecting the operation of two CT scanners. Despite the simultaneous breakdown, the issue was rectified quickly, and a number of mitigations and actions have been put in place to prevent repeat of similar circumstances. Assurance was provided that the Radiology Department's response will complement, and be built into, the Acute Business Continuity Plan.

The Director of Acute Services provided an update on the discussions with Siemens, (the manufacturers of the CT scanners), and advised that there are a number of unresolved issues that are being worked through. Following a question from C Grieve, Non-Executive Member, around assurances being sought that the issue would not reoccur, it was advised that this is also being worked through and discussions are ongoing. An update will be provided to the Committee in due course in relation to providing more assurance in those terms.

Action: Director of Acute Services

The Radiology Team were praised for all their efforts and hard work during this period, and a thanks was extended to neighbouring NHS Health Boards for all their support and mutual aid.

The Committee took **assurance** from the update and next steps planned.

6. GOVERNANCE MATTERS

6.1 Corporate Risks Aligned to Clinical Governance Committee, including Deep Dive: Off-Site Area Sterilisation and Disinfection Unit Service

The Director of Nursing spoke to the report and advised that no risks have been closed and no new risks have been identified. It was reported that the Public Health & Wellbeing Committee recently reviewed the Covid 19 risk, and it was agreed to reduce the risk rating based on the continued effectiveness of the vaccination and reduced impact of illness within the population. It was advised that Public Health closely monitor the Covid 19 risk, in terms of new variants, and that the Corporate Risk Register would be updated accordingly, should there be a change to the risk rating. An overview was also provided on the key risk updates, as provided in the paper.

The Chair commented that it was agreed at the previous meeting to review the Quality & Safety risk score, and she noted that it is still at the same position as the last update. The Associate Director of Quality & Clinical Governance explained that this work is ongoing, and the risk will be updated for the following meeting.

Action: Associate Director of Quality & Clinical Governance

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

The Director of Property & Asset Management presented the deep dive into the offsite sterilisation and disinfection risk and advised that the issues faced relate to planned care, in terms of operations being carried out; procedures being carried out; and emergency procedures, particularly trauma and obstetrics, both of which are critical services.

The Director of Property & Asset Management described in detail the root cause of the risk, the issues faced and the mitigation actions. It was reported that discussions are underway at a national level to develop a national plan, with involvement from the Scottish Government. A brief overview was provided on the challenges of a national approach.

The Director of Acute Services commented that everything is being done to mitigate the risk as far as possible.

The Chair requested that a review is carried out on the likelihood score for the management actions.

Action: Director of Property & Asset Management

Following discussion from members around the challenges and issues faced, it was agreed to take a briefing paper to the NHS Fife Board in Private Session, to provide full oversight of the potential risks at Board level.

Action: Director of Property & Asset Management

The Committee took limited **assurance** from the deep dive, given the unresolved aspects of the risk.

6.2 Corporate Calendar – Proposed Clinical Governance Committee Dates 2024/25

The Board Secretary presented the paper, listing the proposed committee dates for the year ahead, and advised that the full Corporate Calendar will go to the Board at their September 2023 meeting for approval. Thereafter, electronic diary invites will follow to members and attendees for the next cycle of dates.

The Committee **agreed** the proposed Committee dates for 2024/25.

6.3 Delivery of Annual Workplan 2023/24

The Committee took **assurance** from the tracked workplan.

7. STRATEGY / PLANNING

7.1 Annual Delivery Plan 2023/24

The Associate Director of Planning & Performance provided assurance that the review process had now concluded with the Scottish Government, and she reported that the Annual Delivery Plan 2023/24 has been approved and the confirmation letter is included within the appendix of the paper. It was noted that the Scottish Government had asked for further detail on particular areas, and this is provided within the paper.

The Committee took **assurance** from the Annual Delivery Plan 2023/24 and **noted** the Annual Delivery Plan Review Feedback letter for 2023/24.

7.2 Scottish Healthcare Associated Infection (HCAI) Strategy 2023-25

The Director of Nursing advised that the HCAI Strategy has been developed in line with other frameworks and strategies, to support the recovery from the pandemic response and to continue to reduce healthcare-associated infection rates. An overview on the aims of year one and two of the strategy was provided, and it was advised that a subsequent five-year strategy will be developed on infection prevention & control.

The Chair queried the expectations from the Scottish Government for year two of the strategy. It was advised that a Steering Group has been formed to take forward the Infection Prevention Workforce Strategic Plan 2022-24, and that they will support the Scottish HCAI Strategy 2023-25 going forward, particularly around the education and training aspects.

Following a question from the Chair, it was advised that HCAI surveillance is moving towards being reinstated, however, no dates have yet been confirmed.

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

7.3 The Infection Prevention Workforce Strategic Plan 2022-24

The Director of Nursing spoke to the report and advised that a Local Integrated Service Delivery Plan Steering Group has been formed, which will meet for the first time in October 2023. The focus of the plan was outlined, and it was advised that progress reports will be presented to the Committee as the recommendations are taken forward.

With respect to the Terms of Reference for the Local Integrated Service Delivery Plan Steering Group, the Chair requested a glossary be added to the plan. She also requested that within the Scope section of the plan, the link to NHS Fife's Population Health & Wellbeing Strategy is made explicit. It was also suggested to add to the membership a representative from Fife Care Homes Collaborative, and to include within the accountability section oversight from the Integrated Joint Board through their Qualities & Communities Committee. The Director of Nursing thanked members for the helpful feedback and agreed to take these points forward.

Action: Director of Nursing

Following a comment from S Braiden, Non-Executive Member, around pressures on workforce and students, it was advised that careful consideration is being given to requirements and implementation of expanding the workforce within the infection control areas.

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

8. QUALITY/PERFORMANCE

8.1 Integrated Performance and Quality Report (IPQR) including Deep Dive: Pressure Ulcers

The Director of Nursing provided a summary on the performance for major and extreme adverse events, inpatient falls and pressure ulcers, SAB infections rates, C Diff infection rates, ECB infections rates and complaints, as detailed within the IPQR. The Chair praised the improvement for inpatient falls. She also requested evidence around C Diff infection rates and poor recurrent infections.

It was advised that a review of significant adverse events (SAER) is being undertaken, and a progress update will be provided to the Committee at the next meeting. The Associate Director of Quality & Clinical Governance added that a large amount of work has been carried out in relation to SAER over the previous six months, and work continues to further improve the process. It was also reported that the work around development and implementation of the adverse events policy work is underway, along with development of a management resource pack and bespoke training.

C Grieve, Non-Executive Member, questioned the timing of the SAER key deliverables. It was advised that panels were formed to look at the SAERs, which has improved the process, however, not as far as expected, and the process is being revisited with involvement from the Executive Team.

The Chair questioned the level of risk in terms of closure of SAERs, and following discussion it was agreed that consideration will be given to the actions required to improve the key deliverable risk ratings, metrics and to expanding the narrative in relation to organisational learning. It was advised that the Organisation Learning Group will also consider the points raised.

Action: Director of Nursing

Following questions from the Chair with regards to the complaints process, the Director of Nursing advised that it is recognised complaints are held up both at the waiting for clinical statements or approval stage, due to the number of steps required to complete those parts, and it was advised that work is ongoing to refine the process. It was also advised that consideration is being given to dedicating time for staff to focus on the backlog. The Chief Executive explained that a different approach is required to meet the response time of replying to complaints. The Director of Nursing praised the Complaints Team for all their hard work.

<u>Deep Dive – Pressure Ulcers</u>

The Director of Nursing outlined the contents of the paper.

The Associate Director of Nursing noted that teams continually report into Datix and are open and transparent with regards to clinical areas and the care and treatment that is provided. It was advised that large amounts of work are ongoing to reduce pressure ulcers, including regular meetings around pressure ulcer prevention.

Following a question from A Haston, Non-Executive Member, it was advised that the Tissue Viability Steering Group has an overview on the activities that are ongoing, and the data within specific areas, and that there is planned coordination in terms of quality improvement initiatives.

Following queries from members around the root factors of pressure ulcers, it was advised that positive enquiries are continuing to be made in the hospital and

community areas around preventative methods, and that the data being provided informs quality improvement programmes of work.

The Committee took **assurance** and **examined** and **considered** the NHS Fife performance as summarised in the IPQR.

8.2 Healthcare Associated Infection Report (HAIRT)

The Director of Nursing provided an update on the Medical E-Governance (MEG) system, which is a system to audit infection and control, and she noted that discussions are ongoing, including with other Health Boards, to examine the effectiveness of the system.

The Director of Nursing highlighted the main points from the HAIRT report, and the report produced by Dr Keith Morris on E. Coli Bacteraemia, which is included as an appendix.

A Haston, Non-Executive Member, questioned how the learning from the Complex Care Reviews in relation to the seven instances of dialysis line-related SABs would be fed back to the frontline, and was advised that this would take place through the leadership teams, and include the sharing of any actions.

Following a question from A Haston, Non-Executive Member, it was advised that there is no date to restart Surgical Site Surveillance, and no concerns were noted.

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

8.3 Deteriorating Patient Improvement Project Update

The Director of Nursing spoke to the paper and advised it provides an update on work carried out to date on the care and management of deteriorating patients, including a draft project brief from Dr Gavin Simpson. It was reported that the Scottish Safety Programme is running a national improvement collaborative focussed on supporting improvements in the management of deteriorating patients. It was also reported that the Scottish Intercollegiate Guidelines Network has produced new guidelines in the management of acute clinical deterioration.

Following a query from A Haston, Non-Executive Member, clarity was provided that the project brief refers to deteriorating patients in general, and not exclusively to those with cardiac issues.

C Grieve, Non-Executive Member, highlighted the resource required for the project and sought assurance that this work would be resourced appropriately given the patient safety improvements piece of work, and was advised that there is a project lead who will support the focus and the work around deteriorating patients. C Grieve also highlighted the resource required for the project and was advised that there is a project lead who will support the focus and the work around deteriorating patients. It was also noted that training will be undertaken.

Assurance was provided that the planning & performance team are prioritising measuring key milestones throughout the project.

The Committee took **assurance** from the update and noted the Deteriorating Patients Project Brief.

9. DIGITAL / INFORMATION

9.1 Information Governance and Security Steering Group Update

The Associate Director of Digital & Information provided an update and advised that the Information Governance & Security Steering group is working on a new reporting mechanism, which has been modelled on the IPQR and will combine reporting from activities of the Information Commissioner's Office (ICO) Accountability Framework and the Scottish Public Sector Cyber Resilience Framework (SPSCRF), which is key to reducing risks.

It was reported that the recent ICO audit is complete, which was conducted in March 2023, and subsequent actions are being taken forward. It was noted that the audit concluded a reasonable assurance rating and further work on risk management has taken place, including introducing risk tolerance levels.

It was highlighted that the paper outlines the work on Key Performance Indicators (KPIs), implementation of subject access review improvements, ongoing assimilation of information asset registers, records management approach, and conclusion of the Network Information Security Directive (NISD) action plan.

It was advised that appendix 1 relates to the data within Datix.

The Committee **noted** the progress being made across the Information Governance & Security domains and took **assurance** from the governance, controls and measures in place.

10. ANNUAL REPORTS / OTHER REPORTS

10.1 Patient Experience & Feedback Report Q1

The Director of Nursing advised that this is the first quarterly report for 2023/24 and that additional information has been added around learning from complaints and the complaints process experience.

It was reported that initial discussions have taken place around making updates to the improvement plan. A more robust plan will be brought back to the next Committee meeting.

Action: Director of Nursing

The Chair agreed to provide feedback on the indicators to the Director of Nursing for consideration within the next iteration of the report.

Action: Chair

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

10.2 Care Opinion Feedback Report

The Director of Nursing advised that the report provides an update on care opinion and opportunities for learning. Background detail was provided and the key points from the report were highlighted.

C Grieve, Non-Executive Member, commented on the positively high number of patient stories and queried if the negative stories are linked to complaints. The Director of Nursing advised that the care opinion team contact the complaints team as soon as negative stories are received. Following a question from the Chair, the process for identifying when changes have been taken forward was explained.

The Committee **noted** the report and took **assurance** that feedback is sought and welcomed from patients, families and carers to influence and shape change person-centred care and services.

10.3 Allied Health Professional Assurance Frameworks

The Director of Nursing highlighted the key points from the paper and advised that the frameworks will enhance the reporting and governance of the work of the Allied Health Professions. It was noted that the frameworks are part of the annual reporting cycle to the Committee.

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

10.4 Controlled Drug Accountable Officer Annual Report

The Director of Pharmacy & Medicines explained the role and history of Controlled Drug Accountable Officers, noting the requirement to fulfil responsibilities and the importance of good governance. Assurance was provided that NHS Fife has a good reporting culture. The mechanisms, processes and parallels that could be drawn into other areas of clinical governance going forward were highlighted.

The Associate Director of Nursing praised the medicine safety minute, which has had positive feedback across the organisation.

The Director of Pharmacy & Medicines explained the schedule of drugs and gave assurance around the management of risks.

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

10.5 High Risk Pain Medicines - Patient Safety Programme, End of Year 1 Report

The Director of Pharmacy & Medicines advised that the report was also presented to the Public Health & Wellbeing Committee, as there are both clinical and population health aspects. It was advised that the report highlights the complexity and issue of the problem of high-risk pain medicine prescribing in Fife. It was reported that the main aim of the programme is to raise awareness and reduce unnecessary prescribing.

The Director of Pharmacy & Medicines advised that a further update will be brought back to the Committee in January 2024 on the Measures Framework and Benefits Framework, and the quantitative data that will be utilised for the programme.

Action: Director of Pharmacy & Medicines

Following questions from the Chair, it was advised that individual patient level harm would be raised through adverse events procedures. It was also advised that high risk pain medicines and controlled drugs are all reported via Datix. The Director of Pharmacy & Medicines provide a detailed update on the reporting of all medicines, noting that learnings are shared as a priority.

The Committee took **assurance** from the delivery of year one of the High Risk Pain Medicines Patient Safety Programme, and plans outlined for year two.

10.6 Occupational Health Annual Report 2022/23

The Chair welcomed S Ponton, Interim Head of Service, to the meeting.

The Interim Head of Service advised that the Occupational Health Service has re-established itself following the pandemic. An overview on activity levels was provided. It was reported that Covid fatigue has been added as an additional service, and the mental health service has been expanded. A large surge in DNA rates was highlighted, and it was advised that work is ongoing to identify the root causes. It was also reported that there has been positive work, with more proactive activity, which is being supported with additional resource.

Following questions from A Haston, Non-Executive Member, the process for following up DNA rates was explained. It was also advised that a pool of counsellors support the increase in mental health support required, and it was noted that this area is still challenging in terms of waiting times.

The Committee **noted** the report for information.

11. LINKED COMMITTEE MINUTES

The Committee **noted** the linked committee minutes:

11.1 Area Clinical Forum held on 3 August 2023 (unconfirmed)

11.2 Area Medical Committee held on 27 June 2023 (confirmed)

11.3 Clinical Governance Oversight Group held on 20 June 2023 (unconfirmed)

11.4 Digital & Information Board held on 19 July 2023 (unconfirmed)

11.5 Fife Area Drugs & Therapeutic Committee held on 21 June 2023 (confirmed)

11.6 Fife IJB Quality & Communities Committee held on 3 May 2023 (confirmed)

11.7 Information Governance & Security Steering Group held on 13 July 2023 (unconfirmed)

11.8 Medical Devices Group held on 14 June 2023 (unconfirmed)

11.9 Research, Innovation & Knowledge Oversight Group held on 21 June 2023 (unconfirmed)

11.10 Resilience Forum held on 8 June 2023 (unconfirmed)

12. ESCALATION OF ISSUES TO NHS FIFE BOARD

12.1 To the Board in the IPQR Summary

There were no performance related issues to escalate to the Board.

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

Apart from the agreement to provide the Private session of the Board with a brief on the Central Sterilisation Decontamination Unit, there were no other matters for escalation to NHS Fife Board, and it was advised that the Chair will provide a brief at the NHS Fife Board meeting on the pertinent points from the meeting.

13. ANY OTHER BUSINESS

There was no other business.

14. DATE OF NEXT MEETING

The next meeting will take place on **Friday 3 November 2023** from 10am – 1pm via MS Teams.

KEY:	Deadline passed / urgent
	In progress / on hold / deadline not reached
	Closed

CLINICAL GOVERNANCE COMMITTEE – ACTION LIST

Meeting Date: Friday 8 November 2023

NO.	DATE OF MEETING	AGENDA ITEM / TOPIC	ACTION	LEAD	TIMESCALE	COMMENTS / PROGRESS	RAG
1.	08/09/23	**Deep Dive: Off-Site Area Sterilisation and Disinfection Unit Service**	A review to be carried out on the likelihood score for the management actions.	**NM**	November 2023	A verbal update will be provided at the meeting.	In progress
2.	07/07/23	**Development Session**	A Development Session to be arranged on Excellence in Care.	**JK/HT**	TBC		In progress
3.	08/09/23	**IPQR**	Consideration to be given to the actions required to improve the key deliverable risk ratings, metrics and to expanding the narrative in relation to organisational learning, with regards to SAERs.	**JK**	January 2024	Under consideration.	In progress
4.	08/09/23	**Patient Experience & Feedback Report Q1**	To bring back to the next Committee meeting, a more robust improvement plan.	**JK**	January 2024	A more robust improvement plan has been developed and further work is underway with PMO.	In progress
5.	08/09/23	**High Risk Pain Medicines - Patient Safety Programme**	To bring a further update back to the Committee in January 2024 on the Measures Framework and Benefits Framework, and the quantitative data that will be utilised for the programme.	**BH**	January 2024		Deadline not reached
6.	08/09/23	**Computerised Tomography (CT) Scanner**	Further assurance to be provided to the Committee that the CT Scanner issue would not reoccur, following the work that is currently ongoing and discussions that are taking place with Siemens.	**CD**	November 2023	On agenda.	Closed

NO.	DATE OF MEETING	AGENDA ITEM / TOPIC	ACTION	LEAD	TIMESCALE	COMMENTS / PROGRESS	RAG
7.	07/07/23	**Digital and Information Strategy 2019-24 Update**	To bring back to the next meeting, the one-page document in relation to the High-Level Delivery Plan within the appendix.	**AG**	November 2023	On agenda.	Closed
8.	05/05/23	**Development Session**	A Development Session to be arranged on Optimal Clinical Outcomes.	**CM/HT**	Priority	Held on 23 October 2023 at 3.30pm via MS Teams.	Closed
9.	08/09/23	**Off-Site Area Sterilisation and Disinfection Unit Service**	A briefing paper to be presented to the NHS Fife Board in Private Session, to provide full oversight of the potential risks at Board level.	**NM**	November 2023		Closed
10.	08/09/23	**Corporate Risks Aligned to Clinical Governance Committee – Quality & Safety**	To update the Quality & Safety risk for the November 2023 meeting, following the work that is ongoing to review this risk.	**SAS**	November 2023	Included in the corporate risk paper.	Closed
11.	08/09/23	**The Infection Prevention Workforce Strategic Plan 2022-24**	To take forward the feedback provided, on the plan, as described in the minutes.	**JK**	November 2023	Additions made to the Terms of Reference, as recommended.	Closed
12.	08/09/23	**Patient Experience & Feedback Report Q1**	To provide feedback on the indicators to the Director of Nursing for consideration within the next iteration of the report.	**AW**	November 2023	Completed	Closed

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**3 November 2023**
Title:	**Computerised Tomography Scanner Update**
Responsible Executive:	**Claire Dobson, Director of Acute Services**
Report Author:	**Jane Anderson, Radiology Manager**

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Update report

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

- Safe

2 Report summary

2.1 Situation

The purpose of this paper is to provide an update following the failure of two CT scanners at Victoria Hospital Kirkcaldy (VHK) leaving Fife with no access to CT imaging from Saturday 15th July 2023 at 16.30 hours to Tuesday 18th July 2023 at 12.30hrs.

A follow up meeting was held between NHS Fife and Siemens on 5th October 2023. In attendance were representatives from Siemens, NHS Fife Executive Directors Group, NHS Fife Senior Leadership team and NHS Fife Radiology team.

2.2 Background

Following failure of 2 CT scanners in NHS Fife, Siemens provided an improvement action plan in August 2023, to mitigate risk of a repeat incident. The follow up meeting was organised by NHS Fife to review the progress of the action plan and discuss next steps.

2.3 Assessment

This report is a follow up to the SBAR submitted to EDG in August 2023 and a discussion held at the last Clinical Governance Committee it outlines the progress made by Siemens to mitigate risk of repeat incident.

Action Plan and update

Communication

1. Communication issues were identified, in particular periods of radio silence when NHS Fife were not updated frequently enough by Siemens to ensure timely sharing of information with internal and external colleagues.

    a. Siemens have advised that there is an internal review ongoing and they will report improvement changes in communication to NHS Fife by end of 2023.

2. Delays within Siemens Customer Care Centre to escalate and prioritise the NHS Fife CT failure.

    a. Siemens have acknowledged that an acute hospital with no access to CT imaging should take priority over all other downtime/failure reports. An updated and improved escalation process has been shared with the NHS Fife Radiology Team along with primary contacts. This will enable NHS Fife to circumvent the call centre if the situation is deemed critical.

Fault Diagnosis and RCA

1. Siemens raised the possibility that the fault could have been linked to a power supply issue within NHS fife
    a. This was reviewed and no links to NHS Fife environment, power supply or air circulation have been found.

2. There was a delay in diagnosis of the fault, due failure of the CT technical support engineer to recognise the log entry linked to the brake resistor. A communication update has been shared with all CT technical support engineers.

3. This was an unusual fault, 390 systems worldwide with 6 recorded brake resistor faults (2 in NHS Fife). Issues with brake resistors being are monitored across the fleet of SOMATOM X.cites in UK (18) by Siemens Escalation Manager. No further issues have been identified to date with brake resistors across UK

Availability of suitably experienced engineer

1. Delays were caused due to the lack of suitability trained engineers; there are five CT engineers in Scotland but only 1 trained on this model of scanner.

    a. Siemens have confirmed a training plan is established for CT-trained engineers to have full X.cite training:
        i. Two engineers December 2023
        ii. One engineer on pre-requisite training early December 2023. X.cite training will be booked as soon as possible after training completed.

    b. Additional CT/MRI Head for Scotland post has been approved by Siemans and recruitment is in progress.

c. A national training review and potential structure is change taking place within Siemens to ensure that engineer training matches the installed base and to ensure that Siemens have right level of expertise in right area

Availability of replacement parts

1. Delays were caused due to logistics and the process required to arrange the shipment of spare parts from Germany.

    a. There is now a plan in place to hold spare parts in UK stock increase ongoing
        i. Phase 1 (MR) – in progress.
        ii. Phase 2 will be CT – intention for early 2024.

    b. Once in place, the cut-off time for part ordering parts will be extended with the potential for same-day delivery, due to distribution from Coventry (dependent on time fault logged and part being held in UK).

    c. Two brake resistor spare parts have been left on site at VHK as a precautionary measure.

2.3.1 Quality / Patient Care

- Currently both VHK scanners remain operational with continued remote dial in from Siemens to monitor the systems and identify risk early.
- No current quality or patient care issues.

2.3.2 Workforce

- The CT Workforce and Radiology Leads group have been informed of the new escalation procedure

2.3.3 Financial

- Siemens acknowledged NHS Fife's intent to recover the costs associated with the failure.

2.3.4 Risk Assessment / Management

The two CT scanners at VHK are 12 months old (CT Phase 2) and 16 months old (CT Phase 3), both units have had a level of downtime which is unacceptable for the age of the equipment.

The risk of repeat of double failure is deemed low and the improvement plan presented by Siemens will enable a more timely fix with reduced downtime. Siemens continue to monitor the systems remotely and Radiology will now have access to 'teamplay fleet' an on-line service portal which allows us to track all logged calls and track progress.

2.3.5 Equality and Diversity, including health inequalities and Anchor Institution ambitions

During this incident and down time, patients with a conditional pacemaker or patients who were ventilated could not be offered MRI as an alternative imaging technique due to the lack of dedicated MRI safe equipment. If successful in recovering costs associated with the downtime, consideration could be given to the purchase of this specialist equipment to ensure equity of access.

2.3.6 Climate Emergency & Sustainability Impact

No current issues

2.3.7 Communication, involvement, engagement and consultation

- Radiology had a review meeting with Siemens on 10th August 2023 and a further meeting on with EDG members present on the 5th October 2023.

2.3.8 Route to the Meeting

- EDG 2nd November 2023

2.4 Recommendation

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

3 List of appendices

None

Report Contact
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Radiology manager
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NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**3 November 2023**
Title:	**Letter to Cabinet Secretary re. Countess of Chester Hospital Inquiry**
Responsible Executive:	**Carol Potter, Chief Executive**
Report Author:	**Gillian MacIntosh, Head of Corporate Governance & Board Secretary**

1 Purpose

This is presented for:

- Assurance

This report relates to a:

- Emerging issue
- Government policy / directive

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

After the horrific events brought to light by the recent Lucy Letby criminal trial in England, in late August the Cabinet Secretary wrote to NHS Board Chairs and Chief Executives, seeking assurances from individual health boards that their existing processes and systems for the early identification, reporting and robust timely investigation of patient and staff safety concerns within NHS Scotland are fully effective. This paper provides the formal NHS Fife response and details next steps.

2.2 Background

Lucy Letby is a former neonatal nurse who murdered seven infants and attempted to murder six others at the Countess of Chester Hospital between 2015 and 2016. A statutory public inquiry into the circumstances behind the case has recently been announced. The inquiry is expected to cover the broader context of events at the Trust, including the handling of concerns raised by some doctors in the years leading up to Letby's arrest and trial.

Governance procedures and the measures undertaken by regulators and the wider NHS will also likely be scrutinised.

2.3 Assessment

The NHS Fife response to the Cabinet Secretary details the various assurance systems currently in place within the organisation that help support patient safety and allow for the prompt reporting and escalation of any staff concerns. Further detail is included in the letter attached. As detailed therein, the review has prompted further consideration of the placement of the existing Organisational Learning Group (OLG) and how its work can gain better oversight and visibility at Executive level. A review of the OLG is currently underway, commissioned by the Chief Executive. Further triangulation of the various sources of data that combined give insight into the quality of care we provide is also necessary.

At the request of the Board Chair, the letters has formed part of an in-depth discussion with the Non-Executive Board membership at a meeting held on Monday 9 October, reviewing the robustness of assurance processes within NHS Fife.

Via separate consideration at EDG, Directors have also been encouraged to reflect on the issues raised in the letters and discuss ways of taking forward this work, to further enhance our internal processes around quality of care and the safety of our patients.

2.3.1 Quality / Patient Care

This is central to the core issue at hand, as the NHS Fife response to the Cabinet Secretary details at length.

2.3.2 Workforce

No direct impact.

2.3.3 Financial

No direct impact.

2.3.4 Risk Assessment / Management

Triangulation of all strands of governance for quality assurance purposes is likely to have a positive impact on our overall risk environment. The Board currently has a number of related risks, including Optimal Clinical Outcomes and Quality & Safety, which are both regularly reviewed by the Committee. Improving the overall assurance systems of the Board are likely to have a positive impact on these extant risks.

2.3.5 Equality and Diversity, including health inequalities and Anchor Ambitions

There are no specific Equality and Diversity issues arising from undertaking this work.

2.3.6 Climate Emergency & Sustainability Impact

No direct impact.

2.3.7 Communication / Route to the Meeting

Informal input into the response letter was sought from the Chief Executive, Medical Director, Director of Nursing, Director of Pharmacy & Medicines, Director of Workforce and the Chair of the Board.

EDG considered the draft letter at its meeting on 21 September. Non-Executives were issued the response and have discussed the topic of assurance processes at their meeting held on 9 October.

2.4 Recommendation

This paper is presented for:

- **Assurance** – for members' information.

3 List of appendices

The following appendices are included with this report:

- Appendix No 1 – Letter from Cabinet Secretary to Board Chairs and Chief Executives, 26 August 2023
- Appendix No 2 – NHS Fife response to the Cabinet Secretary, 13 September 2023

Report Contact
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NHS Board Chairs
NHS Board Chief Executives

26th of August 2023

PATIENT SAFETY IN THE WAKE OF THE LUCY LETBY VERDICT

Dear Colleagues,

I raised the awful case of Lucy Letby at my meeting with NHS Board Chairs on 21 August. My thoughts are with the parents and families of her victims.

In light of this horrific case, I believe there is a need to reassure ourselves that the existing processes and systems for the early identification, reporting and robust timely investigation of patient safety concerns within NHS Scotland are fully effective. I am therefore asking that you provide that reassurance in several ways, considering multiple sources of information, including data on patient outcomes, alongside concerns that may already have been raised through your whistleblowing procedures or escalation from the point of care to senior leaders.

Well-integrated corporate and clinical governance is a fundamental element of a well-functioning healthcare system. Much work has been done on good governance within NHS Scotland and I believe there is a merited level of confidence in its quality: but, in the interests of guarding against complacency and identifying any further improvements - no matter how small - I would like you to review your clinical and staff governance committees, to gauge their level of effectiveness.

Healthcare Improvement Scotland is updating the *Learning from adverse events through reporting and review* framework. It is essential that executive and clinical leaders are engaged with this work and, as part of your review, I would appreciate your confirmation that this is the case.

All Boards will now have sight of the results of the iMatter questions relating to raising concerns, both at Board and Directorate level. I expect these results to be used to identify areas for improvement within your Boards, and to aid meaningful discussions with staff and managers. We need to be certain that staff benefit from psychologically safe environments, where they feel empowered to raise issues and concerns that they see in the workplace, driving better and safer outcomes for patients and for staff.

We should all be proud of the good work that has taken place over the last few years on improving workplace culture and increased protection for whistleblowers, in light of the valuable improvements they can enable. The Scottish Government takes speaking up and whistleblowing in our NHS very seriously and has, over several years, put in place a number of policies to support, promote and

encourage staff to use whistleblowing arrangements to raise concerns, including about patient safety, so that Boards can address these at the earliest possible stage.

The Scottish Government will publish the Improving Wellbeing and Workplace Cultures Framework and Action plan in late 2023, which builds on the actions set out in the 2022 National Workforce Strategy. I welcome the joint working with Boards to develop a clear framework of values, behaviours and competencies for our most senior leaders, to ensure that those who lead our organisations demonstrate and support the creation of positive working cultures. As Board Chairs, you are responsible for holding the Board Chief Executives to account for the culture of your organisations. I would be grateful for your assurance, supported by evidence, that you are discharging this responsibility.

I suggest that you reply to me with your initial responses before our next Chairs' meeting on XX , when we will discuss your findings and consider whether any further work is needed.

For the future, it is possible that the forthcoming inquiry may reveal lessons or make recommendations that are relevant to our work here in Scotland. The Scottish Government is engaging with the Department of Health and Social Care to understand the scope of the inquiry in response to the Letby verdict. My officials will monitor the inquiry carefully, and liaise with you throughout.

Of course, the Letby case is a dreadful aberration, and I ask that you, alongside your executive teams, consider what support you can offer staff, particularly in those areas that may feel most vulnerable following the outcome of the trial. I have asked my officials to follow up on this staff engagement through the usual channels.

We should never be complacent. We all have a responsibility to make sure we can give assurance to patients, families, staff and the people of Scotland that we treat matters of patient care with the utmost gravity. I look forward to working with you to make sure we have full confidence in giving that assurance.

MICHAEL MATHESON

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NHS Fife, Hayfield House, Hayfield Road, Fife, KY2 5AH
01592 643355 | www.nhsfife.org

Date: 13 September 2023
Our ref: AM/CP/GMac/0913 CabSecNRHSC
Enquiries to: Valerie Muir
Direct line: 01592 648080 | Email: Valerie.muir@nhs.scot

Michael Matheson MSP
Cabinet Secretary for NHS Recovery and Health & Social Care
Scottish Government
(via email: CabSecNRHSC@ov.scot)

Dear Cabinet Secretary

We write in reference to your letter of 26 August, to Board Chairs and Chief Executives, seeking assurances from each Health Board on the governance systems in place to support patient safety in light of the horrific circumstances brought to light by the recent Lucy Letby trial.

In our respective capacities as Acting Chair and Chief Executive for NHS Fife, we are pleased to be able to provide detail on the current effectiveness of our clinical, staff and corporate governance arrangements, which combined give the appropriate level of assurance around issues of patient safety and adequacy of staff reporting of any identified concerns, with regular scrutiny and oversight via the overarching governance structures of the Board. We are not complacent. There is always the opportunity to strengthen our processes and improve our data gathering, to triangulate related information around the patient and staff experience to enhance the visibility of any areas that should prompt concern and action.

Existing processes and systems for the early identification, reporting and robust timely investigation of patient safety concerns within NHS Fife are currently in place. In March 2023, the Board approved a new Clinical Governance Strategic Framework, which is fundamental to our aims of delivering safe, effective, patient-centred care, as befits an organisation which listens, learns and improves on a continuous basis. The publication of this framework has also been supported by a comprehensive rewrite of the Board's internal Adverse Events Policy. Within the new Clinical Governance Strategic Framework, we have a clearly defined set of quality performance indicators (QPIs) that allow us to monitor, evaluate and seek to continually improve quality and safety over time. QPIs, combined with the data output from frequent reporting on adverse events, patient complaints, legal claims, feedback from external inspections, Whistleblowing-related activities, workforce and patient/service user/public feedback, are all regularly monitored and reviewed (both via management and Board committee routes) to identify any safety or quality concerns.

A Fife-wide Organisational Learning Group is already in place within the Board; further work to enhance the distribution of learning from incidents, based on a bottom-up approach, is presently being undertaken by the Executive Team, to ensure we maximise safety across our integrated healthcare system.

In particular reference to data on patient outcomes and clinical effectiveness, such as the collation of data via clinical audits, application of Duty of Candour legislation, Health & Safety reporting etc., this is also supported by a dedicated risk within our refreshed Corporate Risk Register. The Board's Clinical Governance Committee has as recently as May 2023 undertaken a 'deep dive' of our dedicated risk on optimal clinical outcomes, with a commitment to hold a further Committee Development Session on this topic next month. In July 2023, the Committee undertook a 'deep dive' on the Quality & Safety corporate risk, noting progress with actions aimed at mitigating this particular risk. Further work will be undertaken on how data related to this topic can best be triangulated from the various sources of information and reporting available across the organisation.

In relation to the effectiveness of our Board-level governance structures (in particular our Clinical Governance Committee, Public Health & Wellbeing Committee (which has responsibility for some aspects of clinical governance related matters) and Staff Governance Committee), each Board Committee is provided with a strong, objective membership from our Non-Executive appointees and undertakes a robust self-assessment exercise each year-end, with improvement actions identified to be progressed within the current reporting year. A comprehensive annual assurance report for each Committee is agreed with members, openly published and is also carefully scrutinised by the full Board and our Internal and External Audit colleagues as part of their annual governance-related review processes. Benchmarking and active reflection by the Board against the requirements of the second edition of the NHS Scotland *Blueprint for Good Governance* will be undertaken by members in the near future and the Board and Executive Team look forward to contributing to the development of a refreshed Board-level action plan to undertake further ongoing enhancement of our local governance processes and structures.

With regard to providing confirmation that Executive and Clinical Leaders in NHS Fife are engaged in the update of the Healthcare Improvement Scotland (HIS) *Learning from Adverse Events through Reporting and Review* Framework, since its original issue in 2013 NHS Fife has been involved in ongoing developments and is a participant in the standardised notification system to HIS. The Board currently employs dedicated staff situated within our Risk Management team to support the recording and assessment of adverse events, and, as reported previously, our local policy and guidance has been updated in this calendar year.

At the time of writing, the Board is currently analysing this year's staff responses to the annual iMatter survey, with reporting on this to the Board's September cycle of governance committees that is currently underway. Via team action planning, staff are encouraged to identify areas for ongoing improvement and to undertake meaningful discussions with managers to address any concerns identified in the exercise. For the second consecutive year, NHS Fife and Fife H&SCP staff engagement in the survey has exceeded the national NHS Scotland average outcome by a figure of some 7%.

Reviewing the survey's findings, 80% of staff confirmed they were confident to raise any concerns they may have and 75% of staff were confident their concerns would be followed up. We will, of course, strive to improve these figures, but note meantime these are encouraging statistics. The action planning period remains open at the time of writing, for staff in the H&SCP, and we are anticipating that the number of completed actions plans from teams will meet or exceed last year's figure.

As part of developing the Board's new Population Health & Wellbeing Strategy, we have established a clear framework of values and behaviours for our most senior leaders, which ensures that those in a leadership role within NHS Fife demonstrate and support the creation of positive working cultures. This is also embedded in our annual Corporate Objectives for the Executive Team. The role of the Chief Executive is understandably central to this, being accountable overall for the culture of the organisation. Since the onset of the Covid pandemic, with the financial support of Fife Health Charity, we have invested heavily in staff wellbeing and support, including the creation of standalone staff wellbeing hubs at each of our main hospital sites. The Board held a dedicated discussion at its April 2022 Development Session on developing an open and transparent culture. This has recently been followed up by a second Board Development Session on behaviours and values in April 2023, which has helped set the scene for this year's initiatives on promoting a positive culture.

The Board has implemented the National Whistleblowing Standards launched in April 2021. Since their introduction, the Board has received regular reports on the embedding of the new Standards and, as part of performance reporting, quarterly data on cases within the Board that fall within the scope of the Standards. The Board's Whistleblowing Champion, Kirstie Macdonald, is an *ex officio* member of the Staff Governance Committee and is also a member of the Clinical Governance Committee. The Whistleblowing Champion is predominantly an assurance role, providing critical oversight and ensuring managers are responding to whistleblowing concerns appropriately (in services delivered directly by NHS Fife and indirectly by the H&SCP and contractors), in accordance with the national Standards. The Whistleblowing Champion is also expected to raise any issues of concern with the Board as appropriate, either in relation to the implementation of the Standards, patterns in reporting of concerns or in relation to specific cases. The Whistleblowing Champion also has a direct route to the Chair of the Board, to discuss any issues or concerns she may have.

Further work is underway by the Board on the format of quarterly Whistleblowing reports, in particular to improve the timeliness of data reporting and to evidence an open and learning culture. Capturing staff feedback on the Whistleblowing process, substantiating learning being extracted from each case, and providing assurance of the organisation's culture and values overall remains a work-in-progress within the formal reporting mechanism. Enhancements have been recommended for both quarterly reporting and the Annual Report for 2022/23. Additional data on staff take-up of Whistleblowing training (which has been designated as 'core' training for all staff and managers), to gain assurance of widespread understanding and visibility of the practical process, has been strengthened in ongoing reporting to the Staff Governance Committee and the Board. A third online training module for managers responsible for recording and reporting Whistleblowing concerns has been introduced this year, details on the uptake of which are contained in the regular quarterly reports to the Staff Governance Committee.

It has been agreed to capture the number of 'anonymous' concerns raised within the Board, though these do not strictly fall within the definition of Whistleblowing under the Standards. Additionally, acknowledgement of instances where staff concerns have been raised externally (for instance, anonymously with the local media) have also been included, to improve the overall picture of staff concerns and evidence the reporting culture. Consideration has additionally been given to including staff stories in future reporting, to provide a more nuanced reflection of the awareness of the Standards across the organisation. Two Whistleblowing concerns were raised during 2021-22, with two anonymous concerns (recorded for management purposes) submitted also during the year. In 2022-23, one Whistleblowing concern was raised, with three anonymous and unnamed concerns submitted and three press articles responded to. In the current year, there was also one referral to the INWO, which, although not upheld, has prompted a learning-focused review of this case internally.

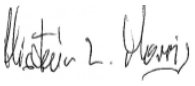
It is recognised that the formal Whistleblowing reporting process sits alongside a number of established ways for staff to raise concerns, such as the reporting of Adverse Events and risk-based events via Datix cases, employment-related routes of raising issues, and direct contact with staff-side colleagues, who are often a route of escalation to senior management and the Board. We welcomed the recent nationally led 'Speak Up' week for staff, including the widespread promotion of the 'Know Who To Talk To' campaign, noting this reflects NHS Fife as an organisation that is open, wants to learn from concerns or issues and, importantly, values the opportunity to address them.

As you mention, it is also vital that staff feel empowered to raise issues and concerns that they see in the workplace, particularly in vulnerable areas, driving better and safer outcomes for patients and for staff. The Board has recently appointed both a Staff Health & Wellbeing Champion and a Spiritual Care Champion to provide visible leadership in these areas and to support management-led initiatives to improve the offering to staff. As we have emerged from Covid restrictions in place on our hospital sites, Non-Executive Board members have resumed their regular programme of site visits to the full range of our hospital estate, both clinical facing and non-clinical, giving an opportunity for the Board to meet directly with staff and assess their workplace environment. This complements the regular walkarounds by the Chief Executive, Employee Director and senior staff, to enhance leadership visibility and approachability.

I hope this letter provides you with an appropriate summary of the multitude of initiatives underway in Fife to ensure our healthcare systems are as high quality and safe for patients and our workforce, as befits the Board's and Executive Team's strategic ambitions. It should also give comfort that we have already identified key areas of risk and have been proactive in managing these. We will continue to improve and build on our existing successes, particularly around triangulating the various sources of data related to patient safety specifically, and all strands of governance more generally, to gain better insight into overall performance and our own assurance that no areas are being overlooked.

We look forward to discussing with other Board colleagues at our respective Chairs' and Chief Executive meetings the ways in which we can all learn important lessons from the Letby case, to ensure these tragic events can never be repeated.

Yours sincerely



Alistair Morris
Acting Chair

Carol Potter
Chief Executive

Chief Medical Officer for Scotland

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The Scottish Government
Riaghaltas na h-Alba

Dear Colleague

REPORT OF THE TRANSVAGINAL MESH CASE RECORD REVIEW

Key points:

- The final report of the Transvaginal Mesh Case Record Review has been published. The Review found historic failings in respect of the consent processes that preceded some patients' treatments, and also inadequate or misleading recording of those consent processes and subsequent treatments.
- Health Board Mesh Accountable Officers have discussed the findings of the Review.
- **Medical Directors should seek assurance that measures are in place locally that prevent a recurrence of the failings identified in the report.**
- The measures set out in CMO (2018) 10 and CMO (2018) 12, concerning treatment of stress urinary incontinence (SUI) and pelvic organ prolapse (POP) continue to apply.
- Patients must be listened to, have their concerns taken seriously and have them acted upon appropriately.

Actions:

- Distribute this letter to relevant individuals.

From the Chief Medical Officer for Scotland
Professor Sir Gregor Smith

10 October 2023

SGHD/CMO(2023)18

Addresses

For action
NHS Scotland Health Board Medical Directors
Board Nominated Leads for Mesh

Further Enquiries to:

Medical Devices and Legislation Unit
First Floor Rear
St Andrew's House
EDINBURGH EH1 3DG

Dear colleague,

On 20 June the final report of the Transvaginal Mesh Case Record Review was published.

Professor Alison Britton and a panel of clinicians reviewed the patient records of a number of women who had concerns that their clinical records did not accurately reflect the treatment they had received while seeking mesh removal after experiencing complications. The Review found that patients also had concerns around flawed or inadequate consent processes at the time mesh was implanted.

The report focused on themes such as the importance of consent discussions and processes; the information given to patients to allow informed consent; and the importance of accurate recording of discussions with the patient, information given to the patient, decisions on treatment, and, where relevant, the recording of the procedure subsequently undertaken.

The report concluded in particular that, in many instances in relation to the records considered, there was a lack of clarity regarding the necessity of surgery, the outcome of 'conservative' treatments or, where relevant, an explanation of the risks and benefits of potentially undergoing mesh surgery. In a number of cases the Review Panel observed a lack of clarity in the case records documenting the nature and potential outcome of mesh revision surgery. Most alarmingly, the Review Panel concluded that some notes "did not bear any reflection to the surgery that had occurred, nor its outcomes".

I would strongly encourage any clinician involved in the mesh treatment pathway to read Professor Britton's report.

Health Board Mesh Accountable Officers have discussed Professor Britton's findings and have reported to Scottish Government officials that there are measures in place within the Complex Mesh Surgical Service (CMSS) in Glasgow and, more widely, in Health Boards, to prevent a recurrence of the failings identified in the Review. I am grateful to have received those assurances.

I would ask that **Medical Directors now take steps to satisfy themselves and their clinical governance committee chairs that measures in place are indeed sufficiently comprehensive and rigorous**, such that GMC guidance on decision making and consent and the principles of Realistic Medicine are conformed to in all cases.

I would also stress that all measures set out in CMO (2018) 10 and CMO (2018) 12 continue to apply. Nominated Accountable Officers in each Health Board remain responsible for ensuring that all requirements are adhered to, without exception.

I would lastly want to draw your attention again to the letter issued by my predecessor in February 2018 that stressed the importance of ensuring patients' concerns are listened to, taken seriously, and acted upon appropriately.

I would be grateful if you would ensure that this letter is distributed to appropriate clinicians and other relevant individuals within your Health Board area.

Yours sincerely

Gregor Smith

Professor Sir Gregor Smith
Chief Medical Officer

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**3 November 2023**
Title:	**Corporate Risks Aligned to the Clinical Governance Committee**
Responsible Executive:	**Dr Chris McKenna, Medical Director, NHS Fife**
Report Author:	**Pauline Cumming, Risk Manager, NHS Fife**

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Annual Delivery Plan
- Local policy
- NHS Board / IJB Strategy or Direction / Plan for Fife

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This paper provides an update on the risks aligned to this Committee since the last report on 8 September 2023, along with a Deep Dive review of Corporate Risk 18 - Digital and Information.

The Committee is invited to:

- note details of the corporate risks as at 27 October 2023 set out at Appendix No. 1;
- consider the Deep Dive Review - Digital & Information provided at Appendix No. 2;
- review all information provided against the Assurance Principles at Appendix No. 3; and the Risk Matrix at Appendix No. 4;
- consider and be assured of the mitigating actions to improve the risk levels;
- conclude and comment on the assurance derived from the report

2.2 Background

The Corporate Risk Register aligns to the 4 strategic priorities. The format is intended to prompt scrutiny and discussion around the level of assurance provided on the risks and their management, including the effectiveness of mitigations in terms of:

- relevance
- proportionality
- reliability
- sufficiency

The risks aligned to this Committee are summarised in Table 1 below and set out at Appendix No 1.

Table 1

Strategic Priority	Overview of Risk Level				Risk Movement	Corporate Risks
To improve health and wellbeing	1	1	-	-	◀▶	• 3 - COVID 19 Pandemic • 5 - Optimal Clinical Outcomes
To improve the quality of health and care services	1	-	-	-	◀▶	• 9 - Quality and Safety
To deliver value and sustainability	2	1	-	-	◀▶	• 16- Off Site Area Sterilisation and Disinfection Unit Service • 17- Cyber Resilience • 18 - Digital and Information

2.3 Assessment

Since the last report to the Committee on 8 September 2023:

- Six risks continue to be aligned to the CGC.
- The risk level breakdown is unchanged - 4 High and 2 Moderate.
- No risks have been closed.
- No new risks have been identified.

The updated Strategic Risk Profile is provided in Table 2 below.

Strategic Risk Profile

Table 2

Strategic Priority	Total Risks	Current Strategic Risk Profile				Risk Movement	Risk Appetite
To improve health and wellbeing	5	2	3	-	-	◄►	High
To improve the quality of health and care services	5	5	-	-	-	◄►	Moderate
To improve staff experience and wellbeing	2	2	-	-	-	◄►	Moderate
To deliver value and sustainability	6	4	2	-	-	◄►	Moderate
Total	**18**	**13**	**5**	**0**	**0**		

Summary Statement on Risk Profile

The current assessment indicates that delivery against 3 of the 4 strategic priorities continues to face a risk profile in excess of risk appetite.

Mitigations are in place to support management of risk over time with some risks requiring daily assessment.

Assessment of corporate risk performance and improvement trajectory remains in place.

Updates

Risk 3 - COVID 19 Pandemic

As previously reported, this risk's rating has reduced from Moderate 12 to Moderate 9, due to the continued effectiveness of vaccination and the reduced impact of illness in the population.

National surveillance continues and there was investigation of one new variant in September 2023 which has been assessed as posing a low risk.

Consideration continues to be given to the potential to close as a corporate risk, and monitor via the Public Health Risk Register. Discussions have taken place at EDG, and with the Director of Public Health and at the Public Health Assurance Committee (PHAC), where the risk is regularly reviewed. The PHAC will review the risk at its meeting in December 2023. Based on that assessment, a recommendation will be taken through EDG and the appropriate governance routes, to retain or close as a corporate risk. An update on the risk will be provided to this Committee on 12 January 2024.

Work continues on the previously reported risk scoping exercise on the longer term risk around preparedness for future biological threats, including pandemics.

Risk 4 - Optimal Clinical Outcomes

This risk was the focus of a Clinical Governance Committee Development Session on 23 October 2023. It was agreed that an update on the deep dive review based on discussions at the session will be presented to the Committee in January 2024.

Risk 9 - Quality and Safety

Following the deep dive review presented to the Committee in July 2023, members requested that the risk and its scores be reviewed, in particular, the risk likelihood which was scored very high, despite the governance arrangements in place, and the number of completed mitigating actions.

A review of the risk scores has been carried out which indicates the potential to reduce the current and target risk ratings and levels to Moderate. Additionally, this would bring the risk within the Moderate risk appetite set for this Strategic Priority.

Members are advised that this exercise has been undertaken during a period in which the Board is considering its response to events at the Countess of Chester Hospital. This includes the NHS Fife Board Chief Executive, commissioning a review of our governance arrangements, including systems for organisational learning.

It is anticipated this review will allow an objective opinion to be formed on the adequacy and effectiveness of our systems and processes, provide evidence of positive assurance, and where indicated, recommend improvement actions.

The Medical Director therefore recommends that the extant risk scores are retained pending the outcome of the review.

Risk 16 - Off-Site Area Sterilisation and Disinfection Unit Service

Following presentation of a deep dive on this risk to the Committee on 8 September 2023, as directed, the Director of Property & Asset Management (DoPAM) took a briefing paper to the NHS Fife Board in Private Session on 26 September 2023 to provide oversight of the potential risks at Board level.

The review of the risk likelihood score for the management actions previously requested by the Committee, is being taken forward by the DoPAM, and will be considered at the NHS Fife Decontamination Group at its meeting on 10 November 2023.

Risk 17- Cyber Resilience

Members will note that the risk update states, that following the conclusion of the Network Information System Directive (NISD) and Cyber Resilience Framework Audit, the compliance rate has increased to 87%, up from 76% from the previous year. The Associate Director of Digital & Information has asked the leads to review the risks linked to the corporate risk. The outcome of this review will indicate if the corporate risk rating needs to be changed.

Deep Dive Reviews

Deep dives continue to form a key component of our risk assurance arrangements, with reviews commissioned by the governance committees, or via a recommendations from EDG or the Risks & Opportunities Group. Going forward, generally, though not exclusively, deep dives will be commissioned to review e.g. deteriorating or static corporate risks, risks continually above appetite and other priority areas or concerns associated with a committee's remit.

The Risks and Opportunities Group (ROG) will undertake a piece of work which will reflect on our experience and learning from deep dives carried out over the last year, and the associated processes. Recommendations on areas for development and / or improvement will be presented to the next meeting of the Committee.

The Deep Dive risk review schedule for the CGC is as follows:

Risk Title	Committee Meeting Date
Risk 18 - Digital & Information (D&I)	3 November 2023
Risk 17 - Cyber Resilience	12 January 2024
Risk 3 - COVID 19 - Pandemic	12 January 2024

Corporate Risk Reporting

The Corporate Risk Register will continue to be updated to match the Committee cycle, including through review at ROG and recommendations to the EDG.

The format and content of the Register and corporate risk reports, including deep dive reviews, will continue to evolve. Feedback from this Committee and other stakeholders will continue to be considered in order to reach consensus on priority areas for further development and / or improvement.

Members are advised that an Audit & Risk Committee Development (ARC) session with the topic 'Reviewing Progress and Effectiveness of Risk Management Arrangements and Reporting', took place on 12 October 2023. In summary, the focus included the developments undertaken in the last 12 months to improve corporate risk reporting, consideration of the ARC's responsibilities, and the role of the ROG in supporting effective risk management.

The ROG will consider outputs and possible developments from the session, and submit recommendations to EDG and the governance committees as appropriate.

Next Steps

The ROG will continue to deliver its role in considering emergent risks and opportunities arising in particular, from the Population Health and Wellbeing Strategy, the Strategic

Planning and Resource Allocation process, and the Annual Delivery Plan, in order to recommend changes or additions to the corporate risks.

2.3.1 Quality / Patient Care

Effective management of risks to quality and patient care will support delivery of our strategic priorities, to improve health and wellbeing and the quality of health and care services.

2.3.2 Workforce

Effective management of workforce risks will support delivery of our strategic priorities, to support staff health and wellbeing, and the quality of health and care services.

2.3.3 Financial

This paper does not raise, directly, financial impacts, but these do present significant elements of risk for NHS Fife to consider and manage in pursuit of our strategic priorities.

2.3.4 Risk Assessment / Management

Management of the corporate risks aligned to this Committee continues to be maintained, including through close monitoring of agenda, work- plans, and clear governance through groups including the Clinical Governance Oversight Group, the Digital and Information Board, and the Public Health Assurance Committee. These groups provide fora which allow for transparency and due diligence to take place on the risks, which in turn will add legitimacy to decision making and contribute to good corporate governance.

50 % of the risks aligned to the Committee currently remain above risk appetite, reflecting the current organisational context and continuing challenges across all areas of service delivery.

2.3.5 Equality and Diversity, including health inequalities and Anchor Institution ambitions

An Equality Impact Assessment (Stage 1) was carried out to identify if any items of significance need to be highlighted to EDG. The outcome of that assessment concluded that no further action was required.

2.3.6 Climate Emergency & Sustainability Impact

This paper does not raise, directly, issues relating to climate emergency and sustainability. These items do form elements of risk for NHS Fife to manage.

2.3.7 Communication, involvement, engagement and consultation

Report creation reflects communication with the Clinical Governance Oversight Group, and associated stakeholders.

2.3.8 Route to the Meeting

- NHS Fife Clinical Governance Oversight Group on 24 October 2023

- Dr Chris McKenna, Medical Director, on 24 October 2023
- Dr Shirley- Anne Savage, Associate Director of Quality & Clinical Governance, on 24 October 2023
- Alistair Graham, Associate Director of Digital & Information on 24 October 2023
- Neil McCormick, Director of Property & Asset Management on 24 October 2023
- Dr Joy Tomlinson, Director of Public Health on 24 October 2023

2.4 Recommendation

- **Assurance** – For Members' information. This report details the latest position in relation to the management of corporate risks linked to this Committee. The Committee is asked to take a **"reasonable"** level of assurance that, all actions, within the control of the organisation, are being taken to mitigate these risks as far as is possible to do so.

3 List of appendices

The following appendices are included with this report:

- Appendix No. 1, NHS Fife Corporate Risks Aligned to the Clinical Governance Committee as at 27 October 2023
- Appendix No. 2, Deep Dive Risk Review - Digital and Information
- Appendix No. 3, Assurance Principles
- Appendix No. 4, Risk Matrix

Report Contact
Pauline Cumming
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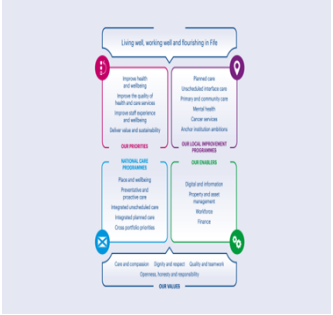
Appendix No 1

NHS Fife Corporate Risks Aligned to the Clinical Governance Committee as at 27 October 2023

To improve health and wellbeing

	Risk	Mitigation	Current Risk Level / Rating	Target Risk Level & Rating by date	Current Risk Level Trend	Appetite (High)	Risk Owner
3	**COVID 19 Pandemic** There is an ongoing risk to the health of the population, particularly the clinically vulnerable, the elderly and those living in care homes, that if we are unable to protect people through vaccination and other public health control measures to break the chain of transmission or to respond to a new variant, this will result in mild-to-moderate illness in the majority of the population, but complications requiring hospital care and severe disease ,including death in a minority of the population.	A range of indicators together provide an assessment that overall numbers of people affected by COVID19 in Scotland remain low. Treatments are available for individuals at higher risk of adverse outcomes. National surveillance continues and there was investigation of one new variant in September 2023 which has been assessed as posing a low risk. Tailored support continues to be provided to Care Homes with positive staff or resident cases. The Coronavirus (COVID 19) guidance for extended use of masks and face coverings across health and social care was withdrawn on 16th May. The risk is regularly reviewed by the Public Health Assurance Committee.	Mod 9 (3x3)	Mod 12 (4x3) by October 2023	◄►	Below	Director of Public Health

		An update on the deep dive review presented to CGC on 03/03/23 will be provided to the Public Health Assurance Committee in December 2023 and to the CGC in January 2024.					
5	**Optimal Clinical Outcomes** There is a risk that recovering from the legacy impact of the ongoing pandemic, combined with the impact of the cost-of-living crisis on citizens, will increase the level of challenge in meeting the health and care needs of the population both in the immediate and medium-term.	The Board has agreed a suite of local improvement programmes, as detailed in the diagram below to frame and plan our approach to meeting the challenges associated with this risk. The governance arrangements supporting this work will inform the level of risk associated with delivering against these key programmes and reduce the level of risk over time.  This risk was the focus of a CGC Development Session on 23 October 2023. Based on discussions at the session, an update on the deep dive review of May 2023 will be presented to the Committee in January 2024.	High 15 (5x3)	Mod 10 (5x2) by 31/03/24	◄►	Within	Medical Director

			To improve the quality of health and care services				
	Risk	**Mitigation**	**Current Risk Level / Rating**	**Target Risk Level & Rating by Date**	**Current Risk Level Trend**	**Appetite (Moderate)**	**Risk Owner**
9	**Quality & Safety** There is a risk that if our governance arrangements are ineffective, we may be unable to recognise a risk to the quality of services provided, thereby being unable to provide adequate assurance and possible impact to the quality of care delivered to the population of Fife.	Effective governance is in place and operating through the clinical Governance Oversight Group (CGOG) providing the mechanism for assurance and escalation of clinical governance (CG) issues to Clinical Governance Committee (CGC). This is further supported by the Organisational Learning Group to ensure that learning is used to optimise patient safety, outcomes and experience, and to enhance staff wellbeing and job satisfaction. There are also effective systems & processes to ensure oversight and monitoring of national & local strategy / framework / policy /audit implementation and impact. Following the deep dive review of this risk presented to the CGC in July 2023, members requested that the risk and the risk scores be reviewed. This was given that the likelihood of occurrence was scored very high, despite the governance arrangements in place, and the number of completed	High 15 (5x3)	Mod 10 (5 x 2) by 31/03/24	◀▶	Above	Medical Director

		mitigating actions. A review of the risk scores has been carried out which indicates the potential to reduce the current and target risk ratings and levels. This would bring the risk within its risk appetite. This exercise has been undertaken during a period in which the Board is considering its response to events at the Countess of Chester Hospital. This includes the NHS Fife Board Chief Executive, commissioning a review of our governance arrangements, including systems for organisational learning. The review will allow an objective opinion to be formed on the adequacy and effectiveness of our systems and processes, provide evidence of positive assurance, and where indicated, recommend improvement actions. The Medical Director therefore recommends that we retain the extant risk scores pending the outcome of the review.					
			 To deliver value and sustainability				

	Risk	Mitigation	Current Risk Level / Rating	Target Risk Level & Rating by date	Current Risk Level Trend	Appetite (Moderate)	Risk Owner
16	**Off-Site Area Sterilisation and Disinfection Unit Service** There is a risk that by continuing to use a single off-site service Area Sterilisation Disinfection Unit (ASDU), our ability to control the supply and standard of equipment required to deliver a safe and effective service will deteriorate.	Monitoring and review continues through the NHS Fife Decontamination Group. Establishment of local SSD for robotics is progressing. Health Facilities Scotland (HFS) have agreed the design and the unit at St Andrews Community Hospital (SACH) should be operational by December 2023. An option appraisal for delivery of the service is being explored. Following presentation of a Deep Dive review on 08/09/23, the risk owner is reviewing the likelihood score for the management actions as requested by the Committee. This will be considered by the NHS Fife Decontamination Group on 10/11/23. A briefing paper on the challenges and issues faced was prepared for the Private Session of NHS Fife Board, on 26/09/23 to provide full oversight of the potential risks at Board level.	Mod 12 (4x3)	Low 6 (2x3) by 01/04/2026 at next SG funding review	◄►	Within	Director of Property & Asset Management

17	**Cyber Resilience** There is a risk that NHS Fife will be overcome by a targeted and sustained cyber attack that may impact the availability and / or integrity of digital and information required to operate a full health service.	Considerable focus continues in 2023 with heightened threat level to improve our resilience to attack and ability to recover quickly. The Network Information System Directive (NISD) and now Cyber Resilience Framework Audit has concluded. The compliance rate has increased to 87%, up from 76% from the previous year. The action plan for improvement will be assured by the Information Governance and Security Steering Group.	High 16 (4x4)	Mod12 (4x3) by Sept 2024	◄►	Above	Medical Director
18	**Digital & Information (D&I)** There is a risk that the organisation maybe unable to sustain the financial investment necessary to deliver its D&I Strategy and as a result this will affect our ability to enable transformation across Health and Social Care and adversely impact on the availability of systems that support clinical services, in their treatment and management of patients.	Consistent alignment of the D&I Strategy with the NHS Fife Corporate Objectives and the Population Health & Wellbeing Strategy. Active review of the Strategy deliverables against current strategic objectives is underway as part of the refresh of the Digital Strategy for 2024. The revised strategy will include, financial and workforce planning, to support the mitigation of this risk. D&I Board Governance established and supporting prioritisation with ongoing review.	High 15 (3x5)	Mod 8 (4x2) by April 2025	◄►	Above	Medical Director

Risk Movement Key

▲ Improved - Risk Decreased
◄► No Change
▼ Deteriorated - Risk Increased

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**3 November 2023**
Title:	**Deep Dive – Digital and Information**
Responsible Executive:	**Dr Chris McKenna – Medical Director**
Report Author:	**Alistair Graham – Associate Director of Digital and Information**

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Annual Delivery Plan
- Government policy / directive
- NHS Board Strategy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

As part of the Clinical Governance Committee workplan a series of deep dives into the committee's associated corporate risks was agreed. The report provides the deep dive associated with risk 18 – Digital and Information.

The report and deep dive seeks to provide the committee with a reasonable level of assurance.

2.2 Background

The corporate risk associated with Digital and Information is described as:-

"There is a risk that the organisation maybe unable to sustain the financial investment necessary to deliver its D&I Strategy and as a result this will affect our ability to enable

transformation across Health and Social Care and adversely impact on the availability of systems that support clinical services, in their treatment and management of patients."

This risk was identified as part of a pro-active Internal Audit review identified in August 2020 (B31/20), following a review of the NHS Fife Digital Strategy (2019-2024) and has been tracked consistently through the Board Assurance Framework process and more recently the Corporate Risk Register.

At this time the Digital Strategy will require assessment, review and rewrite to match the revised Population Health and Wellbeing Strategy and align to the wider strategic landscape including Strategic Plan for Fife (2023-26), Scottish Government's Digital Health and Care Strategy, Data Strategy and Artificial Intelligence Strategy.

The deep dive and associated management actions present the activities associated with the creation of a future Digital Strategy, which is informed by the 2019-2024 strategy, the alignment to current strategic ambitions and programmes. The creation of a future strategy allows for specific consideration of the financial plan required to underpin the outcomes required by NHS Fife.

2.3 Assessment

The deep dive review is provided and presented to the Committee that a reasonable level of assurance can be provided through the progress and activities outlined in the management actions.

Deep Dive Review

Corporate Risk Title	**Digital & Information** There is a risk that the organisation maybe unable to sustain the financial investment necessary to deliver its D&I Strategy and as a result this will affect our ability to enable transformation across Health and Social Care and adversely impact on the availability of systems that support clinical services, in their treatment and management of patients.			
Strategic Priority				
Risk Appetite	**Moderate**			
Level of Risk Assurance	**Substantial Assurance** 	**Reasonable Assurance** 	**Limited Assurance** 	**No Assurance** 
Confirm Assurance Level (Add a Yes)		**Yes**		
Risk Description	There is a risk that the organisation maybe unable to sustain the financial investment necessary to deliver its D&I Strategy and as a result this will affect our ability to enable transformation across Health and Social Care and adversely impact on the availability of systems that support clinical services, in their treatment and management of patients.			
Root Cause (s)	The Digital and Information Strategy (2019-2023) sets out the digital ambitions against the backdrop of what is now a historic strategic picture i.e. NHS Fife's former strategies.			

	The demands on our clinical and corporate services have changed significantly during and following the pandemic period and the need for transformational interventions is described as an increased need. The expectations of the digital capacity to delivery changes and projects increased during the pandemic period and now remain with an increased and sustained demand. The capabilities provided during the pandemic period have not been supported with recurring funds or ongoing capital investment. Historic investment decisions in clinical system capabilities have not been accurately quantified. The capability expected from our national delivery partners has not materialised during the strategic period i.e. National Digital Platform, Digital Front Door, National Data Sharing or has been significantly delayed GP IT, CHI and Child Health. Supplier engagement has prevented the ability to maintain the pace of change and adoption required. Significant levels of compliance introduced in relation to Information Commissioners Office Accountability Framework, Scottish Public Sector Cyber Resilience Framework, the supporting technical and architecture standards and the ability to comply with the Medicines and Health Regulatory Authority for Software as a Medical Device compliance. Additional national strategic drivers associated with Digital Health and Care Strategy, Data Strategy, Artificial Intelligence Strategy and the Innovation sector. The funding ratio to Digital and Information falls below recommended investment levels for		
Current Risk Rating ([LxC] & Level (e.g. High Moderate, Low)	**Likelihood -** **3 - Possible**	**Consequence -** **5 - Extreme**	**Level** **High - 15**
Target Risk Rating([LxC] & Level (e.g. High, Moderate, Low)	**Likelihood -** **2 - Unlikely**	**Consequence -** **4 - Major**	**Level** **Moderate - 8** **Target Date: April 2025**

Management Actions

Action	Status	Impact on Likelihood/ Consequence
Baseline analysis of the current Digital Strategy (2019-2024) and its outputs. This assessment has been considered by Digital and Information Board and will be presented to Clinical Governance Committee (November 2023). This will inform the future strategy. Complete	Completed	**No impact**
Realignment of current Digital Strategy (2019-2024) with the new NHS Fife Population Health and Wellbeing Strategy and supporting strategic programmes. The realignment will be considered by the Digital and Information Board and the Senior Responsible Officers (SRO) of the strategic programmes. Target completion – January 2024	On track	**No impact**

Action	Status	Impact on Likelihood/ Consequence
Assessment of existing capabilities and active projects in their support to achieving the strategic ambitions – including re-prioritisation and stopping, where identified, unnecessary change programmes. This assessment will seek to, where possible rationalise the number and complexity of projects and bring additional focus to the implementation of existing digital capability. Target completion – January 2024	Not started	**Reduced Likelihood**
Assessment of new capabilities required to be implemented to achieve the strategic ambitions and present the case for investment. Examples of this may include an increasing benefit to be derived from automation for many of our staffing groups and the extension of the capability in the digital front door allowing our patients and their carers to contribute to their active Health Record and promote alignment to value based healthcare. Target completion – March 2024	Significant level of delivery challenge	**Reduced Likelihood**
Realignment of the current Digital Strategy (2019-2024) with the wider strategic landscape including Strategic Plan for Fife (2023-26), Scottish Government's Digital Health and Care Strategy, Data Strategy and Artificial Intelligence Strategy. Continued influence and expectation that national strategies will provide effective additional digital capability in an affordable manner at a local and regional level. Target completion – March 2024	On track	**Reduced Likelihood**
Decommissioning and convergence programme to be outlined to support savings identification and maximising the use of existing systems and capability. Target completion – March 2024	On track	**Reduced Likelihood**
Revised strategy to be produced, supported with an associated finance and workforce plan, and made available to governance groups. Target completion – July 2024	Not started	**Achievement of Target**

Action Status Key
Completed
On track
Significant level of delivery challenge
At risk of non-delivery
Not started

2.3.1 Quality, Patient and Value-Based Health & Care

The design of this approach aims to align to the ambitions laid out in several key strategies and plans at a local, regional, and national level. The requests for support which have

followed the pandemic focus mainly on the use of technology to support improvements in quality and patient care, and to this end it is apparent the requirement is to provide a robust review and determination of the elements of a future digital strategy. The work associated with the ability for patients, their families, and carers to contribute to their health record is a fundamental requirement to support the necessary conversations at the heart of Value-Base Health Care.

2.3.2 Workforce

As we prepare for a revised Digital Strategy, we also consider the work necessary to ensure our wider workforce can feel supported in their digital adoption. We will work closely with colleagues in Partnership and Workforce to ensure this support is well designed and considered of the support and changes as we progress.

A revised workforce plan has been developed by the Digital and Information SLT with implementation now underway. This will be directly considered as part of the digital strategy refresh and outlined in the mitigating actions.

2.3.3 Financial

The scale of the ambition in the Strategy and the financial impact associated continues to be a risk that is managed. Digital and Information continue to work closely with Finance and Clinical colleagues to establish the prioritisation of business cases and deliverable to ensure maximum return on investment is achieved. Several Cost Improvement Plans have been provided in support of the financial sustainability challenge. The scale of demand for digital solutions does not match the available funding or resourcing and so ranking is a key requirement for all initiatives.

Additional risk is also associated with the medium-term cost to digital capability that was introduced as a direct response to the COVID-19 pandemic in additional to the continual requirement for a capital replacement programme.

2.3.4 Risk Assessment / Management

The Risk Management approach continues to be maintained via the Corporate Risk Register, with additional risk reporting and presentation being provided to the Information Governance and Security Steering Group and Digital and Information Board.

A formal risk appetite and tolerance statement has been agreed by the Steering Group and Board allowing a refreshed reporting of Risk controls and mitigations.

2.3.5 Equality and Diversity, including health inequalities and Anchor Institution ambitions

An Equality Impact Assessment will be conducted as part of the strategy refresh work and will be presented in the future.

2.3.6 Climate Emergency & Sustainability Impact

Consideration of the Scottish Public Sector Green ICT Strategy forms part of the revised strategic thinking.

2.3.7 Communication, involvement, engagement and consultation

- The Digital and Information Strategy and associated risks continue to be a focus at all relevant Groups.
- The engagement approach is outlined in the mitigation actions section of the deep dive and forms part of the work plan for the Digital & Information Board.
- The engagement model has been further developed to include Acute and HSCP SLTs

2.3.8 Route to the Meeting

This paper has been considered by the following groups as part of its development.

Executive Directors' Group – 2 November 2023

2.4 Recommendation

This paper is provided to members for:

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

3 List of appendices

The following appendices are included with this report:

No appendix

Report Contact
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Risk Assurance Principles:

Board

- Ensuring efficient, effective and accountable governance

Standing Committees of the Board

- Detailed scrutiny
- Providing assurance to Board
- Escalating key issues to the Board

Committee Agenda

- Agenda Items should relate to risk (where relevant)

Seek Assurance of Effectiveness of Risk Mitigation

- Relevance
- Proportionality
- Reliable
- Sufficient

Chairs Assurance Report

- Consider issues for disclosure
- Emergent risks or → Escalation / Recording
- Scrutiny or risk delegated to Committee

Year End Report

- Highlight change in movement of risks aligned to the Committee, including areas where there is no change
- Conclude on assurance of mitigation of risks
- Consider relevant reports for the workplan in the year ahead related to risks and concerns

Assurance Principles

General Questions:

- Does the risk description fully explain the nature and impact of the risk?
- Do the current controls match the stated risk?
- How weak or strong are the controls? Ae they both well-designed and effective i.e., implemented properly?
- Will further actions bring the risk down to the planned/target level?
- Does the assurance you receive tell you how controls are performing?
- Are we investing in areas of high risk instead of those that are already well-controlled?
- Do Committee papers identify risk clearly and explicitly link the strategic priorities and objectives/corporate risk?

Specific Questions when analysing a risk delegated to the committee in detail:

- History of the risk (when was it opened) – has it moved towards target at any point?
- Is there a valid reason given for the current score?
- Is the target score:
  - In line with the organisation's defined risk appetite?
  - Realistic/achievable or does the risk require to be tolerated at a higher level?
  - Sensible/worthwhile?
- Is there an appropriate split between:
  - Controls – processes already in place which take the score down from its initial/inherent position to where it is now?
  - Actions – planned initiatives which should take it from its current to target?
  - Assurances – which monitor the application of controls/actions?
- Assessing Controls
  - Are the controls "Key" i.e., are they what actually reduces the risk to its current level (not an extensive list of processes which happen but don't actually have any substantive impact)?
  - Overall, do the controls look as if they are applying the level of risk mitigation stated?
  - Is their adequacy assessed by the risk owner? If so, is it reasonable based on the evidence provided?
- Assessing Actions – as controls but accepting that there is necessarily more uncertainty
  - Are they on track to be delivered?
  - Are the actions achievable or does the necessary investment outweigh the benefit of reducing the risk?
  - Are they likely to be sufficient to bring the risk down to the target score?
- Assess Assurances:
  - Do they actually relate to the listed controls and actions (surprisingly often they don't)?
  - Do they provide relevant, reliable and sufficient evidence either individually or in composite?
  - Do the assurance sources listed actually provide a conclusion on whether:
    - the control is working
    - action is being implemented
    - the risk is being mitigated effectively overall (e.g. performance reports look at the overall objective which is separate from assurances over individual controls) and is on course to achieve the target level
  - What level of assurance can be given or can be concluded and how does this compare to the required level of defence (commensurate with the nature or scale of the risk):
    - 1st line – management/performance/data trends?
    - 2nd line – oversight / compliance / audits?
    - 3rd line – internal audit and/or external audit reports/external assessments?

Level of Assurance:

Substantial Assurance	Reasonable Assurance	Limited Assurance	No Assurance
			

Document developed from diagram produced by NHS Lanarkshire based on principles compiled by the Assurance Mapping Group of members of Boards covered by the FTF Internal Audit Service, 2022

Risk Assessment Matrix

Figure 1

Likelihood	Consequence				
	Negligible 1	**Minor 2**	**Moderate 3**	**Major 4**	**Extreme 5**
Almost certain 5	LR 5	MR 10	HR 15	HR 20	HR 25
Likely 4	LR 4	MR 8	MR 12	HR 16	HR 20
Possible 3	VLR 3	LR 6	MR 9	MR 12	HR 15
Unlikely 2	VLR 2	LR 4	LR 6	MR 8	MR 10
Remote 1	VLR 1	VLR 2	VLR 3	LR 4	LR 5

In terms of grading risks, the following grades have been assigned within the matrix.

- Very Low Risk (VLR)
- Low Risk (LR)
- Moderate Risk (MR)
- High Risk (HR)

Likelihood of Recurrence Ratings

Figure 2

Descriptor	Remote	Unlikely	Possible	Likely	Almost Certain
Likelihood	Can't believe this event would happen – will only happen in exceptional circumstances (5-10 years)	Not expected to happen, but definite potential exists – unlikely to occur (2-5 years)	May occur occasionally, has happened before on occasions – reasonable chance of occurring (annually)	Strong possibility that this could occur – likely to occur (quarterly)	This is expected to occur frequently / in most circumstances – more likely to occur than not (daily / weekly / monthly)

Figure 3: Consequence Ratings

Descriptor	Negligible	Minor	Moderate	Major	Extreme
Objectives / Project	Barely noticeable reduction in scope / quality / schedule	Minor reduction in scope / quality / schedule	Reduction in scope or quality, project objectives or schedule	Significant project over-run	Inability to meet project objectives, reputation of the organisation seriously damaged.
Injury (Physical and psychological) to patient / visitor / staff.	Adverse event leading to minor injury not requiring first aid	Minor injury or illness, first aid treatment required	Agency reportable, e.g. Police (violent and aggressive acts).Significant injury requiring medical treatment and/or counselling.	Major injuries/long term incapacity or disability (loss of limb) requiring medical treatment and/or counselling.	Incident leading to death or major permanent incapacity.
Patient Experience	Reduced quality of patient experience / clinical outcome not directly related to delivery of clinical care	Unsatisfactory patient experience / clinical outcome **directly related to care provision – readily resolvable**	Unsatisfactory patient experience / clinical outcome, short term effects – expect recovery <1wk	Unsatisfactory patient experience / clinical outcome, long term effects – expect recovery - >1wk	Unsatisfactory patient experience / clinical outcome, continued ongoing long term effects
Complaints / Claims	Locally resolved verbal complaint	Justified written complaint peripheral to clinical care	Below excess claim. Justified complaint involving lack of appropriate care	Claim above excess level. Multiple justified complaints	Multiple claims or single major claim
Service / Business Interruption	Interruption in a service which does not impact on the delivery of patient care or the ability to continue to provide service	Short term disruption to service with minor impact on patient care	Some disruption in service with unacceptable impact on patient care Temporary loss of ability to provide service	Sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked.	Permanent loss of core service or facility Disruption to facility leading to significant “knock on” effect
Staffing and Competence	Short term low staffing level temporarily reduces service quality (less than 1 day). Short term low staffing level (>1 day), where there is no disruption to patient care	Ongoing low staffing level reduces service quality **Minor error** due to ineffective training / implementation of training	Late delivery of key objective / service due to lack of staff. **Moderate error** due to ineffective training / implementation of training Ongoing problems with staffing levels	Uncertain delivery of key objective / service due to lack of staff. **Major error** due to ineffective training / implementation of training	Non-delivery of key objective / service due to lack of staff. Loss of key staff. **Critical** error due to ineffective training / implementation of training
Financial (including damage / loss / fraud)	Negligible organisational / personal financial loss (£<1k)	Minor organisational / personal financial loss (£1-10k)	Significant organisational / personal financial loss (£10-100k)	Major organisational / personal financial loss (£100k-1m)	Severe organisational / personal financial loss (£>1m)
Inspection / Audit	Small number of recommendations which focus on minor quality improvement issues	Recommendations made which can be addressed by low level of management action.	Challenging recommendations that can be addressed with appropriate action plan.	Enforcement action. Low rating Critical report.	Prosecution. Zero rating Severely critical report.
Adverse Publicity / Reputation	Rumours, no media coverage Little effect on staff morale	Local media coverage – short term. Some public embarrassment. Minor effect on staff morale / public attitudes.	Local media – long-term adverse publicity. Significant effect on staff morale and public perception of the organisation	National media / adverse publicity, less than 3 days. Public confidence in the organisation undermined Use of services affected	NationalInternational media / adverse publicity, more than 3 days.MSP / MP concern (Questions in Parliament). Court Enforcement Public Enquiry

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**3 November 2023**
Title:	**Clinical Governance Oversight Group Assurance Summary from August 2023 Meeting**
Responsible Executive:	**Dr Chris McKenna, Medical Director**
Report Author:	**Dr Shirley-Anne Savage, Associate Director for Quality and Clinical Governance**

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Annual Delivery Plan
- Local policy
- NHS Board / IJB Strategy or Direction / Plan for Fife

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This paper and the associated appendix provide an overview of the Clinical Governance Oversight Group (CGOG) Meeting on the 22nd August for added assurance.

2.2 Background

There was an Internal Audit Recommendation to add a summary of the CGOG meeting to compliment the minutes and provide additional assurance to the Clinical Governance Committee.

2.3 Assessment

After further discussion it was agreed that a summary of the CGOG meeting would provide a clear update from the CGOG meeting and along with a note of the minutes would provide the CGC with additional assurance.

2.3.1 Quality / Patient Care

Quality and patient care

2.3.2 Workforce

N/A.

2.3.3 Financial

N/A

2.3.4 Risk Assessment / Management

N/A

2.3.5 Equality and Diversity, including health inequalities and Anchor Institution ambitions

N/A

2.3.6 Climate Emergency & Sustainability Impact

N/A

2.3.7 Communication, involvement, engagement and consultation

Internal Audit Recommendation discussed with Dr Christopher McKenna, Medical Director and Janette Keenan, Director of Nursing.

2.3.8 Route to the Meeting

Dr Christopher McKenna, Medical Director and Janette Keenan, Director of Nursing.
Clinical Governance Oversight Group 24 October 2023

2.4 Recommendation

- **For Assurance**

3 List of appendices

The following appendices are included with this report:

- Appendix 1**,** Assurance Summary, NHS Fife Clinical Governance Oversight Group 22nd August 2023

Report Contact
Shirley-Anne Savage
Associate Director for Quality and Clinical Governance
Email shirley-anne.savage@nhs.scot

ASSURANCE SUMMARY
NHS FIFE CLINICAL GOVERNANCE OVERSIGHT GROUP
22nd AUGUST 2023

1. Purpose

1.1 To provide the NHS Fife Clinical Governance Committee with an assurance summary from the Clinical Governance Oversight Group (CGOG) held on the 22nd August 2023. This assurance statement summarises the key aspects of business covered.

2. Governance

2.1 Deteriorating Patient

The Welsh Allyn equipment was approved through the Capital Equipment prioritisation and has arrived and now awaiting Digital & Information (D&I) to work on the interfacing.

The NEWS2 rollout will be led by D&I, supported by the Patient Resuscitation Lead and be implemented within the next 12 months.

The Q1 Deteriorating patient report was shared and in terms of the Deteriorating Patient Improvement work, a project brief was presented updating on work to date and the proposed approach. The group will seek to relaunch "Know the Score".

As part of the scoping work, the Deteriorating Patient Group is engaging with a wide range of stakeholders at an engagement workshop planned for Wednesday 23rd August. This engagement will be used to inform the approach to supporting improvement.

2.2 Alcohol and Drug Deaths Review

The high prevalence of drug and alcohol deaths continues to be a challenge across Scotland. Although the prevalence of alcohol and drug deaths in Fife is below the national average, the demand for alcohol and drug death reviews by Addiction Services continues to be high. This, compounded with resource challenges and Covid restrictions, resulted in a situation where timeliness of reviews and 'closing the loop' process became a concern.

The group were sked to acknowledge the work which has progressed thus far – particularly the significant progress in addressing the backlog (up to April 2022) of cluster reviews and LAERs and in the inputting of all learning's into the Datix reporting platform against each incident web identifier.

The group were also asked to acknowledge the positive integrated joint work that is underway between Fife Addictions Services, Public Health and Alcohol and Drug Partnership.

For assurance, it was recommended by Addiction Services that the work continues to progress with a further paper to be presented to the CGOG and (Quality Matters assurance Group) QMAG in December 2023 to report on progress.

The following were noted by the group:

- Alcohol & Drug Death Cluster Review in Service Standard Operating Procedure
- SBAR Alcohol & Drug Death Reviews - March 2022
- Alcohol & Drug Death reviews - Addiction Services - Quality Matters Assurance Group (QMAG) November 2022
- HSCP Cluster Review Sign Off & Clinical Care Governance Team (CCGT) Sign Off
- Deaths in Service Themed Action Plan

2.3 NHS Fife Health & Social Care Partnership Clinical Governance Assurance Update

This is a standing agenda item presented for assurance. Items highlighted from the report were adverse events, falls, pressure ulcers, medication incidents, mental health ward incidents, rate of restraint within mental health inpatient wards and rate of physical violence.

The Mental Health Quality Improvement (MHQI) team are supporting a range of quality improvement activities across HSCP mental health inpatient wards, including Simple Pleasures; PRN Reports; Older Adult Community Mental Health Team Quality Standards; Scottish Patient Safety Collaborative

2.4 NHS Fife Health & Social Care Partnership Clinical Governance Inspection Update SBAR

The Mental Welfare Commission (MWC) has continued their programme of inspection visits across mental health and learning disability services. An updated was provided regarding the visits to a number of inpatient areas and identified recurring themes over the last 12 months.

This report was presented for information and assurance regarding work in progress to improve service delivery and patient experience.

The ward areas visited since the last update are:

- Mayfield, Lynebank Hospital, Dunfermline (20/04/23)
- Daleview, Lynebank Hospital, Dunfermline (25/05/23)
- Muirview, Stratheden Hospital, Cupar (20/07/23)
- Elmview, Stratheden Hospital, Cupar (20/07/23)
- Hollyview, Stratheden Hospital, Cupar (27/07/23)

There was an acknowledgement that reduced staffing numbers and use of bank staff impacted on consistent person-centred care and was a recurring theme.

The team were thanked for their report and once all the work around these inspections is complete it will be escalated to Clinical Governance Committee.

The following were noted by the group:

- NHS Fife Health & Social Care Partnership, Mental Welfare Commission action plan across services
- Mental Welfare Commission for Scotland, announced visit and action plan, Mayfield Ward, Lynebank Hospital Visit 20 April 2023
- Mental Welfare Commission for Scotland, announced visit to Elmview Ward, Stratheden, 19 July 2022
- Mental Welfare Commission for Scotland, announced visit to Hollyview Ward, IPCU, Stratheden, 25 August 2022
- Mental Welfare Commission for Scotland, announced visit to Muirview Ward, Springfield, 28 June 2022 (LC)
- Mental Welfare Commission for Scotland, announced visit to Radernie, Low Secure Unit, Stratheden, 22 August 2022
- Mental Welfare Commission for Scotland, draft report, announced visit to Daleview Ward, Lynebank, 25 May 2023
- Mental Welfare Commission for Scotland, unannounced visit to Ravenscraig Ward, Whyteman's Brae Hospital, Kirkcaldy, 9 January 2023
- Mental Welfare Commission for Scotland, announced visit to Cairnie House, Stratheden Hospital, Springfield, 3 October 2022

2.5 NHS Fife Health & Social Care Partnership Missing Persons Update

A paper was presented in order to give assurance of the work that is being undertaken by the short-life working group on missing persons within the Health & Social Care Partnership (HSCP) and specifically around mental health services.

The data highlights that between July and November 2022 there was an upward trend in missing person incidents which then decreased between December and February 2023. This then rose sharply between February and March 2023. Between March and May 2023 there has been 50 incidents reported under criteria of missing patients; 6 patients have accounted for 26 of these incidents.

The reasons for the increase are unclear and may relate to variations in reporting practices and assessment of risk.

The group is scheduled to meet on 3 more occasions by the end of 2023 and a flash report will be provided through the QMAG structures updating on progress and completed actions from the group.

2.6 NHS Fife Clinical Effectiveness Register

In the last 6 months of projects registered there were 46, 38 are from the Acute Services Division and 8 are from HSCP.

2.7 NHS Fife Clinical Policy & Procedure Update

At the June meeting of the NHS Fife Clinical Policy & Procedure Co-ordination & Authorisation Group that there was one new procedure approved (NHS Fife Wide Procedure Trial without Catheter).

There are five Fife wide procedures and one acute services division procedures past their review date.

The group were given assurance that there is 94% compliance rate for all clinical policies and procedures for NHS Fife.

2.8 NHS Fife Activity Tracker

An update was given of:

- One new consultation; Health and care (Staffing) (Scotland) Act 2019 statutory guidance consultation issued 22 June 2023
- One new Publication; Healthcare Staffing Programme (HSP)
- Two new standards were issued; Congenital heart disease CHD standards published 24 July 2023 and Standards for cataract surgery published 26 July 2023

2.9 NHS Fife Corporate Risk Register

PC presented a summary of the corporate risks which align to the Clinical Governance Committee and their status. She pointed out that there has been a reduction in the rating of Corporate Risk 3 - Covid-19 Pandemic. Consideration will be given to the potential for this risk to be closed as a corporate risk due to the continued effectiveness of vaccination and the reduced impact of illness in the population. The final decision will be taken through EDG and the appropriate governance routes to retain or close as a corporate risk.

PC also brought to the attention of the group, the Deep Dive review into Corporate Risk 16 - Offsite Area Sterilisation and Disinfection Unit Service, which will be presented to the Clinical Governance Committee on 8 September 2023.

3. Adverse Events & Duty of Candour Update

3.1 NHS Fife Adverse Events KPI's

As part of continuing to improve processes there has been work with the CPR SBAR Review Team to streamline the completion and review process of Cardiac Arrest SBARs. From 1st September the process will move to fully electronic, with the SBAR completion and review taking place within the related Datix record.

15-minute bite-size training sessions were taking place twice per day, every day, w/b 21/08 and 28/08 on TEAMS and the uptake from staff so far had been good.

3.2 NHS Fife Adverse Events Themes & Trends Report

The number of reported major and extreme events has decreased from a monthly average of 40 per month in the last 12 months, to 37 per month over the last few months.

There were no themes of major / extreme events identified from the themes analysis, so the opportunity was taken to focus further on the 589 open actions (443 of which are overdue for completion within the timeframe) and the top action types which are:

- Training & Education
- Documentation
- Care & Treatment
- Communication & Feedback

- Policies & Procedures

Improvement work has commenced with the first stage of raising awareness of actions and offering support from the Adverse Event and Risk Management Team through a sharing of information on Staff Link. Information was shared in May 2023. This resulted in an observed increase in the number of actions closed with 91 actions closed in May and 111 in June. This is an increase from on average 50 actions closed per month in the preceding 12 months and is reflected in an improvement in the KPI target currently set at 50% of actions closed within

4. Patient Experience

4.1 Patient Experience Flashcard

Looking at the yearly report for complaints, concerns and enquiries; there has been an increase throughout of 12.42%, with a large increase in concerns & enquiries of 51%. This shows that there is a lot of work happening within the Patient Experience department. The overall themes haven't changed over the last year:

- disagreement with treatment
- co-ordination and clinical treatment
- staff attitude
- unacceptable waiting times for appointments and admissions.

At the end of July 80% of live complaints were still awaiting statements or approvals showing there is a lot of work to be done within the services.

The complaints currently being received are generally more complex, often multi-directorate, making the process very difficult and the complexity scoring higher.

5. NHS Fife Integrated Performance & Quality Report (IPQR)

Noted by the group.

6. Linked Meeting Minutes

There were no escalations from the linked meeting minutes.

Appendix 1 – Attendance

Member	**Designation**	**22nd August 2023**
Lynn Barker	Associate Director of Nursing, Health Social Care Partnership	x
Norma Beveridge	Interim Associate Director of Nursing, Acute	✓
Dr Sue Blair	Consultant in Occupational Medicine	x
Andy Brown	Principal Auditor - Finance	x
Gemma Couser	Associate Director of Quality & Clinical Governance	x
Pauline Cumming	Risk Manager	✓
Fiona Forrest	Deputy Director of Pharmacy & Medicines	✓
Claire Fulton	Adverse Events Lead	✓
Cathy Gilvear	Quality, Clinical & Care Governance Lead, HSCP	✓
Ben Hannan	Director of Pharmacy and Medicines	x
Dr Helen Hellewell	Associate Medical Director, HSCP	x
Janette Keenan	Director of Nursing	✓
Aileen Lawrie	Associate Director of Midwifery	✓
Dr Sally McCormack	Associate Medical Director for Emergency Care & Planned Care	x
Dr Chris McKenna (Chair)	Medical Director, NHS Fife	✓
Dr Iain MacLeod	Deputy Medical Director, Acute	✓
Siobhan McIlroy	Head of Patient Experience	✓
John Morrice	Associate Medical Director for Women and Children's Services	✓
Elizabeth Muir	NHS Fife Clinical Effectiveness Manager	✓
Sally O'Brien	Head of Nursing	x
Nicola Robertson	Assistant Director of Nursing, Corporate Division	✓
Shirley-Anne Savage	Associate Director of Quality & Clinical Governance	✓
Geraldine Smith	Lead Pharmacist, Medicines Governance & Education Training	x
Prof Morwenna Wood	Associate Medical Director for Emergency and Planned Care	✓
Amanda Wong	Associate Director of Allied Health Professionals	✓
In Attendance	**Designation**	
Dr Gavin Simpson	Consultant Anaesthetics	✓
Alistair Graham	Associate Director Digital and Information	x
Lee Cowie	Clinical Services Manager, Child/Adolescent Mental Health, HSCP	✓
Dr Susanna Galea-Singer	Clinical Lead, Addiction Services, HSC	✓
Tanya Lonergan	Head of Nursing, HSCP	✓
Tom McCarthy	Portfolio Manager	✓
April Robertson	Clinical Governance Administrator (Minute Taker)	✓

CLINICAL GOVERNANCE COMMITTEE
ANNUAL WORKPLAN 2023 / 2024

Governance - General							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Minutes of Previous Meeting	**Chair**	✓	✓	✓	✓	✓	✓
Action list	**Chair**	✓	✓	✓	✓	✓	✓
Escalation of Issues to Fife NHS Board	**Chair**	✓	✓	✓	✓	✓	✓
Active or Emerging Issues							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Health Improvement Scotland (HIS) Inspection Update	**Director of Nursing**			✓			
Computerised Tomography (CT) Scanner Update and Next Steps	**Director of Acute Services**			✓			
Letter to Cabinet Secretary re. Countess of Chester Hospital Inquiry	**Medical Director**				✓		
Letter from Chief Medical Officer re. Report of the Transvaginal Mesh Case Record Review	**Medical Director**				✓		
Governance Matters							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Annual Assurance Statements from Subcommittees (D&I Board, H&S Subcommittee, IG&S Steering Group, IJB Q&C Committee, Resilience Forum, Medical Devices)	**Board Secretary**	✓					
Annual Committee Assurance Statement (inc. best value report)	**Board Secretary**	✓					
Annual Internal Audit Report	**Director of Finance & Strategy**		✓				

Governance Matters (cont.)							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Annual Statement of Assurance for Clinical Governance Oversight Group	**Medical Director / Associate Director of Quality & Clinical Governance**		✓		✓ **Summary from Aug '23 mtg**		**To be included in Ass. Statements in May 2024**
Committee Self-Assessment Report	**Board Secretary**						✓
Corporate Calendar / Committee Dates	**Board Secretary**			✓			
Corporate Risks Aligned to CGC, and Deep Dives	**Medical Director/Director of Nursing**	✓ **Optimal Clinical Outcomes**	✓ **Quality & Safety**	✓ **Off-Site Area Sterilisation and Disinfection Unit Service**	✓ **Digital & Information**	✓ **Cyber Resilience**	✓
Review of Terms of Reference	**Board Secretary**						✓ Approval
Review of Annual Workplan	**Associate Director of Quality & Clinical Governance**	✓	✓	✓	✓	✓	✓ Approval
Strategy / Planning							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Advanced Practitioners Review	**Director of Nursing**	✓					
Annual Delivery Plan Quarterly Performance Report 2023/24 *(also goes to FP&R, PH&W & SGC)*	**Director of Finance & Strategy / Associate Director of Planning & Performance**	**Deferred to July**	✓	✓	✓ **Q2**		✓ **Q3**
Cancer Strategic Framework & Delivery Plan	**Medical Director**				✓		
Clinical Governance & Strategic Framework Delivery Plan 2023/24	**Medical Director / Associate Director of Quality & Clinical Governance**	**Deferred to July**	✓		✓ **Mid-year update**		
Corporate Objectives	**Director of Finance & Strategy / Associate Director of Planning & Performance**	✓					
Data Loch	**Medical Director / Associate Director for Research, Development & Innovation**		**Deferred – date tbc**			**TBC**	

Strategy / Planning (cont.)							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Development Assistant Practitioner Role	**Director of Nursing**	✓					
Integrated Unscheduled Care	**Medical Director**	✓	**Removed from workplan – Ad hoc item the previous year**				
Quality / Performance							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Breast Screening Adverse Event Paper	**Director of Public Health**		**Removed – July PHWC only**				
Integrated Performance and Quality Report	**Medical Director / Director of Nursing**	✓	✓	✓	✓	✓	✓
Healthcare Associated Infection Report (HAIRT)	**Director of Nursing**	✓	✓	✓	✓	✓	✓
National Cervical Exclusion Audit	**Director of Public Health**		**Removed – covered at PHWC in May**				
Nursing & Midwifery Professional Assurance Framework	**Director of Nursing**	**2 yearly report – due September 2024**					
Covid Mortality Report	**Medical Director**					✓	
Digital / Information							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Digital and Information Strategy 2019-24 Update	**Medical Director / Associate Director of Digital & Information**		✓		✓		
Laboratory Information Management System Update	**Associate Director of Digital & Information**			✓ **Private Session**			
Hospital Electronic Prescribing and Medicines Administration (HEPMA) Programme	**Medical Director**			✓ **Private Session**			✓
Information Governance and Security Steering Group Update	**Associate Director of Digital & Information**			✓			✓

Person Centred Care / Participation / Engagement							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Equalities Outcome Report *(also goes to PHWC)*	**Director of Nursing**						✓
Patient Experience & Feedback	**Director of Nursing**	✓	✓	✓	✓	✓	✓
Annual Reports / Other Reports							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Adult Support & Protection Annual Report 2020-22 *(also goes to PHWC)*	**Director of Nursing**	✓					
Allied Health Professional Assurance Framework	**Director of Nursing**	**Deferred to July**	**Deferred to Sept.**	✓			
Annual Resilience Report 2022/23	**Director of Public Health**	**Partial Assurance Statement**			✓ **Mid-year Assurance Report**		✓ **Annual Report**
Clinical Advisory Panel Annual Report 2022/23	**Medical Director**		✓				
Controlled Drug Accountable Officer Annual Report	**Director of Pharmacy & Medicines**			✓			
Director of Public Health Annual Report 2023 *(also goes to PHWC)*	**Director of Public Health**		✓				
Equality Outcomes Progress Report	**Director of Nursing**					✓	
Fife Child Protection Annual Report 2022/23 *(also goes to PHWC)*	**Director of Nursing**	**Deferred to July**	✓				
Hospital Standardised Mortality Ratio (HSMR) Update Report	**Medical Director**				✓		
Integrated Screening Annual Report	**Director of Public Health**	**Will be presented to the Public Health & Wellbeing Committee only**					
Medical Education Report	**Medical Director**				**Deferred to January**	✓	
Medical Appraisal and Revalidation Annual Report	**Medical Director**				**Deferred to January**	✓	

Annual Reports / Other Reports (cont.)							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Occupational Health Annual Report 2022/23	**Director of Workforce**			✓			
Organisational Duty of Candour Annual Report	**Medical Director**						✓
Participation & Engagement Report and Quality Framework for Participation & Engagement Self-Evaluation	**Director of Nursing**				**Deferred to January**	✓	
Prevention & Control of Infection Annual Report	**Director of Nursing**				✓		
Radiation Protection Annual Report 2022/23	**Medical Director**	✓					
Research & Development Progress Report & Strategy Review	**Medical Director**					✓	
Research, Innovation and Knowledge Annual Report	**Medical Director**					✓	
Review of Deaths of Children & Young People	**Director of Nursing**						✓
Volunteering Annual Report	**Director of Nursing**				✓		
Linked Committee Minutes							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Area Clinical Forum	**Chair of Forum**	06/04 **Mtg Cancelled**	✓ 08/06	✓ 03/08	✓ 05/10	✓ 07/12	✓ 08/02
Area Medical Committee	**Medical Director**	✓ 14/02	✓ ~~11/04~~ 02/05	✓ ~~13/06~~ 27/06	✓ 08/08	✓ 10/10	✓ 12/12
Area Radiation Protection Committee	**Medical Director**	✓ 31/08			✓ 10/05	TBC	TBC
Cancer Governance & Strategy Group	**Medical Director**	✓ 30/03	✓ 31/05		✓ 17/08	✓ 02/11	

Linked Committee Minutes (cont.)							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Clinical Governance Oversight Group	**Medical Director**	✓ 14/02	✓ 18/04	✓ 20/06	✓ 22/08	✓ 24/10	✓ 12/12
Digital & Information Board	**Medical Director**	✓ 19/04		✓ 19/07		✓ 18/10	
Fife Area Drugs & Therapeutic Committee	**Medical Director**		✓ 26/04	✓ 21/06	✓ 16/08	✓ 21/10	✓ 20/12
Fife IJB Quality & Communities Committee	**Associate Medical Director**	✓ 10/03		✓ 03/05	✓ 30/06 & 07/09	✓ 02/11	
Health & Safety Subcommittee	**Chair of Subcommittee**	✓ 10/03	✓ 09/06		✓ 08/09	✓ 08/12	
Infection Control Committee	**Director of Nursing**	✓ 05/04	✓ 07/06		✓ 09/08	✓ 04/10 & 06/12	
Ionising Radiation Medical Examination Regulations Board (IRMER)	**Medical Director**					TBC	TBC
Information Governance & Security Steering Group	**Director of Finance & Strategy**	✓ 11/04		✓ 13/07		✓ 10/10	
Medical Devices Group	**Medical Director**	✓ 08/03		✓ 14/06	✓ 13/09		✓ 13/12
Research, Innovation & Knowledge Oversight Group	**Medical Director**	✓ 27/03		✓ 21/06	✓ 19/09	✓ 11/12	
Resilience Forum	**Director of Public Health**	✓ 01/03		✓ 08/06	07/10 **rescheduled to 10/10**	✓ 10/10 & 07/12	
Ad Hoc Items							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Mental Health Estates Initial Agreement	**Medical Director**	**Deferred**	**Deferred**		**Deferred to next mtg**	✓	

Ad Hoc Items (cont.)							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Medical Devices	**Director of Property & Asset Management**	✓					
Public Protection, Accountability & Assurance Framework	**Director of Nursing**	✓					
Fatal Accident Enquiry	**Medical Director**	✓	✓				
Excellence in Care Presentation	**Director of Nursing**		✓				
Infection Control Inspection by Health Improvement Scotland Report	**Director of Nursing**		✓				
Medical Devices Update	**Medical Director**			**Ad Hoc**			
Deteriorating Patient Cardiac Arrest Update	**Director of Nursing**			✓			
Incident Management Framework	**Director of Public Health**				✓		
Scottish Healthcare Associated Infection (HCAI) Strategy 2023-25	**Director of Nursing**			✓			
The Infection Prevention Workforce: Strategic Plan 2022-24	**Director of Nursing**			✓			
Care Opinion Report	**Director of Nursing**			✓			
High Risk Pain Medicines - Patient Safety Programme, End of Year 1 Report	**Director of Pharmacy & Medicines**			✓			
Medicines Safety Review and Improvement Report	**Director of Pharmacy & Medicines**				✓		
Alignment of NHS Fife Cancer Framework and the National Cancer Strategy 2023-2033 and Cancer Action Plan for Scotland 2023-2026	**Medical Director**				✓		

Development Sessions					
	Lead				
Development Session 1 • Medical Education • Addiction Services	**Medical Director**	**12/04/23**			
Development Session 2 • Research relationship between NHS Fife and the University of St Andrews.	**Medical Director**			**18/10/23**	
Development Session 3 • Optimal Clinical Outcomes				**23/10/23**	

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**3 November 2023**
Title:	**Annual Delivery Plan Quarter 2 Performance 2023/24**
Responsible Executive:	**Margo McGurk, Director of Finance**
Report Author:	**Susan Fraser, Associate Director of Planning and Performance**

1 Purpose

This is presented for:

- Discussion
- Assurance

This report relates to:

- Annual Delivery Plan 2023/24 Q2 Progress

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

- Safe
- Effective
- Person Centred

2 Report Summary

2.1 Situation

The Annual Delivery Plan (ADP) 2023/24 was submitted in draft to the Scottish Government (SG) on 8 June 2023 and resubmitted on 26 June.

Formal sign off of the ADP from Scottish Government was received on 11 August 2023.

This paper is to update the EDG on the progress against deliverables within the ADP as of September 2023. This update is to be submitted to the Scottish Government by 27 October 2023.

2.2 Background

The guidance for Annual Delivery Plan (ADP) 2023/24 and Medium-Term Plan (MTP) 2023/26 was received on 28 February 2023. This guidance was intended to support a more integrated and coherent approach to planning and delivery of health and care services, setting out prioritised high-level deliverables and intended outcomes to guide detailed local, regional and national planning, and inform improvement work.

2.3 Assessment

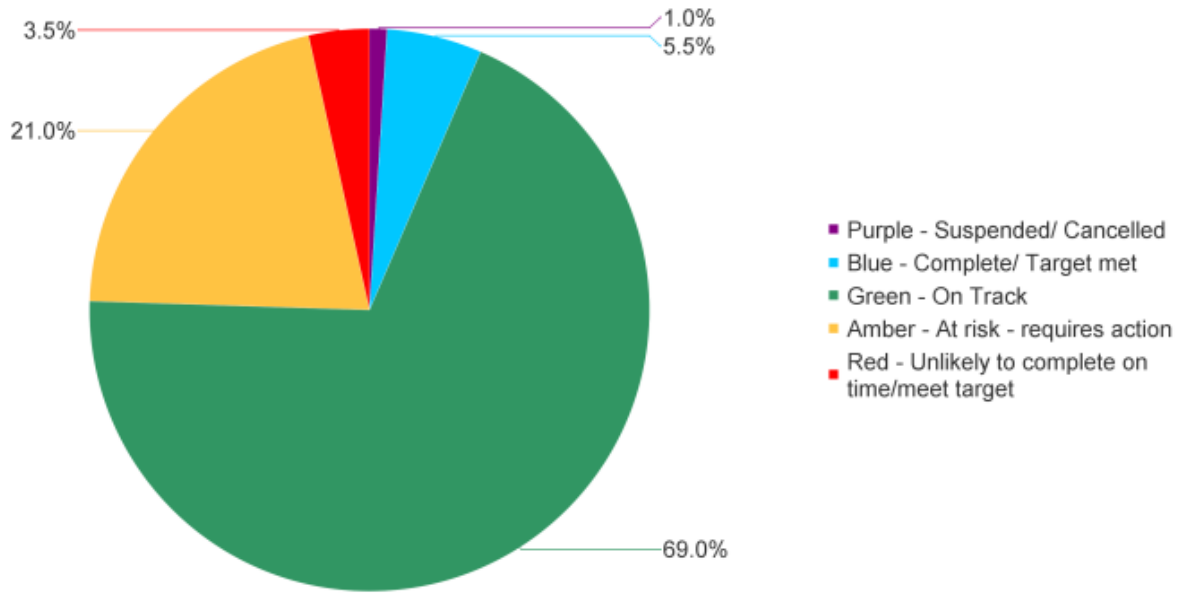
Services have been providing updates to the ADP on a monthly basis with position as of June (Q1) and September (Q2) 2023 submitted to Scottish Government on 27 October. Detailed reports for each Directorate/Division up to September (Q2) 2023 have also been circulated to Executive Directors.

The status of deliverables is based on categories below:

Purple	**Suspended/Cancelled**
Blue	**Complete/Target met**
Green	**On Track**
Amber	**At risk, requires action**
Red	**Unlikely to complete on time/meet target**

The status reported against each deliverable is the progress against actions rather than outcomes. For example, improvement actions for staff absence could be **'completed'** or **'on track'** but the intended outcome of decreasing rate of sickness absence may not be achieved. Work will commence in Q3 to quantify the impact on outcomes aligned to each deliverable.

ADP for Fife contains 200 deliverables with 69% (138) **'on track'** as of September (Q2) 2023.



Deliverables **completed (11)** by end of September (Q2) 2023:

- Implementation of Cancer Framework in NHS Fife to support delivery of Recovery and Redesign: An Action Plan for Cancer Services
- Continued roll out of RCDSs
- Embed referral, where clinically appropriate, to Maggie's rehabilitation service and use of national prehabilitation website in cancer pathways
- To secure recurring baseline funding to cover the current operating Non-Pay costs associated with NHS Fife's application support and maintenance funding
- To secure recurring baseline funding to cover the current additional Pay costs associated with operating the new capabilities and comply with increased levels of regulation and compliance
- Core Infrastructure Replacements as per Capital Plans revised and submitted to FCIG
- Ensuring a robust Primary Care Premises Strategy is in place
- Ensuring the necessary Health & Safety Resources are in place together with robust arrangements for mandatory training
- Reviewing the use of taxi contracts across the organisation
- Continue to deliver the Medical Certification of the Cause of Death (MCCD) service
- Implement IPC Interim Strategy 2023-25

Deliverables **suspended/cancelled (2)** by end of September (Q2) 2023:

- Hospital Pharmacy Redesign - introduction of automation in hospital Pharmacy stores, dispensaries and clinical areas. Centralisation of Pharmacy stores
- Kincardine and Lochgelly Health Centres

Deliverables that are **unlikely to complete on time (7)**:

- Maximise models of care and pathways to prevent presentations and support more timely discharges from ED using a targeted MDT approach
- Roll out of Digital Pathology
- Improve existing pathways and develop new pathways that ensure patients receive the right care at the right time
- Develop data metrics and KPIs that assure and promote confidence in the effectiveness of the FNC
- Improve scheduling processes within FNC increasing the use of Near Me where appropriate and further utilise the Rapid Triage Unit (RTU) as a means of scheduling patients
- Adherence to the NHS Scotland Model Complaints Handling Procedures (DH 2017) and compliance with National targets
- Committed to controlling, reducing and preventing Healthcare Associated Infections (HAI) and Antimicrobial Resistance (AMR) in order to maintain individual safety within our healthcare settings

Deliverables currently **at risk (42)** of being delivered on time and requiring action:

- Develop and scope ambulatory models of care supporting early supported discharge and admission prevention
- Develop, Enhance and re-invigorate Regional Networks
- Operationalise NTC
- Expanding Endoscopy capacity and workforce
- Implement robust ACRT processes
- Implement robust PIR processes
- Embedding potential alternatives for treatment
- Improved Fife-wide ADHD pathways for Children & Young people
- To achieve additional capacity to meet 6-week target for access to 3 key Radiology diagnostic tests
- Best Start
- To meet the recommendations of the WHP by end Dec 2024
- Delivery of New Laboratory Information system (LIMS)
- To ensure routine adherence to optimal diagnostic pathways
- Translation and implementation of agreed Business case Options for Co-badged Clinical Trials Unit/Clinical Research Facility with University of St Andrews
- National & Local Priority - Hospital Electronic Prescribing and Medicines Administration (HEPMA)
- National - eRostering
- National - LIMS Implementation
- Delivery of year one of the QI Network
- Support delivery of SPRA (Strategic Planning and Resource Allocation)
- IPQR Digitisation
- Post successful implementation of the SE Payroll Consortium arrangement
- Ensuring the most effective and appropriate use of Medical Devices
- Digital medicines management programme
- Implementation of the Pharmacotherapy Service
- Deliver a more effective BCG and TB programme
- Deliver a VAM Covid response in alignment with SG guidance
- Pandemic Preparedness: Critical to major incident levels
- Bank Governance – Enhanced Management & Staff Bank Consolidation
- Delivering Anchor Institution workforce aims - Promoting employability priorities
- Create and Nurture a Culture of Person-Centred Care
- Implement IPC Workforce Strategy 2022-24
- Fife Psychology Service will increase capacity to improve access to PTs, eliminate very long waits and meet & maintain the 18-week RTT standard
- Improve compliance with CAPTND dataset
- Increase mental health services spend to 10% of NHS frontline spend by 2026 and plans to increase the spend on the mental health of children and young people to 1%
- Developing the skills of practitioners and professionals to identify and support carers at the earliest possible point in time
- Improve sustainability of Primary Care
- Increase capacity for providing in-hours routine and urgent dental care
- Fife will eliminate Hepatitis C as a public health concern
- Implement new referral management and electronic patient records system (TrakCare/Morse) within P&PC Physiotherapy service.
- Local Enhanced Services Review
- Expand on current system wide Urgent Care Infrastructure to develop more integrated, 24/7 urgent care models
- Child and Adult weight management programmes: Develop a sustainable workforce within the resources available via regional funding award

Summary status as of September (Q2) 2023 is detailed by Recovery Driver in table below.

Q2 Status	Purple - Suspended/ Cancelled	Blue - Complete/ Target met	Green - On Track	Amber - At risk - requires action	Red - Unlikely to complete on time/ meet target	TOTAL
1. Primary and Community Care	1		19	10		**30**
2. Urgent and Unscheduled Care			9	1	4	**14**
3. Mental Health			10	3		**13**
4. Planned Care			4	6		**10**
5. Cancer Care		3	8	3	1	**15**
6. Health Inequalities			13	3		**16**
7. Innovation Adoption			4			**4**
8. Workforce			15	3		**18**
9. Digital	1	3	12	5		**21**
10. Climate			9			**9**
Other		5	35	8	2	**50**
TOTAL	**2**	**11**	**138**	**42**	**7**	**200**

Relevant deliverables have also been mapped to NHS Fife Corporate Objectives for 2023/24. Further detail on these can be found in Appendix.

2.3.1 Quality/ Patient Care

Preparation and delivery of the ADP are key to ensuring high quality patient care.

2.3.2 Workforce

Workforce planning is key to the ADP process.

2.3.3 Financial

Financial planning is key to the ADP process.

2.3.4 Risk Assessment/Management

Risk assessment is part of ADP process.

2.3.5 Equality and Diversity, including health inequalities

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

2.3.6 Other impact

N/A.

2.3.7 Communication, involvement, engagement and consultation

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

2.3.8 Route to the Meeting

The ADP Q2 update was presented at EDG on 19 October and subsequently approved for submission by the Chief Executive.

2.4 Recommendation

This report is being presented to the Clinical Governance Committee for:

- Discussion – the ADP 2023/24 Q2 update submitted to the Scottish Government
- Assurance

List of appendices

1. Annual Delivery Plan 2324 Q2 Update (QE Sep-23)

Report Contact

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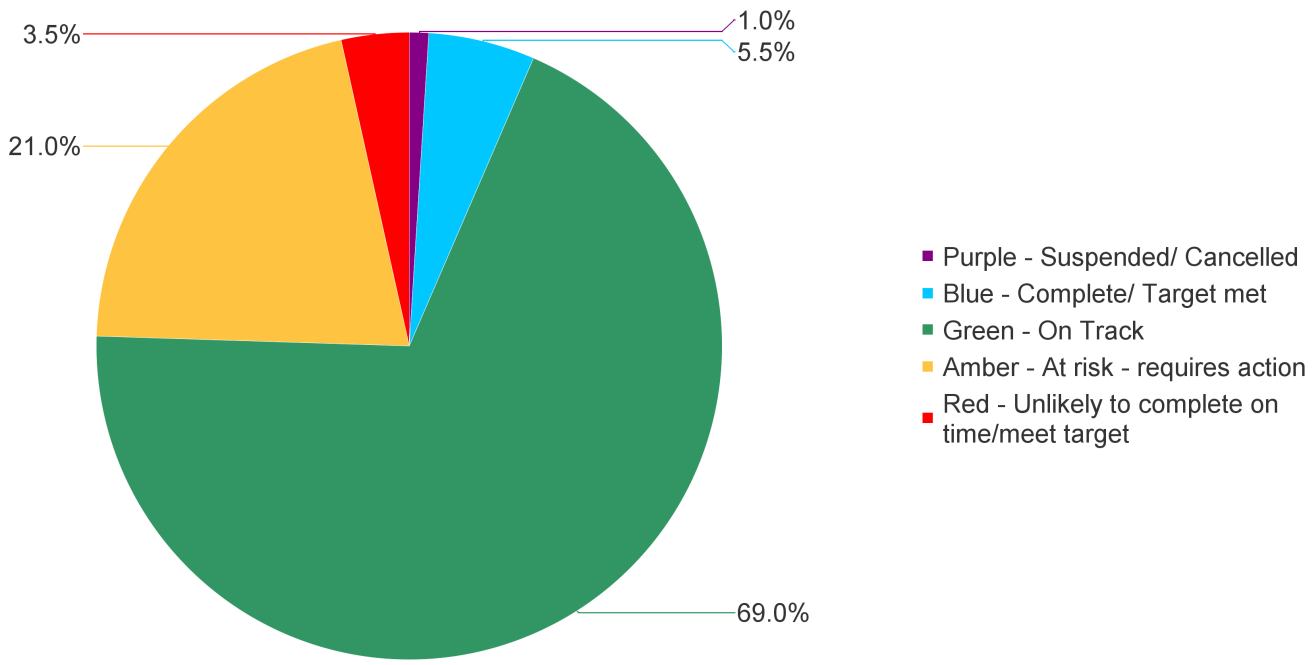
Annual Delivery Plan 2023/24 Progress - Summary

Q2 Status	Purple - Suspended/ Cancelled	Blue - Complete/ Target met	Green - On Track	Amber - At risk - requires action	Red - Unlikely to complete on time/ meet target	TOTAL
1. Primary and Community Care	1		19	10		**30**
2. Urgent and Unscheduled Care			9	1	4	**14**
3. Mental Health			10	3		**13**
4. Planned Care			4	6		**10**
5. Cancer Care		3	8	3	1	**15**
6. Health Inequalities			13	3		**16**
7. Innovation Adoption			4			**4**
8. Workforce			15	3		**18**
9. Digital	1	3	12	5		**21**
10. Climate			9			**9**
Other		5	35	8	2	**50**
TOTAL	**2**	**11**	**138**	**42**	**7**	**200**



Annual Delivery Plan 2023/24 Progress - Corporate Objectives

SP1.1 Progress BC for the mental health services

Deliverable	Dir/Div	Deliverable Q2 RAG Status
Refreshed Mental Health Strategy for Fife for 2023 - 2027	Complex & Critical Care	Green - On Track
Mental Health strategy (Medical Director)	Property & Asset Management	Green - On Track

SP1.2 Delivery of MAT standards

Deliverable	Dir/Div	Deliverable Q2 RAG Status
More ‘one stop shop’ drop-ins in the heart of communities where the prevalence/need is high and access to support and treatment is low A visible one stop shops/approach in Cowdenbeath and Kirkcaldy	Business Enabling	Green - On Track
A sustained lived/living experience panel (including family members) with coproduction approaches in place for the development of ADP strategy, policy and service development. Representation of those with alcohol and drug lived and living experience in other forums beyond alcohol and drug strategic groups and services	Business Enabling	Green - On Track
The Medication Assisted Treatment Standards fully implemented in the ADP system of care as measured by processes, numerical and experiential measures. National Treatment in Target Measure met and sustained	Business Enabling	Green - On Track
Public Health Priority 4: National Drugs Mission Priorities; MAT treatment standards; Fife NFO strategy; Fife ADP strategy	Public Health	Green - On Track

SP1.3 Develop a prevention and early intervention strategy/ delivery plan

Deliverable	Dir/Div	Deliverable Q2 RAG Status
Developing a system wide Prevention and Early intervention strategy which will underpin delivery of the HSCP strategic plan and the NHS Fife Population Health and Wellbeing Strategy	Primary & Preventative Care	Green - On Track

SP1.4 Develop a primary care strategy/ delivery plan

Deliverable	Dir/Div	Deliverable Q2 RAG Status
Develop Strategic vision across all of Primary Care	Primary & Preventative Care	Green - On Track

SP1.5 Develop and deliver system wide medicines safety prog

Deliverable	Dir/Div	Deliverable Q2 RAG Status
High-Risk Pain Medicines Programme Establish a whole system approach to address the issue of High-Risk Medicines prescribing (as an element of Drug related deaths) across Fife	Pharmacy & Medicines	Green - On Track
Contribute to NHS Fife’s High Risk Pain Medicines Patient Safety Programme to support appropriate prescribing and use of High-Risk Pain Medicines and ensuring interventions take into consideration the needs of patients who are at risk of using or diverting High Risk Pain Medicines	Public Health	Green - On Track

SP2.1 Implement redesign and quality improvement mental health services

Deliverable	Dir/Div	Deliverable Q2 RAG Status
CAMHS will build capacity in order to deliver improved services underpinned by these agreed standards and specifications for service delivery.	Complex & Critical Care	Green - On Track
Partners within Fife HSCP will continue to build capacity across services in order to achieve the standards set within the National Neurodevelopmental Specification for children and young people	Complex & Critical Care	Green - On Track
Reprovision of unscheduled care/crisis care provision for patients presenting out of hours with a mental health crisis	Complex & Critical Care	Green - On Track
Community Mental Health Teams for Adult and Older Adult services that are responsive to need and reduce admission by offering alternative pathways	Complex & Critical Care	Green - On Track
Development and Implementation of an Adult Neurodevelopmental Pathway with clear links to CYP NDD Pathway.	Complex & Critical Care	Green - On Track
Mental Health and Wellbeing in Primary Care and Community Settings - development and delivery of service provision in line with Scottish Government reports and planning guidance relating to the remobilisation and redesign of MH services in the context of the COVID-19 pandemic.	Complex & Critical Care	Green - On Track

SP2.2 Review and redesign Front Door model of care

Deliverable	Dir/Div	Deliverable Q2 RAG Status
Maximise models of care and pathways to prevent presentations and support more timely discharges from ED using a targeted MDT approach	Emergency Care	Red - Unlikely to complete on time/ meet target
Improve existing pathways and develop new pathways that ensure patients receive the right care at the right time.	Urgent & Unscheduled Care	Red - Unlikely to complete on time/ meet target
Improve scheduling processes within FNC increasing the use of Near Me where appropriate and further utilise the Rapid Triage Unit (RTU) as a means of scheduling patients.	Urgent & Unscheduled Care	Red - Unlikely to complete on time/ meet target

SP2.3 Deliver ambulatory care model supporting admission avoidance and early appropriate discharge

Deliverable	Dir/Div	Deliverable Q2 RAG Status
Develop and scope ambulatory models of care supporting early supported discharge and admission prevention	Emergency Care	Amber - At risk - requires action
Improve Same Day Emergency Care and rapid assessment pathways	Emergency Care	Green - On Track

SP2.4 Develop QMH ambulatory care and day surgery

Deliverable	Dir/Div	Deliverable Q2 RAG Status
Enhance Theatre efficiency	Planned Care	Green - On Track
Review and redesign Outpatient capacity to maximise capacity and timely access	Planned Care	Green - On Track
Maximising Scheduled Care capacity	Planned Care	Green - On Track
Expanding Endoscopy capacity and workforce	Planned Care	Amber - At risk - requires action

SP2.5 improve patient experience response process

Deliverable	Dir/Div	Deliverable Q2 RAG Status
Adherence to the NHS Scotland Model Complaints Handling Procedures (DH 2017) and compliance with National targets	Nursing Directorate	Red - Unlikely to complete on time/ meet target
Deliver Patient Experience focused work across NHS Fife, gathering patient feedback and lived experiences	Nursing Directorate	Green - On Track
Digital Solution for reporting Live Patient Experience (Complaint) data	Nursing Directorate	Green - On Track

SP3.1 Collaborate with University of St Andrews to develop the ScotCOM medical school

Deliverable	Dir/Div	Deliverable Q2 RAG Status
Development of Medical Education Strategic Framework	Quality & Care Governance	Green - On Track

SP3.2 Develop and deliver action plan to support safe staffing legislation

Deliverable	Dir/Div	Deliverable Q2 RAG Status
Implement Safe Staffing legislation; Preparation of the board to meet requirements of Health Care Staff enactment by April 2024	Nursing Directorate	Green - On Track

SP3.3 Develop and deliver a sustainability plan for the nursing and midwifery

Deliverable	Dir/Div	Deliverable Q2 RAG Status
Develop a Nursing and Midwifery Strategic Framework 2023 - 25; establishment of shared governance model Framework based on CNO and NHS Fife priorities, Recover to Rebuild, Courage of Compassion, Three Horizon Model	Nursing Directorate	Green - On Track

SP3.4 Deliver actions from workforce strategy to support patient care and staff wellbeing

Deliverable	Dir/Div	Deliverable Q2 RAG Status
Development and implementation of the NHS Fife Workforce Plan for 2022-2025	Workforce	Green - On Track
Attracting & Recruiting Staff to deliver Population Health & Wellbeing Strategy; Bank Governance – Enhanced Management & Staff Bank Consolidation	Workforce	Amber - At risk - requires action
Attracting & Recruiting Staff to deliver Population Health & Wellbeing Strategy; Recruitment Shared Services Implementation Consolidation & enhanced International Recruitment service	Workforce	Green - On Track
Delivery of Staff Health & Wellbeing Framework aims for 2023 to 2025	Workforce	Green - On Track
Further developing agile working and use of digital solutions in Directorate through investment in Workforce Analytics provision to support series of org. priorities, including Safe Staffing and eRostering Programmes	Workforce	Green - On Track
Growth of OH services and establishment of resources to assure function sustainability meets the changing needs of the organisation and supports the delivery of care goals through a variety of services including mental health / wellbeing / fatigue management support.	Workforce	Green - On Track
Development of improved digital processes i.e. online pre-employment and management referrals programmes	Workforce	Green - On Track
Delivery of the eRostering Implementation Programme in conjunction with Digital & Information.	Workforce	Green - On Track

SP3.5 Develop and deliver leadership framework to increase team performance

Deliverable	Dir/Div	Deliverable Q2 RAG Status
Create and Nurture a Culture of Person Centred Care	Workforce	Amber - At risk - requires action

SP4.1 Deliver year one actions of the financial improvement and sustainability programme

Deliverable	Dir/Div	Deliverable Q2 RAG Status
Review Opportunities to contribute to the success of the SPRA process and FIS board to secure value and sustainability	Finance	Green - On Track

SP4.2 Implement actions to support climate emergency

Deliverable	Dir/Div	Deliverable Q2 RAG Status
Set out a plan to reduce medical gas emissions through implementation of national guidance	Pharmacy & Medicines	Green - On Track
Set out approach to implement the Scottish Quality Respiratory Prescribing guide across primary care and respiratory specialities to improve patient outcomes and reduce emissions from inhaler propellant	Pharmacy & Medicines	Green - On Track
Decarbonisation of Fleet in line with Targets	Property & Asset Management	Green - On Track
Achievement of Waste Targets as set out in DL(2021) 38	Property & Asset Management	Green - On Track
Reduction of Medical Gas Emissions through implementation of national guidance	Property & Asset Management	Green - On Track
Action plan for the National Green Theatres Programme	Property & Asset Management	Green - On Track
Set out approach to develop and begin implementation of a building energy transition programme to deliver energy efficiency improvements, increase on-site generation of renewable electricity and decarbonise heat sources.	Property & Asset Management	Green - On Track
Outline plans to implement an approved Environmental Management System.	Property & Asset Management	Green - On Track
Work with partners to increase efforts to reduce the impact of climate change on our population	Public Health	Green - On Track

SP4.3 Develop the digital medicines programme

Deliverable	Dir/Div	Deliverable Q2 RAG Status
National & Local Priority - Hospital Electronic Prescribing and Medicines Administration (HEPMA)	Digital & Information	Amber - At risk - requires action
Local - Medicines Automation - Multi Phases (Query if contained in Pharmacy SPRA?)	Digital & Information	Green - On Track
Digital medicines management programme Implementation of Hospital Electronic prescribing system (HEPMA) to all inpatient and outpatient services alongside review and upgrade of stock control system and electronic discharge/ meds rec solution	Pharmacy & Medicines	Amber - At risk - requires action
Hospital Pharmacy Redesign Introduction of automation in hospital Pharmacy stores, dispensaries and clinical areas. Centralisation of Pharmacy stores. * note, this is a joint project with capital planning and D&I	Pharmacy & Medicines	Purple - Suspended/ Cancelled

CC1.1 Develop a corporate communication and engagement plan

Deliverable	Dir/Div	Deliverable Q2 RAG Status
Develop and Implement the Corporate Communication Strategy	Comms	Green - On Track
Develop and Implement the Public Participation and Community Engagement Strategy	Comms	Green - On Track

CC1.2 Develop the strategic plan to secure teaching health board status

Deliverable	Dir/Div	Deliverable Q2 RAG Status
Development of the strategic plan to deliver teaching Health Board Status in partnership with the University of St Andrews	Quality & Care Governance	Green - On Track

CC1.3 Deliver Anchors ambitions working collaboratively with partners

Deliverable	Dir/Div	Deliverable Q2 RAG Status
Work with the Chief Executive of NHS Fife to establish NHS Fife as an Anchor Institution in order to use our influence, spend, employment practices to address inequalities.	Public Health	**Green - On Track**
Delivering Anchor Institution workforce aims - Promoting employability priorities	Workforce	**Amber - At risk - requires action**

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**3 November 2023**
Title:	**Cancer Framework Annual Delivery Plan 2023-24**
Responsible Executive:	**Dr Chris McKenna, Medical Director**
Report Author:	**Kathy Nicoll, Cancer Transformation Manager**

1 Purpose

This report is presented for:

- Decision

This report relates to:

- Annual Delivery Plan
- Government policy / directive
- Legal requirement
- Local policy
- National Health & Wellbeing Outcomes / Care & Wellbeing Portfolio
- NHS Board / IJB Strategy or Direction / Plan for Fife

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The NHS Fife Cancer Framework Delivery Plan 2023-24 actions is being presented to the Cancer Governance and Strategy Group for agreement of the actions. The group is asked to note that the action plan is a working document and therefore may subject to change or update.

2.2 Background

The NHS Fife Cancer Framework has been developed to ensure that we can make a difference to how cancer services are delivered in Fife, ensuring it remains contemporary and reflects strategic changes both locally, regionally and nationally.

2.3 Assessment

The Draft NHS Fife Cancer Framework Annual Delivery Plan for 2023-24 has been reviewed and updated.

The actions outlined within the Cancer Framework Annual Delivery Plan have been developed through:

- Outstanding, incomplete or re-reviewed actions carried forward from Cancer Framework Annual Delivery Plan 2022-23
- NHS Fife Board Annual Delivery Plan 2023-24
- NHS Fife Board Medium Term Plan 2023-25
- Framework for Effective Cancer Management Action Plan
- Engagement with teams

Cancer Framework Engagement MS Forms Questionnaire

A MS Forms questionnaire was sent out widely through NHS Fife to ensure continued engagement. There was a limited response (10 respondents). 80% felt the objectives aligned with their service objective. Where respondents did not feel it aligned, contact has been made for further update.

Some risks to delivery of the actions were identified:

- Lung – workforce planning (recruitment of a Lung Pathway Navigator to support the Optimal Lung Cancer Pathway).
- Specialist Palliative Care – limited time for BSC development work by senior clinicians (limits rate of progress).
- SACT – the timeframes are unrealistic for improvement of capacity and staffing, both medical and nursing. The ongoing funding increases that will be required from the Scottish Government for the desired improvements to be achieved.
- Psychology – limited psycho-oncology resource for service development and delivery
- Gynae Oncology – extended waiting times for post-menopausal bleeding (PMB) appointments and pressure on dermatology vulval service delaying time to first assessment.

Some respondents expressed a desire to have a face-to-face engagement session with the Cancer Leadership Team. This is to be arranged.

A question was also asked as to how the Cancer Leadership Team could be improved. The feedback was as follows:

- Actively visit areas to witness challenges around SACT capacity.
- Include regrading in the delivery plan (NB. this is included)
- Continued psychology input when developing and creating pathways e.g.BSC

Next Steps

- Agree if further amendments required or confirm sign off from the cancer groups
- Arrange a meeting to pick up on queries raised through the MS Forms questionnaire
- Review Cancer Leadership Team improvements and agree actions from MS Forms questionnaire.

2.3.1 Quality / Patient Care

The development of the Framework aims to improve outcomes, patient experience and provide value and sustainability for cancer services.

2.3.2 Workforce

Workforce implications and challenges will be identified through the Framework development within which a review of the cancer workforce is a key priority.

2.3.3 Financial

Financial implications will be considered through the future Framework priorities.

2.3.4 Risk Assessment / Management

Risks associated with the Framework and Delivery Plan have been identified and will remain under review.

2.3.5 Equality and Diversity, including health inequalities and Anchor Institution ambitions

Issues identified around equality and diversity require are fully considered. Continued public and patient engagement forms a key milestone. A full Equality Impact Assessment was carried out as part of the Framework development.

2.3.6 Climate Emergency & Sustainability Impact

Through implementation of the Framework and Delivery Plan we will work with colleagues to ensure we are cognisant of more sustainable, greener healthcare.

2.3.7 Communication, involvement, engagement and consultation

Email to Director of Acute Services for comment/dissemination to Acute Cancer Services Delivery Group as appropriate, 24 October 2023

2.3.8 Route to the Meeting

This paper has been previously considered by the following group 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.

- Cancer Leadership Team (CLT), 24 October 2023
- Cancer Governance and Strategy Group, 2 November 2023

2.4 Recommendation

- **Decision**

3 List of appendices

The following appendices are included with this report:

- Appendix No. 1, Draft Cancer Framework Annual Delivery Plan 2023-24

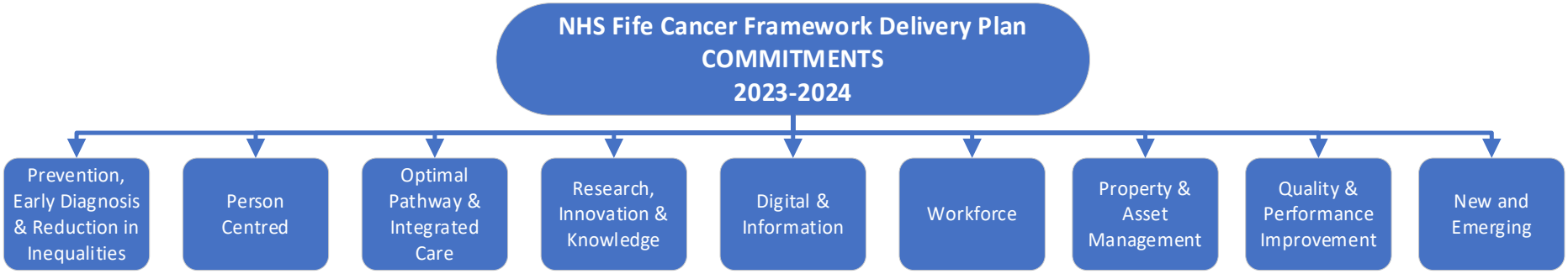
Report Contact
Kathy Nicoll
Cancer Transformation Manager
Email kathy.nicoll2@nhs.scot

Cancer Framework Delivery Plan Year 2

2023–2024

Cancer framework delivery plan year 2 (2023-2024)

The aspiration of this framework will only be fully realised with a clear and focused annual delivery plan which is aligned to the cancer commitments for 2023–2024. This Framework will be reviewed on a monthly basis by the Cancer Leadership Team given the changing nature of our healthcare systems.



Priority for 2023–2024	Description	Outcome (including measures)	Timescale	Leading (L) Responsible for Delivery	Critical (C) Critical for Delivery	Active Contributor (AC) Actively Engaged	Supporter (S) Inform and Support
Commitment 1: A focus to reduce cancer incidence, mortality and inequalities for our patients through effective prevention, screening and early detection initiatives							
1.1 Reduce the harms associated with preventable risk factors for cancer, with a focus on supporting healthy communities, early and targeted intervention, effective and integrated harm reduction and reducing inequalities.	1.1.1 Promote good community orientation through improving awareness.	To test approaches to promote health topic information and key campaigns such as Right Care Right Place in local community settings working. *c/f from 2022-23*	Mar 24	Health Promotion Nurse Manager	Lead Cancer GP Consultant, Public Health		Health Improvement Scotland (HIS) Communications NHS Inform Scottish Government Public Health Scotland
	1.1.2 Support the public, patients and staff to eat well, have a healthy weight and be physically active through revision of Physical Activity for Fife Strategy	Outcome will be in line with Physical Activity for Fife Strategy	Mar 24	Health Promotion Manager	Consultant, Public Health	NHS/H&SCP Delivery Group Fife Council	AHP Implementation Group

*As this is a dynamic document actions are subject to change and update

Priority for 2023–2024	Description	Outcome (including measures)	Timescale	Leading (L) Responsible for Delivery	Critical (C) Critical for Delivery	Active Contributor (AC) Actively Engaged	Supporter (S) Inform and Support
	1.1.3 Support delivery of the Prevention and Early Intervention Strategy	To be determined on publication of the strategy to inform prevention and early intervention	Jan 24	Consultant, Public Health	Health Promotion Managers Head of Primary and Preventative Care Services	NHS/H&SCP Delivery Group	
	1.1.4 work with Community and Wellbeing Partnership on delivering against (ambition 3) of the plan for Fife	Reduced levels of preventable ill health and premature mortality across all communities	Mar 24	CWP Partnership Lead	Fife Council	Public Health	
1.3 Review the impact of the Fife Rapid Cancer Diagnostic Service (RCDS) with a view to expanding to other specific tumour sites.	1.3.1 Implement a cancer education package for Community Pharmacy around red flag symptoms and for patients on cancer treatment. 1.3.2 Explore pathways available to community pharmacy for referral with warning symptoms	Increase competence and confidence of community pharmacy teams recognising and supporting patients when they attend the pharmacy	Mar 24	Lead Pharmacist for Public Health and Community	Community Pharmacy Head of Pharmacy, PH&WB Radiology Clinical Service Leads Lead Cancer Nurse	Cancer Transformation Manager Project Manager	Director of Pharmacy
	1.3.2 Expansion of RCDS principles through Test of Change	Earlier vetting of upper GI and HPB cancers by ACNS Earlier vetting of colorectal cancers by ACNS	Aug 23	Consultant Surgeon	Lead Cancer Nurse ACNS Pathway Navigators Radiology	Cancer Transformation Manager Project Manager	

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Priority for 2023–2024	Description	Outcome (including measures)	Timescale	Leading (L) Responsible for Delivery	Critical (C) Critical for Delivery	Active Contributor (AC) Actively Engaged	Supporter (S) Inform and Support
Commitment 2: The patient will be at the heart of how services are designed.							
2.1 Actively include the views and experiences of patients, families and unpaid carers through continued engagement to ensure shared decision making, including Care Opinion	2.1.1 Ensure the cancer groups have appropriate patient representatives	Patient representative attendances will be noted on Minutes	Mar 24	Lead Cancer Nurse	Medical Director [confirm] Cancer Transformation Manager	Cancer Governance and Strategy group Optimal Lung Cancer pathway Prostate Improvement pathway Single point of Contact group	Associate Director of Quality and Governance Head of Patient Relations
	2.1.2 To develop a quality improvement model using the Cancer Experience Improvement Model (CEIM)	Each nurse within the service to undertake at least 1 discovery conversation per month. Record monthly reflection meetings. Record any changes made as a result of discovery conversation	Mar 24	Lead Cancer Nurse	Advanced Cancer Nurse Specialist (Prostate) Cancer Nurse Specialist (Colorectal) Cancer Nurse Specialist (Head & Neck) Cancer Nurse Specialist (UGI) Cancer Nurse Specialist (HPB)	Patient Navigators HIS	HIS Director of Nursing Heads of Patient Relations
	2.1.3 Introduction of volunteers within services to collect cancer Care Opinion feedback	Ensure real time outcomes on cancer services within RCDS. Record the number of care opinions within RCDS- compare with previous year	Sept 23	Lead Cancer Nurse	Patient Navigator RCDS Volunteer	RCDS Patient Navigators RCDS ACNS Volunteer Manager Theresa Rodigan Care Opinion	National Care Opinion Head of Patient Relations

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Priority for 2023–2024	Description	Outcome (including measures)	Timescale	Leading (L) Responsible for Delivery	Critical (C) Critical for Delivery	Active Contributor (AC) Actively Engaged	Supporter (S) Inform and Support
2.2 Services will be designed to ensure there is a dedicated Single Point of Contact to provide information points for appointments, advice, clinical and other support	2.2.1 Expansion of Single Point of Contact Hub (SPOCH) into the Lung Service	Integration of Optimal Lung Cancer Pathway and Single point of contact within the lung service	Aug 23	Cancer Transformation Manager	Cancer Audit & Performance Manager Lead Respiratory Clinician Radiology Clinical Activity Manager CNS Lung Cancer Project Manager	Pathway Navigators SPOCH	Patient Representative
	2.2.2 Further development of Colorectal services within the SPOCH	Integration of SPOCH and RCDS within the colorectal service SPOCH to manage the negative qFIT pathway	Aug 23	Cancer Transformation Manager	Cancer Audit & Performance Manager RCDS CNS	Pathway Navigators RCDS Pathway Navigators SPOCH	
	2.2.3 Complete 6 month evaluation of SPOCH	Staff and patient questionnaires Analysis of data collected	Nov 23	Cancer Transformation Manager	Cancer Audit & Performance Manager Cancer Project Manager	Pathway Navigators SPOCH	
2.7 Ensure optimal pathways exist to ensure efficient diagnosis and treatment of patients	2.7.1 Implementation of Optimal Lung Cancer Pathway	Reduced waits between steps in the lung pathway	Mar 24	Cancer Transformation Manager	Cancer Audit & Performance Manager Lead Respiratory Clinician Radiology Clinical Activity Manager CNS Lung Cancer Project Manager		Patient Representative

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Priority for 2023–2024	Description	Outcome (including measures)	Timescale	Leading (L) Responsible for Delivery	Critical (C) Critical for Delivery	Active Contributor (AC) Actively Engaged	Supporter (S) Inform and Support
	2.7.2 Review Head & Neck Optimal Pathway	Reduced waits between steps in the Head & neck pathway	Mar 24	Cancer Transformation Manager	Cancer Audit & Performance Manager Head & Neck Lead Head & Neck CNS Service Manager Business Coordinator	Pathway Navigator SPOCH	General Manager (Planned Care)
2.11 Continue to offer patients support through the Macmillan Improved Cancer Journey (ICJ) pathway to ensure they can access support as their circumstances change	2.11.1 Signpost/refer patient to Macmillan Improved Cancer Journey (ICJ)	A Service Level Agreement for electronic Health Needs Assessment (eHNA) will be in place Increased referrals to ICJ to ensure coordinated pathway of care by Uptake of the offer of eHNA within cancer services.	Mar 24	Lead Cancer Nurse	Cancer Nurse Specialists	Macmillan Cancer Support Information governance Improving Cancer Journey services	Heads of Nursing Clinical Nurse manager
Commitment 3: Patients will receive the right treatment at the right time in the right place by the right person. This will be delivered through the development of optimal pathways and integrated care.							
3.1 Implement sustainable optimal cancer pathways with review of timed cancer pathways to improve cancer waiting times performance and to ensure clear timelines for appointments, diagnostics, decisions	3.1.1 Achieve additional capacity for access to the 3 key radiology diagnostic tests (MRI, CT and U/S) to maintain 2 week targets for cancer referrals	One stop clinics for urgent patients Flex Inpatient vs Outpatient capacity	Mar 24	General Manager, Clinical Services	Consultant Radiologists Radiology Service Manager Radiology Clinical Activity Manager		
	3.1.2 Ensure routine adherence to Scottish Cancer Network Clinical Management Guidelines for CMGs through MDT.	Adherence to Scottish Cancer Network Clinical Management Guidelines through MDT	Mar 24	Specialty Lead Clinician	Specialty MDT Lead		

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Priority for 2023–2024	Description	Outcome (including measures)	Timescale	Leading (L) Responsible for Delivery	Critical (C) Critical for Delivery	Active Contributor (AC) Actively Engaged	Supporter (S) Inform and Support
and treatments, including direct patient navigation for the most complex patient pathways from initial referral through to palliative and end of life care	3.1.3 Put in place Breach Avoidance and Effective Breach Analysis SOP	Prevent avoidable breaches and understand reasons for breach	March 24	Cancer Transformation Manager			
	3.1.4 Implementation of Regrading Guidance	Right patient on the right pathway at the right time. Improved communication between Primary and Secondary Care	Dec 23	Cancer Transformation Manager	Lead Cancer Clinician (Surgery)	Acute Cancer Services Delivery Group Cancer Audit & Performance Manager	Cancer Leadership Team
	3.1.5 Expand diagnostic capacity to support cancer services	Improve efficiency of endoscopy booking Expand Cytosponge Develop a reflux pathway	Mar 24	Cancer Lead for Surgery	General Surgeon Endoscopy Business Coordinator		
3.2 Embed a new model of specialist palliative care, optimise on generalist palliative care and develop a best supportive care pathway.	3.2.1 Specialist Palliative Care and Primary Care will collaborate to model a best supportive care (BSC) pathway for Fife	Development of a Framework contributing towards the national agenda	Mar 24	Lead Cancer GP	Consultant in Palliative Care	Lead Cancer Nurse	Cancer Transformation Manager
		Scope digital RESPECT to ascertain if there is a role within NHS Fife	Mar 24	Lead Cancer GP			
		Development of a BSC/Patient Information leaflet	Mar 24	Lead Cancer Nurse	Consultant in Specialist Palliative Care Cancer Clinical Nurse Specialists Cancer Project Manager	District Nurses GP Occupational Therapists Dieticians Palliative care Nurses NHS Lothian CNS MND CNS	Cancer Leadership Team Clinical Nurse Managers Heads of nursing Director of nursing Consultants in Medicine/surgery/oncologists

*As this is a dynamic document actions are subject to change and update

Priority for 2023–2024	Description	Outcome (including measures)	Timescale	Leading (L) Responsible for Delivery	Critical (C) Critical for Delivery	Active Contributor (AC) Actively Engaged	Supporter (S) Inform and Support
		Development of a treatment summary	Mar 24	Lead Cancer Nurse	Cancer Clinical Nurse Specialists Consultant in Specialist palliative Care	District Nurses GP Occupational Therapists Dieticians Palliative care Nurses NHS Lothian CNS MND CNS	Cancer Leadership Team Clinical Nurse Managers Heads of nursing Director of nursing Consultants in Medicine/surgery/oncologists
		Develop a national pathway for BSC for lung cancer	Mar 24	Lead Cancer GP	Consultant in Palliative Care Lead Cancer Nurse	Lung Cancer CNS	Cancer Transformation Manager
	3.2.2 Develop models of prescribing and supply of palliative care medicines	The NHS Fife just in case box policy is under review. The NHS Fife Palliative Care Pharmacist is developing a dose-escalation palliative care Kardex which is currently being reviewed and going through the approval process. *c/f 2022-23*	Oct 23	Lead Pharmacist Community Health			
3.6 Ensure that prehabilitation and rehabilitation are embedded in care pathways	3.6.1 Embed the universal offer of Prehabilitation into Maggies	Initial focus on embedding the universal offer in Lung and Best Supportive Care pathways	Mar 24	Lead Cancer Nurse	Head of Maggie's Lung Lead Clinician Lung Cancer nurse Specialists	Multi disciplinary meeting NHS Lothian Colleagues Cancer Transformational Manager	Cancer Leadership team
Commitment 4: Research, innovation and knowledge is central to the delivery of high quality sustainable cancer services for our patients and population.							

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Priority for 2023–2024	Description	Outcome (including measures)	Timescale	Leading (L) Responsible for Delivery	Critical (C) Critical for Delivery	Active Contributor (AC) Actively Engaged	Supporter (S) Inform and Support
4.8 Seek opportunities to test innovative solutions with the McKenzie Early Diagnosis Institute and the South East Health Innovation Hub (HISES).	4.8.1 Horizon scan for funding applications and/or innovation challenge/catalyst calls 4.8.2 Collaborate with McKenzie Early Diagnosis Institute and/or HISES to submit applications or support successful submissions	One or more innovation projects with NHS Fife as a test bed and McKenzie Early Diagnosis Institute and/or HISES as a collaborator	Mar 24	Innovation Manager	McKenzie Early Diagnosis Institute, HISES Innovation Champions	NHS Fife Clinical Innovation Champion	Assistant Director RIK
Commitment 5: Commitment: Digitally enabled for sustainable and efficient service models which embrace technology and innovation							
5.1 Develop cancer clinical information systems	5.1.1 Explore robust tracking solution to support effective and efficient patient tracking.	Develop business case for change and implementation of project team		Cancer Transformation Manager	Senior Project Manager Cambric	Cancer Audit & Performance Manager	
	5.1.2 Provide a Multidisciplinary Team (MDT) solution which is fit for purpose	Explore the use of Power Apps as an Electronic MDT Solution		Cancer Transformation Manager	Digital & Information		
5.2 Support the improvement of the cancer referral process	5.2.2 Introduction applications ('Apps') to support referral, e.g. photo triage, in a secure and compliant manner	Develop ANIA to work towards National phototriage solution in dermatology. Listed for phase 2 of the National solution, (temporary solution working in Fife.).	?	Dermatology Consultant [Megan to update]	?	?	?
	5.2.3 Prepare for the implementation of nationally provided artificial intelligence (AI) to support early detection	Link with SE Innovation Group to identify AI work		Research Innovation and Knowledge	David Moyle Neil Mitchell		Cancer Transformation Manager
	5.2.4 (i) Introduction of Patient Initiated Review (PIR) in (cancer services TBC)	FECM					Cancer Transformation Manager

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Priority for 2023–2024	Description	Outcome (including measures)	Timescale	Leading (L) Responsible for Delivery	Critical (C) Critical for Delivery	Active Contributor (AC) Actively Engaged	Supporter (S) Inform and Support
	5.2.4 (ii) Introduction of Active Clinical Referral Triage (ACRT)	(Services TBC)					Cancer Transformation Manager
Commitment 6. Recognise workforce challenges and identify system-wide approaches to support wellbeing, education and training to ensure our patients receive the best care							
6.1 Review the cancer workforce, including skill mix and supporting roles, to inform future service delivery models and succession planning	6.1.1 Support the national Oncology Transformation Programme	Appropriate staffing levels in the SACT Unit to support demand now and in the future. Cancer Nurse Specialist Workforce tool			SACT Nurse Consultant Lead Facilitatory PPD Nursing	Lead Cancer Nurse	
6.2 Work towards the national agenda to transform roles with consideration of Senior Professional Leadership/Management of CNS/ANP/AHP workforce.	6.2.1 Promote early engagement with local transforming nursing roles programme	Achievement of objectives outlined for 2022-23 by the national group. Awaiting recruitment within the nursing directorate To carry forward into 2023-24 *c/f from 2022-23*	Mar 24	Lead Cancer Nurse	Director of Nursing Senior Practitioner PPD Nursing	Cancer Nurse Specialists	
6.3 Review wider roles, such as AHPs and palliative care to complement an integrated cancer care	6.3.1 Improve Physiotherapy and Occupational Therapy support for Hospice and Community Specialist Palliative Care	Engage the redesign of palliative care services to develop professional services to support new model	Mar 24	Director or Allied Health Professions	Service Manager, Therapies and Rehabilitation	AHP Team Leads Palliative Care Lymphoedema	

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Priority for 2023–2024	Description	Outcome (including measures)	Timescale	Leading (L) Responsible for Delivery	Critical (C) Critical for Delivery	Active Contributor (AC) Actively Engaged	Supporter (S) Inform and Support
pathway. Ensure the wellbeing and resilience of the cancer workforce including improved access to Spiritual Care and other wellbeing services as part of the approach to staff wellbeing	6.3.2 Embed Psychological Therapies Framework into Cancer Services.	Set up steering group scope workforce	Mar 24	Lead Cancer Nurse	Clinical Psychologist		
Commitment 7. Ensure our healthcare environments are designed to deliver optimum patient care							
7.1 Review the estate across NHS Fife to accommodate new ways of working and new technologies so that capacity can cope with demand now and in the future.	7.1.1 Relocate SACT Services to ensure capacity for now and in the future	Review access to Ward 10 at VHK		General Manager, Emergency Care	SACT Nurse Consultant Principal Pharmacist	Lead Cancer Nurse	
	7.1.2 Development of a Mammography Unit	Review demand, capacity and cost Develop a Business Case		General Manager, Planned Care	Breast Service Radiology Service		
Commitment 8: To make best use of available information sources to assure patients they are receiving high quality, effective care							
8.1 Embed the Effective Cancer Management Framework into the cancer team's workplan, supported by senior management to ensure full adoption	8.1.1 Deliver agreed 2023-24 actions identified in the Framework for Effective Cancer Management	Improved and effective management of cancer patients.	Mar 24	Cancer Transformation Manager			

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Priority for 2023–2024	Description	Outcome (including measures)	Timescale	Leading (L) Responsible for Delivery	Critical (C) Critical for Delivery	Active Contributor (AC) Actively Engaged	Supporter (S) Inform and Support
8.4 Continue to drive and improve quality performance through robust governance of the Quality Performance Indicators and local use of data to improve service delivery	8.4.1 Improve quality of cancer staging data	Improve staging data at MDT for: Prostate – ensure documentation of prostate Likert scale and TNM. Renal - to include the TNM staging Valid TNM staging must be assigned for all patients with suspected renal cancer. staging data collection at Improve pre-radical treatment clinical TNM for Bladder; pathological T staging at TURBT1 + TURBT2 + TURBT Recurrence; and pathological TNM staging at cystectomy.	Mar 24	Cancer Transformation Manager	Cancer Audit & Performance Manager Cancer Audit Facilitators Clinical Leads	Clinical Teams	

Sources: Cancer Framework Actions 2022-23 (C/F), ADP 2023-24, MTP 2023-25, FECM 2022-23 Actions.

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

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NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**3 November 2023**
Title:	**Alignment of NHS Fife Cancer Framework and the National Cancer Strategy 2023-2033 and Cancer Action Plan for Scotland 2023-2026**
Responsible Executive:	**Dr Chris McKenna, Medical Director**
Report Author:	**Kathy Nicoll, Cancer Transformation Manager**

1 Purpose

This is presented for:

- Assurance

This report relates to a:

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

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

Scottish Government have recently published the 10 year National Cancer Strategy 2022-2023. This report is to assure the Clinical Governance Committee that the ambitions of the national strategy align with our recently launched Cancer Framework 2022-2025. This SBAR is to **assure** the group that both strategies align.

2.2 Background

The NHS Fife Cancer Framework was developed prior to publication of the national strategy to ensure local delivery of effective cancer prevention, early diagnosis and high quality sustainable cancer services using a full system approach. The Cancer Framework Annual

Delivery Plan is reviewed annually to assure cancer services in Fife continue to be aligned to national, regional and local strategy.

2.3 Assessment

The ambitions of the 10 year cancer strategy and vision supports commitments and actions outlined in the NHS Fife Cancer Framework.

The strategic aim of the national cancer strategy is:

"To improve cancer survival and provide excellent, equitably accessible care".

These are underpinned by the following outcomes:

- Reduced relative population burden of disease.
- Reduced later stage diagnosis.
- Timely access to treatment.
- More people receiving curative treatment.
- Improved experience of services, across all areas of care.
- Optimised quality of life for each individual.
- Embedded research, innovation and data capture in all services.

Similarly to the NHS Fife Cancer Framework, the national cancer strategy does not stand alone and is expected to compliment and link to wider strategies and operate within broader health aims.

11 ambitions are identified in the cancer strategy which address both cross cutting and cancer pathway priorities (presented without hierarchy):

National Cancer Strategy Ambitions	
Pathway	**Cross-cutting**
1. Preventing More Cancers	6. Sustainable and Skilled Workforce
2. Earlier and Faster Diagnosis	7. Person-Centred Care for All
3. Best Preparation for Treatment	8. Tackling Inequalities
4. Safe, Realistic and Effective Treatment	9. Mental Health as part of Basic Care
5. Excellent Care and Support after Treatment	10. Flourishing Research and Innovation
	11. Cancer Information and Intelligence-led Service

The NHS Fife Cancer Framework strategic aim is:

"For the population of Fife we will deliver effective cancer prevention, early diagnosis and high quality sustainable cancer services for those living with and beyond cancer".

8 commitments have been identified to support this aim which are in line with the national vision:

NHS Fife Cancer Framework Commitments	
1. Prevention, early diagnosis and reduction in inequalities (1,2,8,9*) 2. Person Centred (7*) 3. Optimal pathways and integrated care (3,4,5*) 4. Research, innovation and knowledge (10*)	**Enablers** 5. Digital and Information (10,11*) 6. Workforce (6*) 7. Property and asset management 8. Quality and performance improvement (11*)

(National Strategy Ambitions*)

Whilst there is mention of restructuring how hospitals can best serve the people of Scotland in the introduction of the national document, there are no references, or actions in relation to infrastructure specifically within the strategy or action plan, with the exception of the replacement radiotherapy programme,

The Scottish Government will have oversight of overall strategic progress and direction of this strategy. The Scottish Cancer Strategic Board will 'own' the strategy and associated action plans, and review progress against them. Beyond this, ownership of actions and delivery will be undertaken as appropriate at national, regional and local levels

The aim of the 3 year action plan is to recover and stabilise systems and includes actions which indirectly impact on cancer services.

Many of the actions identified in the national strategy with Board level responsibility are detailed with our Framework, for example, tackling inequalities, introduction of Single Point of Contact, RCDS and Optimal Lung Cancer Pathway, embedding value based healthcare and Realistic Medicine, roll out of Prehabilitation, adoption of the Framework for Effective Cancer Management including a 'Once for Scotland' approach to implementation of the Effective Breach Analysis and Regrading Guidance. People will be at the heart of the strategy.

On review of the strategy and associated action plan there are no specific gaps identified with the exception of genomic technologies; however it is felt this could be within the catchall of 'New and Emerging' noted within our Framework.

A Monitoring and Evaluation Framework is being nationally designed to cover the duration of the 10 year strategy.

2.3.1 Quality/ Patient Care

The patient is at the heart of both the National Cancer Strategy and the NHS Fife Cancer Framework

2.3.2 Workforce

As per the workforce strategy: Plan, attract, employ, train, nurture.

2.3.3 Financial

There is no specific reference to expected financial investment in the strategy itself however there are resource commitments detailed in the 3 year action plan.

- Increasing national resourcing of SACT service across Scotland, alongside developing Acute Oncology services, reaching up to £10 million per annum of additional funding
- Invest up to £30m to support cancer waiting times improvements.
- Universal prehabilitation programme offered through each Maggie's centre in Scotland with an additional investment of up to £80,000 to ensure future sustainability.
- Invest up to £5 million into the Scottish Cancer Network, National Managed Clinical Networks and the Managed Service Network for Children and Young Adults.
- Invest up to £2.8 million in the continued roll out of SABR.
- Continue to invest in our capital radiotherapy replacement programme, investing up to £67.4 million over the next 3 years.
- We will invest up to £690,000 to continue the work of NCMAG.
- Strengthen national cancer intelligence systems with up to £800,000 of investment at a regional level and ensure that new clinical software systems consider standardisation and interoperability of data.
- Invest up to £3 million in the Scottish Cancer Registry Intelligence System (SCRIS) to strengthen and expand the Scottish Cancer Registry and to enhance the Cancer Intelligence Platform through the addition of relevant cancer datasets including radiotherapy, SACT and QPI audit data.
- Financial investment and reform will both be vital to sustainability of the increasing demand for SACT treatments (increase by 10% pa).
- Through UK-wide funding arrangements, continue to facilitate access for researchers based in Scotland to the majority of the National Institute for Health and Care Research (NIHR) research project funding schemes.
- Investment in innovation, and further data and intelligence gathering, including lung cancer.
- Continue to invest and expand diagnostic services across NHS Scotland including workforce, for example, advanced practice and digital solutions such as digital pathology.
- Invest in improving the pathways of less survivable cancers, particularly hepatocellular carcinoma and pancreatic cancer. This will shorten the time to staging and agreeing treatment options.
- We will continue to invest in the work of CMOP.
- Continue to invest in the 12 pilot single point of contact (SPOC) sites, evaluate the impact of the programme and expand its reach.

- Develop and agree on a Once for Scotland basis, core principles for the collection of cancer PROMs (patient-reported outcome measures), influenced by our investment in the regions and Scottish Cancer PROMs Advisory Group.
- Prepare a cancer data roadmap to address identified data gaps, secure wider stakeholder commitment/sponsorship and invest in new data collection that aligns with strategic aims and clear translation into improved equitable treatment and care for people with cancer, for example, surgical, diagnostic and inequalities data.

2.3.4 Risk Assessment/Management

High quality evidence can increase our understanding of what works, maximise the chance of achieving the strategy's ambitions, and reduce delivery risk.

NHS Fife have developed a local risk framework which identifies potential risks to delivery of the Cancer Framework in relation to:

- Cancer Workforce
- Property & Estate
- Financial Delivery
- Edinburgh Cancer Centre
- Digital & Information

2.3.5 Equality and Diversity, including health inequalities

Embedded within both strategies.

2.3.6 Other impact

N/A

2.3.7 Communication, involvement, engagement and consultation

This paper has been circulated for comment to:

- Associate Director of Quality and Clinical Governance
- Cancer Leadership Team

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.

- Cancer Governance and Strategy Group, 17 August 2023

2.4 Recommendation

- **Assurance**

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, National Cancer Strategy 2023-2033
- Appendix No 2, Cancer Action Plan 2023-2026
- Appendix No 3, NHS Fife Cancer Framework 2022-2025

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Scottish Government
Riaghaltas na h-Alba

Cancer Strategy for Scotland 2023-2033

Contents

Foreword from the Cabinet Secretary for NHS Recovery, Health and Social Care

Despite recent advances, cancer remains the largest burden of disease across Scotland and has seen an ongoing increase in incidence. However, alongside this trend, we are seeing reduced death rates, with an 11% reduction over the last 10 years.[1] Looking forward, cancer incidence is projected to increase due to Scotland's ageing population, with the risk of developing cancer more common among older people, which requires increases in diagnostic and treatment capacity for each person with cancer.[2]

In line with the First Minister's Policy Prospectus published in April 2023, we are focusing on improving cancer outcomes through better prevention and diagnosis. We continue to strive for earlier diagnosis as we know this is critical to improving outcomes and survival. As well as being able to provide more curative treatment, we also recognise the importance of treatments to extend life and the provision of holistic palliative care. All of these aims must be underpinned by the principles of person-centred care and an understanding of what matters to every individual with cancer.

We have listened to your views through a public consultation and focus groups, and through engagement with national, regional and local networks of clinical and management representatives. Thank you so much for taking the time to share them.

Our strategic intent is now clear – to **improve cancer survival and provide excellent, equitably accessible care**.

Our 10-year vision for our health service is that **More cancers are prevented, and our compassionate and consistent cancer service provides excellent treatment and support throughout the cancer journey, and improves outcomes and survival for people with cancer**.

This strategy has people living with cancer, their families and carers at its very heart, with a focus on reducing inequities in access to cancer care and cancer outcomes, recognising each person's time of need. Focussing on all people with cancer, the strategy aligns with the Cancer Strategy for Children and Young People 2021–2026 that reflects the distinct needs of children and young people.

Our focus on the four key principles of person-centred care – compassion, personalisation, coordination and enablement – provides the foundation for our approach.[3] By 2033 we will improve cancer survival, particularly among the currently less-survivable cancers such as lung cancer. Strong public health interventions will mean more cancers are prevented, and those who require diagnosis and treatment will have prompt access to quality services, all with the strategic focus of improved survival and excellent care, no matter where someone lives.

To all those who have been involved in developing this strategy, and will be involved in its delivery, I thank you for your invaluable work and contributions. I've been very clear that cancer must remain a priority within our NHS, as well as delivering this strategy along with the associated Cancer Action Plan for Scotland 2023-2026. It will be crucial to continue this prioritisation, while taking all opportunities to further improve experience of our cancer services.

Michael Matheson MSP
Cabinet Secretary for NHS Recovery, Health and Social Care

1. The Strategy and its Context

1.1 Our Vision and Strategic Aim

Cancer remains one of Scotland's single biggest health challenges, affecting every one of our citizens in some way throughout their lifetime. In recent times there have been huge changes in our understanding of the disease and how to improve its prevention, diagnosis and treatment, and it is incumbent on governments across the world to keep pace with the most up-to-date ways of managing cancer within their populations. The scope of these possible interventions is wide-ranging, from evolving our public health system to continuing the search for better scientific understanding; introducing new case-finding and treatment techniques; and doing what really matters to people with cancer by building care and treatment around their specific needs and preferences.

The challenge remains formidable. Cancer survival has improved in Scotland but not at a satisfactory rate. The necessary coalition of effort to meet this challenge is complex, involving many organisations and thousands of individuals. Strong and clear coordination of this effort is required at all levels, and this strategy will provide common direction for all. Our vision for cancer in Scotland in 10 years' time is:

By 2033 every person with cancer will have access to the comprehensive support they need, clinical and non-clinical, reflecting what matters to them. Digital and technological advances will allow people with cancer to access services in different ways, attending clinical settings only where necessary, with wider support provided in ways that work best for them. There will be less unwarranted variation in service delivery and clinical management across Scotland. Systems will integrate to provide efficient and effective care founded on national clinical consensus. Increasing numbers of people with cancer will have access to curative and other cancer treatments, with full supportive and palliative care available where a cure is not possible, all underpinned by a culture of Realistic Medicine. People will be well informed about prevention, signs and symptoms, and people with cancer will be informed about their treatment and care and possible outcomes. People with cancer will know how to access the support they need and be clear about the next step in their journey.

More cancers are prevented, and our compassionate and consistent cancer service provides excellent treatment and support throughout the cancer journey, and improves outcomes and survival for people with cancer.

The Strategy and its Context
continued

Our strategic aim is to **improve cancer survival and provide excellent, equitably accessible care** underpinned by the following outcomes:

a. Reduced relative population burden of disease
b. Reduced later stage diagnosis
c. Timely access to treatment
d. More people receiving curative treatment
e. Improved experience of services, across all areas of care
f. Optimised quality of life for each individual
g. Embedded research, innovation and data capture in all services.

We will aim to reduce inequalities in all these areas.

1.2 Steps to Success

As we publish this strategy, the NHS is under enormous pressure following the impact of the COVID-19 pandemic and the long-term challenges of an ageing population. This requires an increase in diagnostic and treatment capacity for each person with cancer. These pressures are felt across a range of other services and organisations that are crucial to cancer care. NHS Boards across Scotland continue in the 'recovery' phase of the 2020 Re-mobilise, Recover, and Re-design framework. This phase has been included in The NHS Scotland Delivery Plan Guidance for Boards as they set out their Medium Term Plans (three years) and define their Annual Delivery Plan (12 months). During the Medium Term Plan, success of the strategy will be to recover and stabilise systems and services, maintaining cancer as a priority while necessary recovery takes place in health systems and the wider economy. Actions to recover and stabilise services are covered in our first three-year action plan 2023-2026 and aligned with the Medium Term Planning guidance.

Concurrently, it will be necessary to renew our services and approaches to cancer control. This means working collaboratively with people who use services to develop new models of care, and delivering the changes needed to better meet what matters to the people NHS Scotland cares for. Planning for renewal and redesign phases will be underway to help shape and build on recovery phase.

We will develop plans for longer term redesign of services as part of a wider transformation framework that will guide our service development, further harnessing the potential of innovations, integrating many more of our systems, removing associated barriers and, where the evidence is clear, embracing novel treatments and digital opportunities.

1.3 Development of the Strategy

Our public consultation and engagement events during the development of the strategy provided evidence of a strong appreciation of existing cancer services, as well as recognition of the fundamental impact of earlier diagnosis and safe, effective treatment. The

The Strategy and its Context
continued

respondents included people with lived experience of cancer, healthcare professionals, academics, private and third sector representatives amongst others. Those who took part emphasised the importance of action across the whole cancer pathway from prevention to pre-treatment and post-treatment. In addition, respondents also told us that there needs to be a strong focus on the key cross-cutting enablers such as a well-resourced and skilled workforce, capacity for research and innovation, and comprehensive data and intelligence systems. The strongest recommendations emerging from the consultation related to the holistic aspects of providing high quality care. This means putting the person with cancer at the centre of the response, providing holistic care (including psychological support), providing excellent communication and applying the principles of Realistic Medicine.

1.4 Interconnectivity with wider Health and Social Care

This strategy is for all people affected by cancer, but the distinct needs of children and young people are specifically covered by the Collaborative and Compassionate Cancer Care: Cancer Strategy for Children and Young People (2021), delivered through the Managed Service Network for children and young adults.

In addition to that document, the delivery of the strategic ambitions here will be interdependent with a range of other strategic aims in health and beyond. This strategy cannot stand alone, nor can it supersede wider strategies. Rather it complements, links to and will operate within the broader health aims of the Scottish Government. It is accompanied by a 3-year Cancer Action Plan and underpinned by actions in Annual Delivery Plan guidance to Boards alongside Medium Term Planning with longer-term planning and redesign. Actions will change, adapt or be superseded by innovations as yet unknown, and will reflect the change needed in evolving contexts, including NHS capacity and the ability to make new financial investments. Embedding research and focused data collection will help to build a 'learning health system' and will be supported by key drivers including the Scottish Health Industry Partnership (SHIP) and the Accelerated National Adoption (ANIA) Pathway.[4]

Cancer control will be key to meeting Scotland's National Performance Outcome that we are healthy and active, not only through providing treatment and care for those with cancer, but also through a variety of population measures that will help prevent cancers in the future. These will be addressed through plans, strategies and interventions targeted at specific cancer risk factors including tobacco, obesity and alcohol. There are clear, inextricable links between health inequalities and poverty. Our long-term approach is through the national mission to tackle child poverty: Best Start, Bright Futures (2022). It aims to reduce health inequalities in the long-term by reducing child poverty now.

The Strategy and its Context
continued

We will continue the direction of travel laid out in the National Clinical Strategy for Scotland (2016):

- planning and delivering integrated primary care services, like GP practices and community hospitals, around the needs of local communities
- restructuring how our hospitals can best serve the people of Scotland
- making sure the care provided in NHS Scotland is the right care for an individual, that it works, and that it is sustainable
- changing the way the NHS works through new technology
- supporting people to practice Realistic Medicine

The National Clinical Strategy recognises that people often lack a full understanding of the prognosis or outlook for their illness (or the risk of developing a harmful event). They might well make different decisions if they were fully informed about their condition and the treatment options available. Indeed, in many cases, they may choose less aggressive treatment rather than more. This aspect needs to be better reflected in clinicians' discussions with patients about treatment options. A reinvigorated Realistic Medicine approach will support this element of the cancer strategy.

During the pandemic many new and innovative ways of working were developed to support the continued delivery of critical services. These were born out of necessity but, in many cases, they also delivered improvements. We want to build on this work, as set out in the NHS Recovery Plan (2021). This will support innovation in and redesign of services to ensure that more people with cancer receive person-centred care in the right place, at the right time, and in a way and that enables staff to deliver high quality care and treatment. As set out in our steps to success, research, innovation and the redesign of services will be integral to recovery and stabilisation. There are a range of partner organisations that are central to this including the Centre for Sustainable Delivery, NHS National Services Scotland and its Scottish Cancer Network, the Digital Health and Care Innovation Centre, Healthcare Improvement Scotland, and the Scottish Health Industry Partnership. All their work will be rooted in the principles of Realistic Medicine and aligned with broader Scottish Government care and wellbeing programmes. Our Health and Social Care: National Workforce Strategy (2022) will ensure we have a skilled and sustainable workforce to support delivery of our health and social care services. Success will be required across all pillars of that strategy to meet our strategic aims.

As Scotland builds back from the COVID-19 pandemic, we urgently need to tackle the long-standing inequalities in health and wellbeing that have been exacerbated by COVID-19. To do that we have established the Care and Wellbeing Portfolio that brings together work aimed at improving population health and reducing health inequalities, through health and social care and wider public sector service reform. The Portfolio seeks to create the best

The Strategy and its Context
continued

environment to stimulate national and local action to tackle these issues and takes a systematic approach to planning and delivering care and wellbeing. The work set out in this strategy will make an important contribution to these challenges. The diagram below sets out the overall Portfolio mission and outcomes, cross-government priorities that in turn improve health, and the programmes and enabling functions that support delivery.

The Strategy and its Context
continued

Care & Wellbeing Portfolio

Portfolio Aim

Improved Population Health & Wellbeing, Reduced Inequalities and Sustainable Health & Care Services

Our aim is achieved by taking a person-centred approach to delivering clear outcomes spanning short, medium and long-term.

1. Everyone in Scotland gets the **right care, at the right time, in the right place** based on their individual circumstances and needs.

2. **Prevention, early intervention, proactive care and good disease management** keeps people in Scotland healthy, active and independent.

3. **Communities, third sector & public sector work together** to improve health and wellbeing and reduce health inequalities in local communities

Many of the influences on health outcomes lie outwith health and social care. Our cross-government work to date provides an initial focused contribution to the wider government missions for 2026.

Care & Wellbeing Programmes and Enablers

Place & Wellbeing

Preventative & Proactive Care

NHS Recovery, Renewal and Transformation

Enablers
Analysis & Evidence; Digital & Data; Finance; Innovation; Service Co-Design and Improvement; Workforce

Together the Care & Wellbeing Programmes and Enablers provide a comprehensive and progressive health and social care reform package.

The Strategy and its Context
continued

The increase in digital health – planned for before the pandemic and significantly accelerated as part of our response – will increasingly become a choice for people accessing services and for the staff delivering them. It will allow more people to manage their condition(s) at home, enable remote pre- and post-operative assessments, as well as allowing people with cancer to manage their recovery from home. The Digital Health and Care Strategy will be the key driver in all of this and we will engage on its commitment to develop a Digital Front Door (DFD). The DFD work will be a key enabler for people interacting with health and social care services in Scotland. This development aims to allow anyone to manage appointments and conduct routine 'transactions' online. Digital technology can also facilitate the collection and capture of patient-reported outcomes and experience measures (Patient Reported Outcome Measures (PROMS) and Patient Reported Experience Measures (PREMS)).

The Scottish Cancer Network (SCN) will be at the heart of our strategic ambitions. There is evidence that those countries with empowered and clinically led central cancer agencies delivering clear government-owned plans have seen greatest success in cancer control.[5] The SCN will continue to be at the forefront of defining clinical management pathways for cancer from the point of diagnosis. These unique pathways encompass treatment and care right through to the end of life, setting out clinically agreed best practice, and assuring people with cancer of common standards of care, no matter where they live. The SCN will also host national networks, where national integration and collaboration for specific cancers can make best use of expert resources and improve outcomes for people with cancer. It will drive 'Once for Scotland' work, where appropriate, and work closely with regional networks where work is better delivered at that level.

This work will be underpinned by the Scottish Cancer Quality Programme, which will define and drive quality of care in Scotland, using agreed quality performance indicators (QPIs) that meet our strategic aims and wider measures to define quality of treatment and care. Clinically agreed priority indicators linked to our strategic aims will be closely monitored, working with Healthcare Improvement Scotland. The programme will continually review how these indicators are being met, with ongoing international benchmarking to ensure best evidence and comparators are being used in setting standards. All this work will be in clear sight of our overall strategic aim to improve cancer survival and provide excellent, equitably accessible care.

The Centre for Sustainable Delivery (CfSD) has been established to pioneer new, more sustainable ways of delivering services, including improving access for people with cancer. CfSD will be particularly important in driving innovation through their ANIA pathway. It will be key to supporting NHS recovery by reducing unnecessary demand for services, maximising available capacity and developing new pathways of care that are more

The Strategy and its Context
continued

efficient, effective and patient-focused. It will maximise value for people with cancer by devising ways of avoiding waste and will facilitate consistent, high-quality healthcare across Scotland, where possible. The CfSD will build on and accelerate work on redesigning optimal diagnostic pathways, growing Scotland's network of Rapid Cancer Diagnostic Services (RCDS), facilitating the introduction of innovative techniques (for example, Cytosponge), maximising diagnostic capacity, and optimising theatre capacity.[6]

1.5 Realistic Medicine, Person-Centred Care and 'What Matters'

Our primary focus must continue to be on achieving the outcomes that matter to people with cancer. In practising Realistic Medicine, health and care professionals work in partnership with people they care for. People must be involved in decisions made about their care by health and care professionals who understand and respect what matters to them. Desired outcomes are delivered through shared decision making and discussion about the potential benefits and harms of different treatment options, including the option to do nothing. This approach allows people to make an informed choice about their care, and helps reduce regret about treatment decisions.

In cancer services particularly, these guiding principles are tested daily by the complexities of some treatments that can carry significant adverse effects. Realistic Medicine encourages health and care professionals to go beyond explaining risks to considering the impacts, both positive and negative, that a treatment may have on the individual and their families. Making decisions as a partnership increases the likelihood that care is in tune with a person's personal preferences and will improve psychological wellbeing and outcomes. Ultimately, practising Realistic Medicine will enable cancer services to continue to be one of the most compassionate areas of the health and care service, providing the highest quality care that people with cancer value.

Additionally, Delivering Value Based Health & Care: A Vision for Scotland (VBH&C) will help deliver person-centred care, reduce harm and waste and eliminate unwarranted variation in access to health and care, treatment and outcomes. VBH&C also encourages health and care colleagues to be creative and think carefully about how we optimise the use of the resources we have for maximum benefit.

Getting It Right for Everyone (GIRFE) is a proposed multi-agency approach of support and services from young adulthood to end of life care. GIRFE reflects similar values to this strategy. It provides a more personalised way to access help and support when it is needed – placing the person at the centre of decision making to achieve the best outcomes, with a joined-up, coherent and consistent multi-agency approach.

The Strategy and its Context
continued

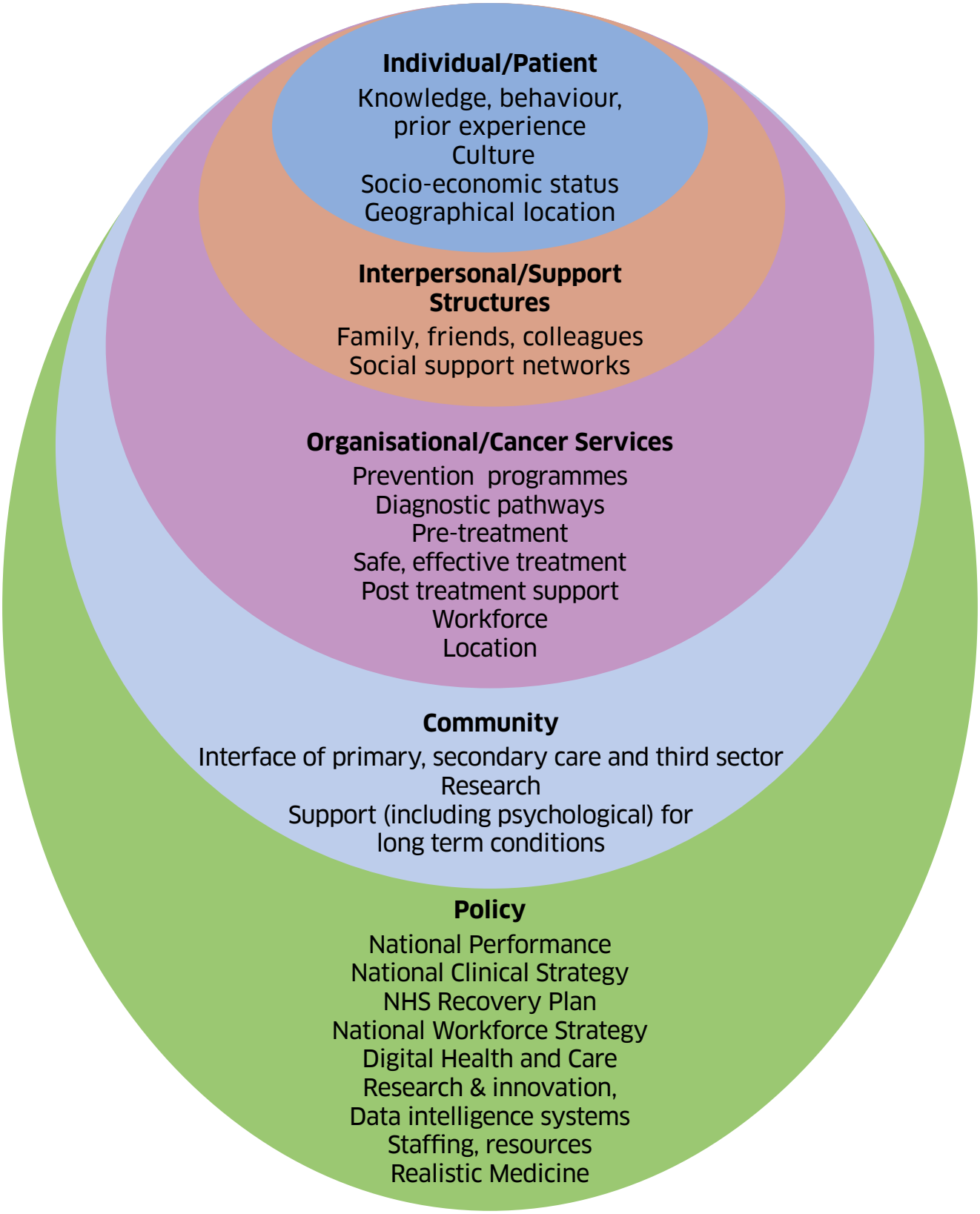
'What matters' is the ongoing reminder that what matters to people with cancer needs to be truly reflected in our thinking and delivery. Evidence from people with cancer has shown that while clinical outcomes are clearly important, so too is treatment and care that reflect their personal preferences and what matters to them. Collectively this means:

- **Equity of access to services** – the treatment and care that people with cancer can access does not vary in quality depending on where they live, or because of characteristics including gender, ethnicity, disability or socio-economic status (see Tackling Inequalities).
- **Non-clinical needs are supported** – a cancer diagnosis entails a clinical pathway for the person with cancer, but it also can have enormous impacts on their physical, mental and spiritual wellbeing as well as areas such as finances, social interactions, employment, housing and access to wider services (see Person-Centred Care for All).
- **Information and communication** - regular, clear and inclusive information can benefit people with cancer and the service provider, facilitating shared decision making and an understanding of what happens next, in line with the principles of Realistic Medicine (see Best Preparation for Treatment and Excellent Care After Treatment).

Our aim is to ensure people with cancer are at the heart of service design. To achieve this, we will co-design whenever possible and we will regularly seek people's voices through direct feedback, for example through the Scottish Cancer Patient Experience Survey and Care Opinion. We will support the generation of relevant and actionable data on both person-centred processes of care and person-centred outcomes. This will further enhance our understanding of quality and value, and what matters, from the perspective of people affected by cancer.

How the person at the centre interacts with services and policies and what we are trying to achieve through this strategy is shown here, noting that many components may be influenced but not controlled.

The Strategy and its Context
continued



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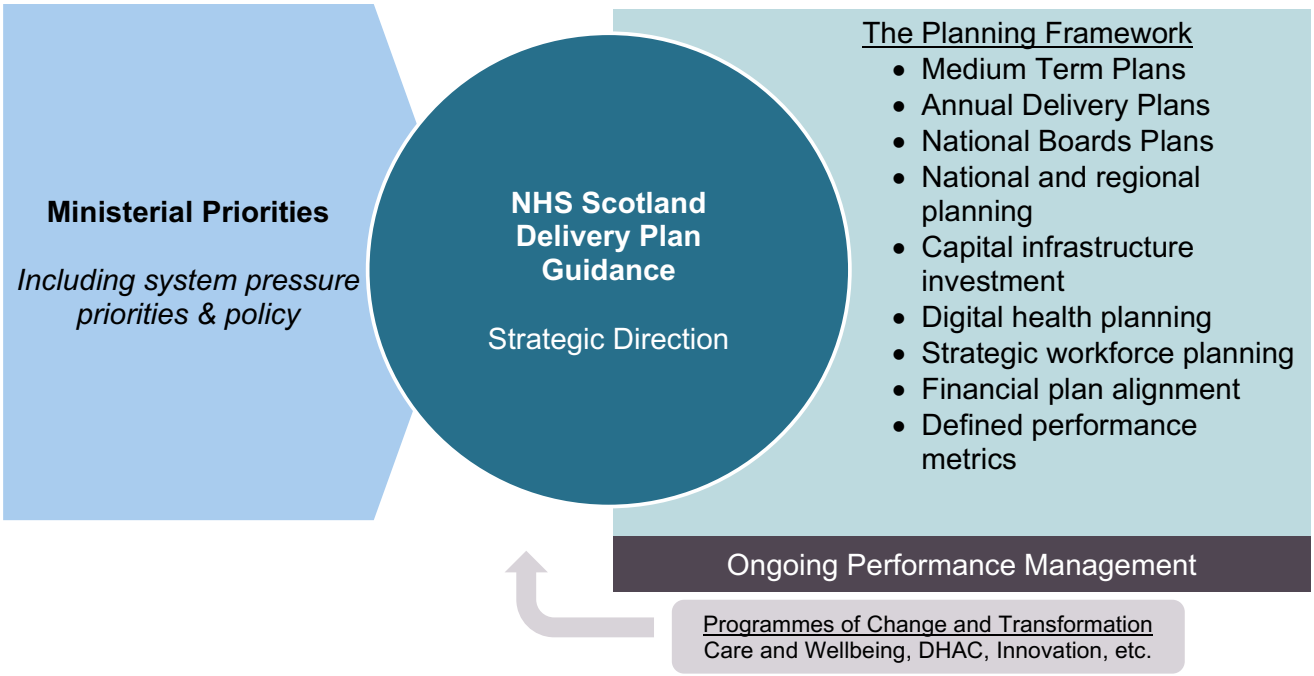
The Strategy and its Context
continued

1.6 Governance and Delivery

To support a more integrated and coherent approach to planning and delivery of health and care services, we have developed the NHS Scotland Delivery Plan Guidance that sets out prioritised high-level deliverables and intended outcomes to guide detailed local, regional and national planning, and inform improvement work. The Re-mobilise, Recover, Re-design Framework (RRR) was published on 31 May 2020, and set out the approach for health boards to safely and gradually prioritise the resumption of paused services.

This NHS Scotland Delivery Plan and associated approach to planning supports the **transition from recovery into a renewal phase** of services. This is a key part of strengthening and developing strategic and operational planning across health and care. The planning work will be supported and overseen by the NHS Scotland Delivery Group in conjunction with regular performance reporting and planning review cycle.



The Strategy and its Context
continued

Planning Framework – response to national policy & strategy set by Scottish Government			
A lens to view the different planning and delivery functions that take place nationally • **What drives activity in each category below?**			
	Policy/Strategy	**Planning/ Coordination**	**Operational Delivery**
National	• Policy imperatives drive model • Require national standardisation • Reflective of interdependencies with other policy areas	• Sustainability & resilience risks • Scarce clinical skills • Improving clinical outcomes • Collaborative approach adds value • Cost reduction	**Quaternary Clinical Services** • Complex clinical services • Low volumes of patients • Scarce clinical skills • High cost **Once for Scotland** • Single approach • System wide approaches add value • Clinical and non-clinical
Regional/ inter-regional	• Strategies need aligned to deliver policy	• Sustainabillity & resilience risks • Scarce clinical skills • Improving clinical outcomes • Collaborative approach adds value • Cost reduction	• Subsidiarity & proportionality • Regional approach • System wide approaches • Clinical and non-clinical • Equitable access an issue
Local	• Strategies need aligned to deliver policy	• Local operational service planning	• Most Services • Board/sub-board delivery

The Strategy and its Context
continued

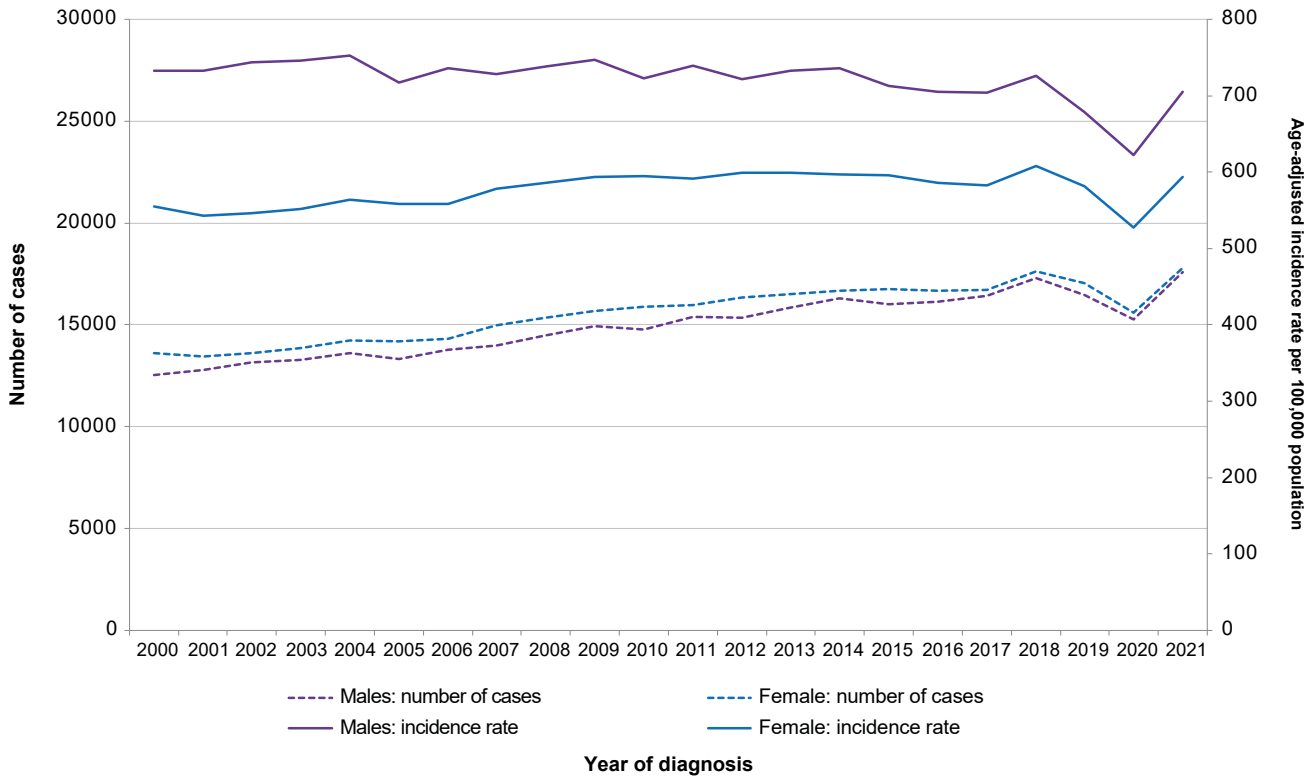
The Scottish Government will have oversight of overall strategic progress and direction of this strategy. The Scottish Cancer Strategic Board will 'own' the strategy and associated action plans, and review progress against them. Beyond this, ownership of actions and delivery will be undertaken as appropriate at national, regional and local levels. Collaboration and integration between health boards, including regional working and regional networks, will be vital in enabling this. Once for Scotland approaches will be a core principle to all our work. Where decisions and agreement on action, guidelines or service design is required at a national level for work that is universally applicable across Scotland, then it will be undertaken only once and not replicated at other levels. This will free up resources at regional and local level, avoid duplication of effort at a time when the service is particularly hard pressed, make for clearer future decision making, and support equitable access. However, many other aspects of delivery will be carried out at a local or regional level, reflecting local services, geographies, populations and the needs of the individual with cancer.

PHS publishes a wide range of statistics including cancer incidence, survival and mortality. These cancer statistics include analysis by tumour type, gender, age and deprivation.

Cancer Research UK (CRUK) publishes a wide range of important research.

2.1 Incidence

Cancer incidence in Scotland, 1997-2021. Number of cases and age-standardised incidence rate by sex.[8]



1. All cancers excluding non-melanoma skin cancers (ICD-10 C00-C97 excluding C44).
2. Age-adjusted incidence rates per 100,000 population, calculated using the 2013 European Standard Population.

There were 35,379 new cancers registered in Scotland (17,600 male; 17,779 female) in 2021 (an increase of 5.5% compared with 2019). This is in-line with a long-term trend of increasing number of cancer diagnoses over time. The rate, or risk, of new cancers also increased to 644 per 100,000 (an increase of 3.1% compared with 2019) and was higher than expected from the long-term trend. These statistics for 2020 and 2021 need to be seen in the context of the pandemic and will continue to be monitored closely.

The risk of all cancers (excluding non-melanoma skin cancers) has historically been higher in males than females. The gap has steadily decreased over time; it reached its lowest in

Cancer in Scotland
continued

2019 with a difference of 14.9% and slightly increased to 16.9% in 2021. To understand the implications of these trends over time, each cancer needs to be considered separately, alongside the contrasting patterns between the number and rate of cancer between the sexes.

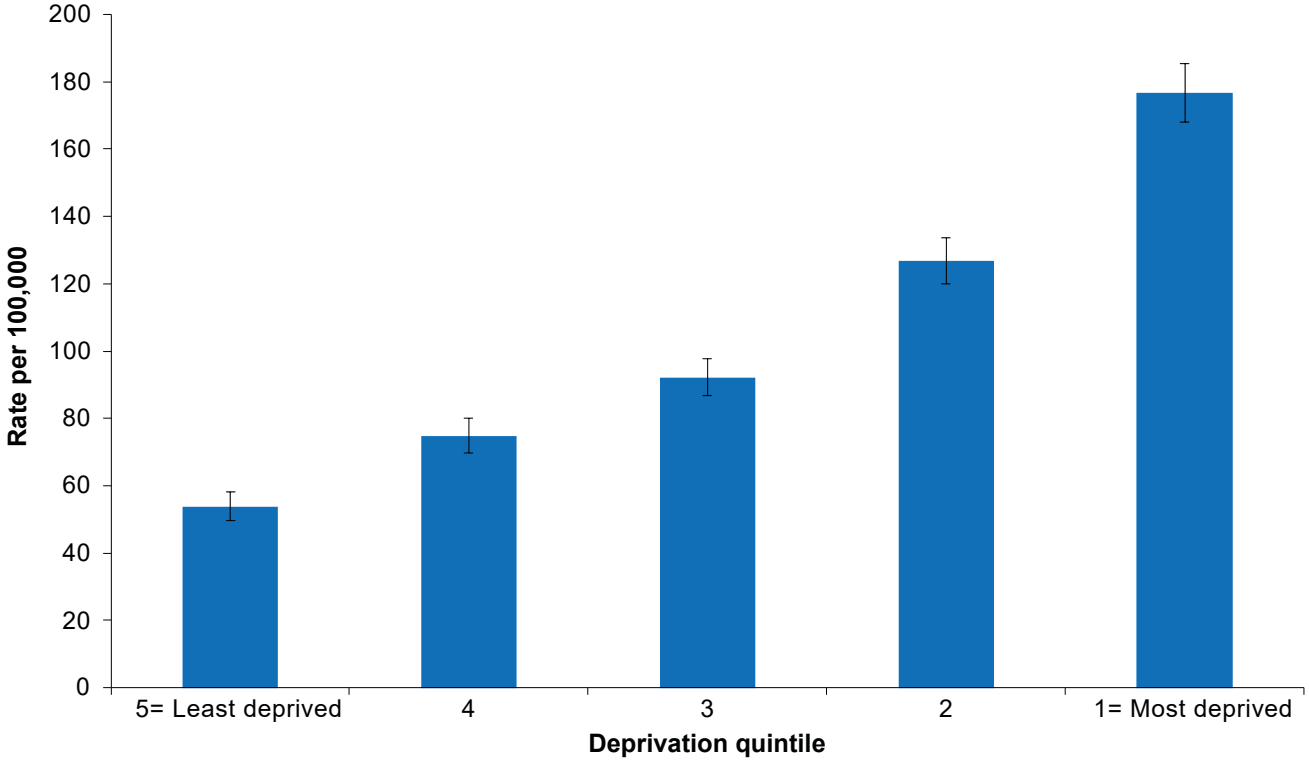
Lung cancer is the most common cancer, although breast and prostate cancers are the most common in females and males, respectively.

Data from 2021 show increased cancer risks for those living in the most deprived areas: a person living in the most deprived areas of Scotland is 30% more likely to develop cancer than one living in the least deprived areas, although this does vary by cancer type.

This overall pattern is strongly influenced by higher rates of smoking-related cancers in more deprived areas. For example, lung cancer is three times more common in the most deprived areas compared with the least deprived areas in Scotland.

When looking at cancer staging, the earlier a person is diagnosed with cancer, the more likely they are to have a good outcome. Four out of five breast cancers (78%) were diagnosed at an early stage (I or II). In contrast, two-thirds of lung cancers (66%) and more than two in five colorectal cancers (44%) were diagnosed at a late stage (Stage III or IV). There was convincing evidence that socio-economic deprivation increased the likelihood of being diagnosed with more advanced cancers of the cervix, breast in females, head and neck, and prostate.

Cancer of the trachea, bronchus and lung (ICD-10 C33-C34)
Age-standardised incidence rates by SIMD 2020 deprivation quintile, persons.[9]



Cancer in Scotland
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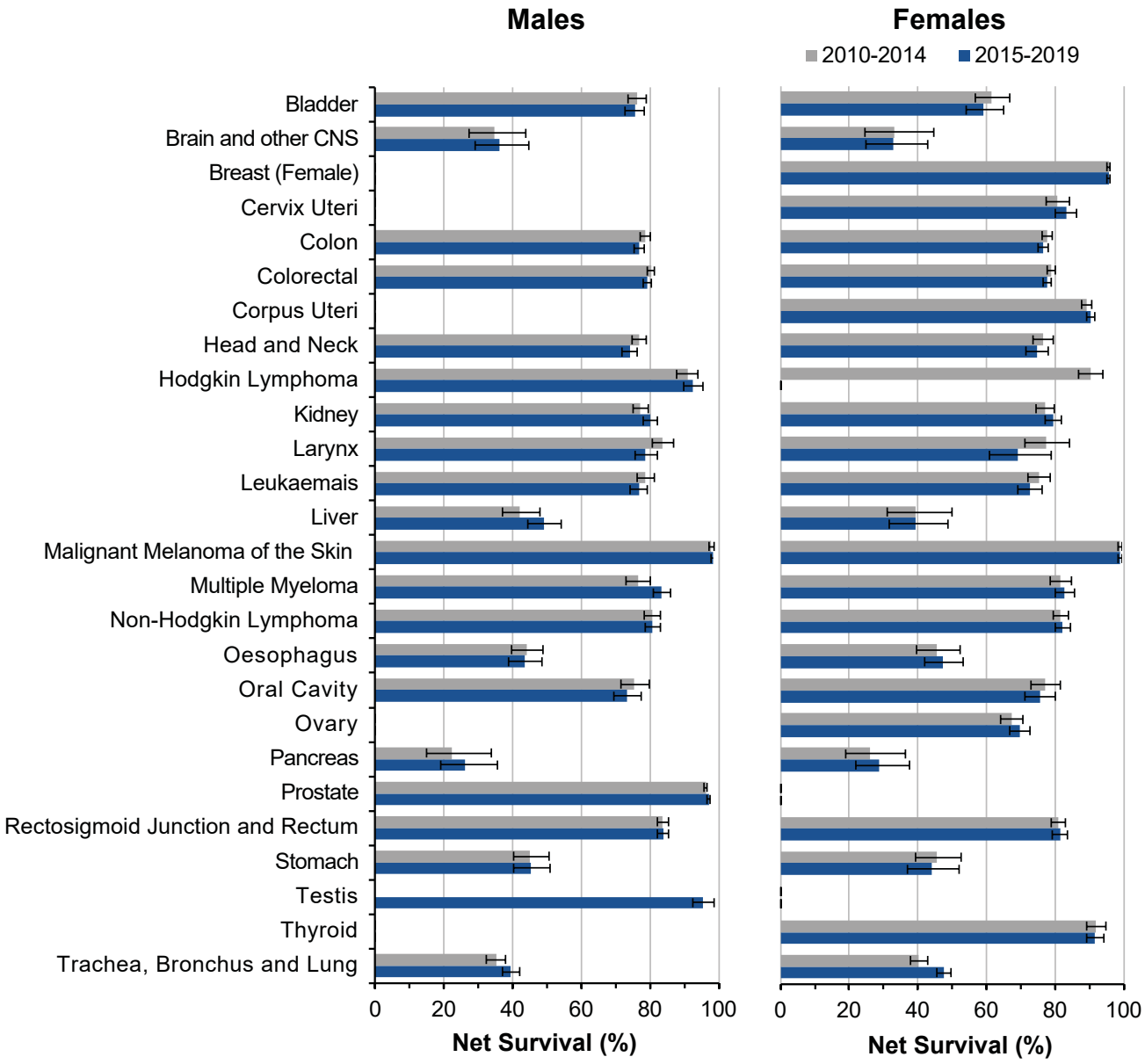
2.2 Survival

Age-standardised net survival at 1 year after diagnosis, for cancers diagnosed in Scotland during 2010-2014 or 2015-2019.[10]



Data published in 2022 allows us to look at both the 1-year and 5-year survival outcomes at the same time. Survival for all cancer patients combined (excluding non-melanoma skin cancers) improved, at both one and five years, between 2010-14 and 2015-19, by around two percentage points for males and one percentage point for females.

During the five-year period 2015-19, for adults who were diagnosed with

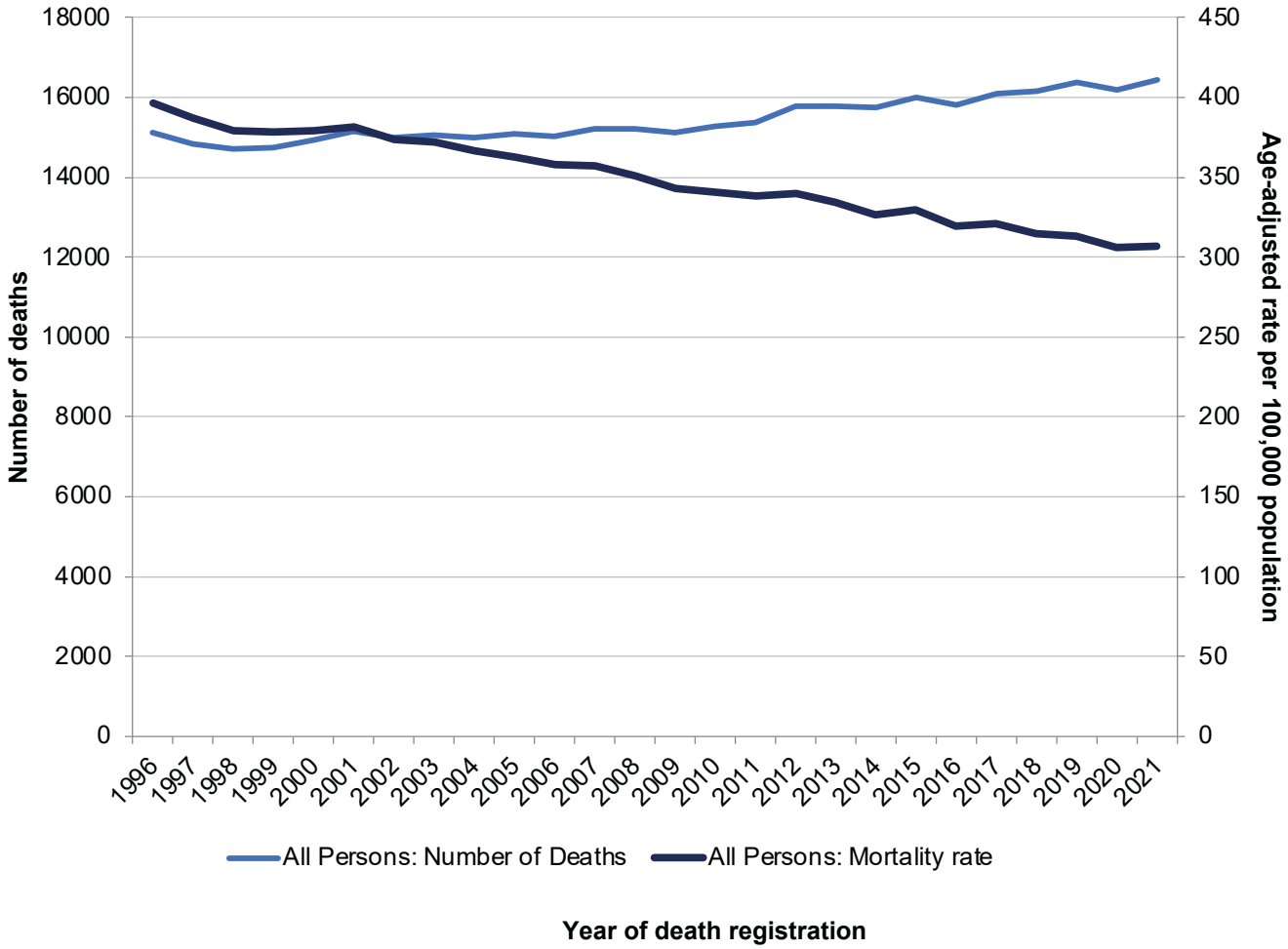
Cancer in Scotland
continued

cancer, two thirds of males (69%) and females (72%) survived for at least one year, while 2 in 5 males (44%) and 1 in 2 females (51%) survived for at least five years. This varies by cancer types, however, with 1-year survival ranging from around 20% to almost 100%.

Reasons for improved cancer survival include diagnosis at an earlier stage and use of more effective treatments.

2.3 Mortality

Cancer Mortality in Scotland, 1996-2021. Number of deaths and age-adjusted mortality rate.[11]



Cancer in Scotland
continued

Between 2012 and 2021, the overall risk of dying from cancer has decreased but the number of deaths due to cancer has increased over the same period. This largely reflects Scotland's aging population as the risk of developing cancer is more common among older people.

Between this 10 year period, the age-adjusted cancer mortality rate for all cancers combined decreased by 11%, with a greater decrease in males (14%) than in females (7%). The continuing decrease in cancer mortality rates is consistent with long-term trends. Therefore, it appears that the pandemic did not adversely impact cancer mortality rates in 2021.

Lung cancer was the most common cause of death from cancer in Scotland (3959 deaths in 2021). Almost a quarter of all deaths from cancer in Scotland were attributed to lung cancer, 45% more deaths than colorectal cancer, the next most common cause of death from cancer.

People living in the most deprived areas were 74% more likely to die from cancer, compared with the least deprived. The possible reasons for these patterns are complex and reflect modifiable and non-modifiable risk factors for developing cancer, uptake of screening, access to treatments and other health conditions.

2.4 Projections

Around 35,400 people are diagnosed with cancer in Scotland each year – more than 4 people every hour. Based on CRUK research, the number of cases is projected to rise by nearly one fifth, to around 42,100 new cases per year in 2040.[12] This would continue the long-term trend of an increasing number of cancer diagnoses over time.

3. Strategy Ambitions

3.1 Our Strategic Priorities

Our strategy will strengthen core elements of the cancer pathway while focussing on cross-cutting issues that will enable success. It will reflect value-based and Realistic Medicine, putting the person affected by cancer at the heart of our approach.

We aim to reduce inequalities across all our ambitions, strive for consistency through a Once for Scotland approach where appropriate, and ensure services are sustainable (in programmes, environmentally, and in resourcing).

The strategy aims to anticipate and reflect the changes over the next 10 years expected in cancer incidence, most common types, treatment options including more precision medicine (where treatment reflects people's genes), and how our health systems diagnose and treat cancer.

We will focus on cancer types that are the largest burden and have worse outcomes. These include lung and other less-survivable cancers (brain, liver, oesophagus, pancreas, stomach) that have seen very little progress in the last five decades. Lung cancer remains Scotland's single biggest cause of cancer mortality and continued focus and action to address this are paramount.

A focus on lung cancer

Lung cancer is the single biggest cause of cancer mortality in Scotland and will require the focus applied to it in the National Cancer Plan 2020 to continue with vigour in the long term. Improved survival will require leadership, prioritisation, resourcing and strong action. The required actions will be set out in each action plan accompanying this strategy and include preventative measures such as smoking cessation services and robust tobacco control; earlier and faster diagnosis, including targeted screening and delivering Scotland's optimal diagnostic pathway; access to specialist treatment; and ongoing research, investment in innovation and further data and intelligence gathering.

Strategy Ambitions
continued

3.2 Our Strategic Aims

To meet our strategic aim of improved cancer survival and providing excellent, equitably accessible care, we have set out eleven ambitions addressing both cross-cutting and cancer pathway priorities, describing our 10-year vision for each. Our eleven priority ambitions are presented without hierarchy:

Pathway

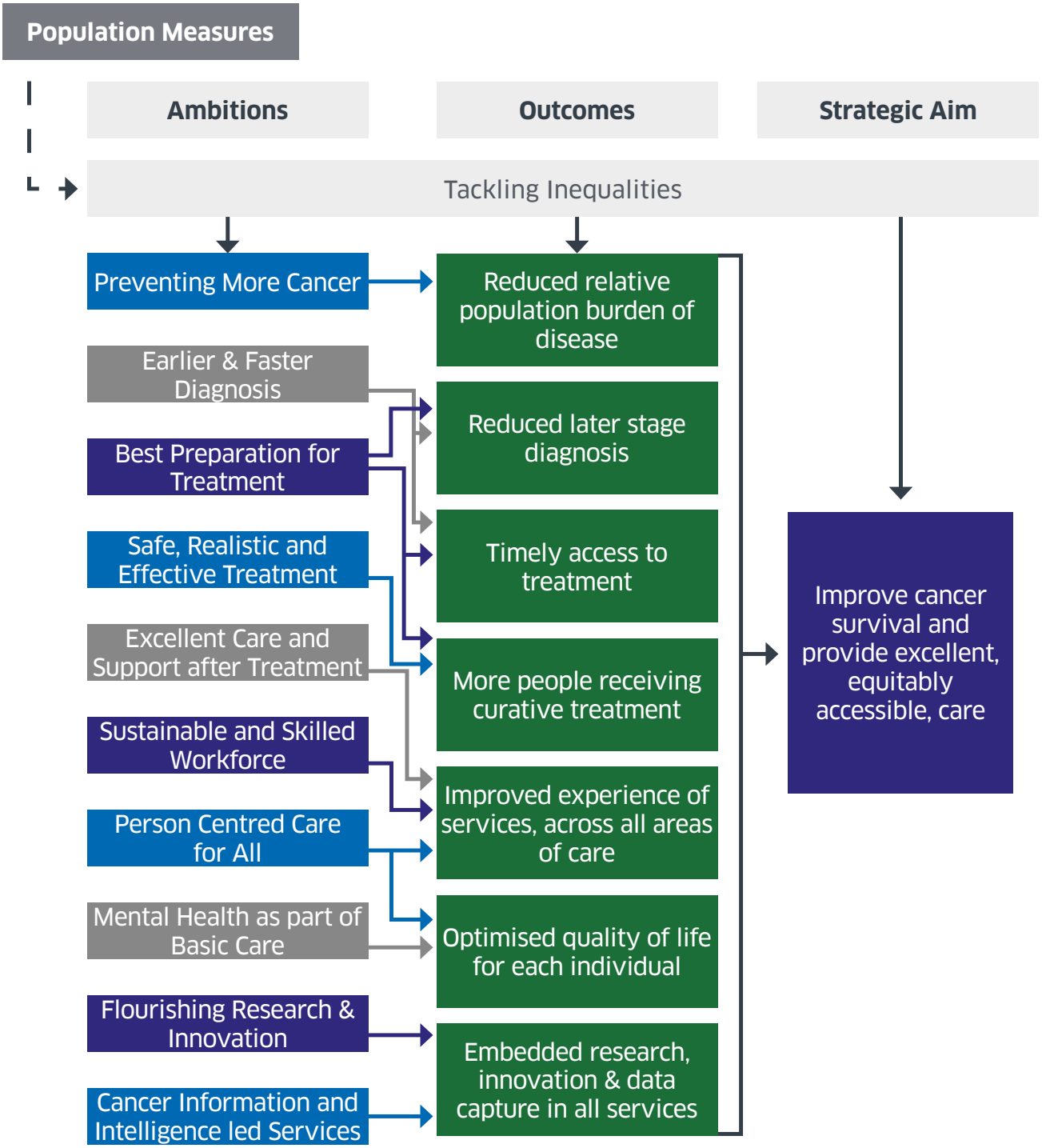
1. Preventing More Cancers
2. Earlier and Faster Diagnosis
3. Best Preparation for Treatment
4. Safe, Realistic and Effective Treatment
5. Excellent Care and Support after Treatment

Cross-cutting

6. Sustainable and Skilled Workforce
7. Person-Centred Care for All
8. Tackling Inequalities
9. Mental Health as part of Basic Care
10. Flourishing Research and Innovation
11. Cancer Information and Intelligence-led Services

Strategy Ambitions
continued

These ambitions relate to our vision and intended outcomes as follows (recognising that the relationship amongst the elements is far more complex than can be displayed in a diagram and that a number of elements are interconnected):



Strategy Ambitions
continued

In addition to an ambition on Cancer Information and Intelligence-led Services, under every other ambition we have included a box on 'Data for Success'. These are not intended to be comprehensive but to highlight the importance of data in determining priorities and in monitoring the implementation and outcomes of our ambitions and actions, including where we would like to do more such as addressing inequalities.

Strategy Ambitions
continued

3.3 Our Strategic Ambitions

Ambition 1: Preventing More Cancers

Our 10-year vision

Scotland is a place where the new generation of young people do not want to smoke. It is a place where everyone eats well and has a healthy weight, underpinned by a population that is more physically active. Alcohol is no longer a major cause of cancer. The incidence of preventable cancers, such as cervical cancer, is reduced.

This means that:

- We live in a Tobacco-Free Scotland, reducing smoking rates to below 5% by 2034
- We live in a Scotland where more people are more active more often, in line with our Active Scotland Outcomes Framework
- Diet-related health inequalities are significantly reduced, supported by the actions in our **2018 Diet and Healthy Weight Delivery Plan**, including legislation to restrict promotions of less healthy food and drink at the point of sale
- People have better informed health-seeking behaviour (know how, when and where to seek help)
- High HPV vaccination coverage is maintained for girls and boys.

Strategy Ambitions
continued

Successful implementation of evidence-based prevention strategies targeted at harmful health behaviours could prevent approximately 40% of cancers. Based on these estimates, around 13,000 Scotland cancer cases could be prevented each year.[13]

- Smoking is the most significant cause of preventable cancer in Scotland (18%).[14]
- Obesity is linked to around 2,200 cases of cancer a year in Scotland. Maintaining a healthy weight reduces the risk of 13 types of cancer, including breast, bowel and liver.[15]
- Physical activity is beneficial for the prevention of some cancers including breast, colon, endometrial, kidney, bladder, oesophageal, and stomach. Decreasing time spent sedentary may also lower the risk of endometrial, colon, and lung cancers. Physical activity before and after a diagnosis of breast, colorectal and prostate cancer is beneficial for survival outcomes.[16]
- There is a clear relationship between alcohol consumption and increased risk of developing certain cancers: in 2015, approximately 6.5% of deaths were attributable to alcohol consumption: 28% of these were from cancer.[17]
- There is strong evidence that physical activity before, during and after cancer treatment can reduce anxiety, depressive symptoms and fatigue, and improve health-related quality of life and physical function.

Reducing these risks, and their contribution to inequalities in cancer incidence, is being addressed through strategies and plans such as the **Tobacco Control Action Plan (2018),** (with a new one due to be published in 2023), the **Diet and Healthy Weight Delivery Plan (2018)** including support for families to make healthier choices; the **Active Scotland Delivery Plan** that supports work to reduce the risk of cancer and contributes to prehabilitation and rehabilitation; and the **Alcohol Framework 2018** that guides actions to reduce alcohol consumption, including increasing awareness of the link between alcohol and cancer.

Skin cancer is one of the most common cancers in the world. Excluding non-melanoma skin cancers (which are more common), malignant melanoma is the 5th most common cancer in Scotland with increasing rates, particularly in males.[18] Exposure to ultraviolet light from the sun is thought to cause most melanomas and non-melanoma skin cancer.[19] Prevention is through reducing exposure to ultraviolet light from the sun, artificial tanning sunbeds and sunlamps.

Strategy Ambitions
continued

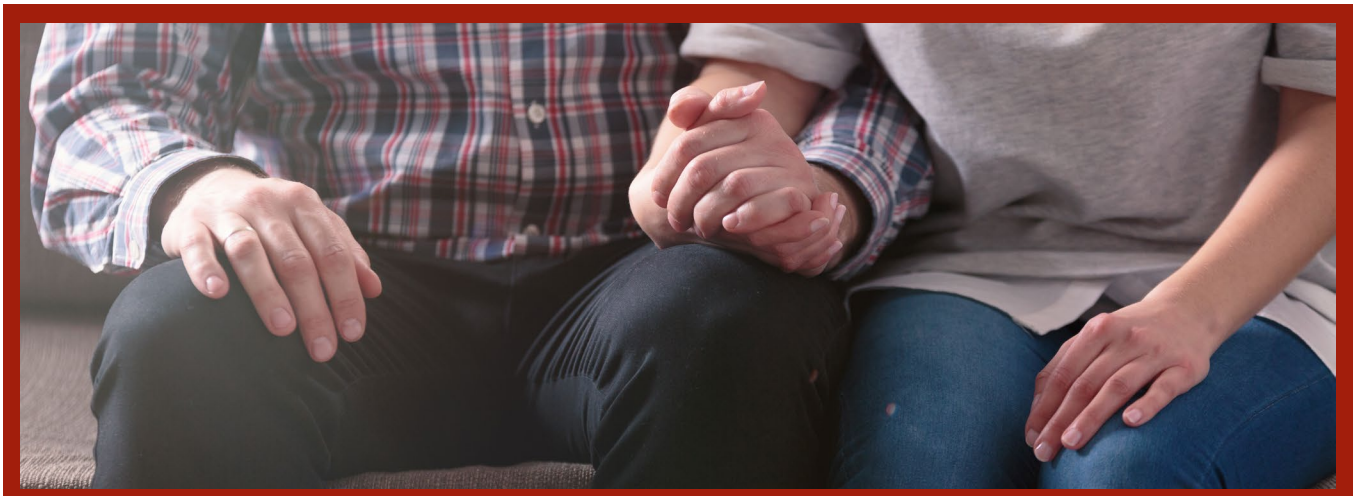
Primary cancer-specific prevention strategies include human papilloma virus (HPV) vaccination. HPV vaccination policy is based on recommendations from the Joint Committee on Vaccination and Immunisation (JCVI) and is being offered in Scotland to all girls and boys in the first year of secondary school. Evidence from England is that the vaccine reduces cervical cancer incidence by almost 90% in those who were vaccinated aged 12 to 13.[20] In Scotland, this equates to the prevention of around 450 cervical cancers and around 17,200 cases of precancerous conditions over an 11-year period.[21]

Secondary prevention of cancer means the early detection and treatment of disease before signs and symptoms are apparent – see also 'Optimise Screening' under Earlier and Faster Diagnosis Ambition.

Data for success

We will interpret health behaviour surveys and use data to better understand public health interventions that are likely to reduce cancer risks.

Strategy Ambitions
continued



Ambition 2: Earlier And Faster Diagnosis

Our 10-year vision

Later stage disease (stages III and IV) has reduced by 18 percentage points. A focus will remain on reducing the health inequality gap, particularly those from areas of deprivation.

Beyond preventing cancers, earlier and faster diagnosis plays the most fundamental role in cancer control. It is vital to further improve cancer survival rates in Scotland which, despite progress in the last 10 years, continue to lag behind international counterparts. This is particularly important for less survivable cancers. Those from areas of deprivation are often more likely to be diagnosed with cancer, particularly at a later stage, and are less likely to take part in screening when invited.

Currently around 42% of cancers are diagnosed at stage III and IV in Scotland, with variation amongst cancer types and socioeconomic groups.[22] Realising our vision would mean that 24% of cancers were diagnosed at stage III and IV in year 10. Based on the latest data available at the time of publication, this would mean around 5000 fewer people in Scotland diagnosed with later stage disease in year 10.

It is recognised that not all cancers can be conventionally staged so additional measurements, such as emergency presentations, will be required to track progress and improvements in other cancer types, including blood and neurological cancers.

There are challenges in meeting the two current cancer waiting times (CWT) standards in NHS Scotland. Latest published data (Q4 2022) show that 72% of people with cancer received first treatment within 62 days of an urgent suspicion of cancer (USC) referral, and 94% received first treatment within 31 days of a decision to treat being made.

We are now treating 36% more on the 62-day pathway than 10 years ago

Strategy Ambitions
continued

(4262 in Q4 2022 compared to 3144 in Q4 2012), and 18% more on the 31-day pathway (6757 in Q4 2022 compared to 5711 in Q4 2012). Embedding all eight key principles of the Effective Cancer Management: Framework (2021) will remain a priority for health boards' cancer management teams to diagnose cancer earlier and faster – improving waiting times performance, experience and outcomes for people with cancer.

Our response to the challenge of diagnosing cancer earlier and faster will require action in a range of areas through our national whole systems Detect Cancer Earlier (DCE) Programme, including:

Improve Public Education and Empowerment: Raise awareness of possible signs, symptoms and risk factors of cancer – tumour site and non-specific – to empower people to seek help in a timely manner. Break down engrained behaviours and attitudes including fear of cancer that can often act as a barrier to earlier diagnosis, with a focus on reducing the health inequality gap.

Support primary care: Primary care plays a pivotal role in the diagnosis of cancer. The vast majority of people with cancer will develop symptoms prior to diagnosis so it is imperative to continue to support primary care clinicians in identifying and appropriately referring those with a suspicion of cancer. That support must highlight the role of socio-economic and health inequalities in cancer and the implications of unmet need in relation to earlier diagnosis. Primary care has unique capacity to deliver prevention and early intervention. For example, many recommendations in the Primary Care Health Inequalities Short-Life Working Group: report (2022) should contribute to earlier and faster diagnosis for those at greatest need, especially by addressing unmet need and earlier, increased engagement with primary care by individuals who otherwise might not seek care and support.

Optimise Screening: Screening will continue to keep up with technological innovation and emerging clinical evidence to ensure the people of Scotland have access to the most effective screening tools possible, including taking forward recommendations from the UK National Screening Committee on targeted lung screening and exploring the use of self-sampling for cervical screening. It will be a responsive, person-centred system that facilitates equality of access and encourages uptake in all groups. To direct and support this work the first Equity in Screening Strategy has been produced by National Screening Oversight in collaboration with NHS and Third Sector partners and sets out a vision to achieve equity for all those eligible for screening. A whole system approach will be taken to ensure that reducing inequalities is recognised by all as a priority. Outcomes will include increased awareness and understanding of screening programmes, with targeted information for under-served groups. Health professionals across the screening programme will have a greater understanding of the reasons for inequalities in the system and effective ways to address them. A strategic approach will be taken to identify, address, and remove barriers to participants across the entire screening pathway. Data collection and

Strategy Ambitions
continued

presentation around inequalities will be improved, for example through the development of a Screening Intelligence Platform, to help target evidence-based interventions. Robust evaluation of actions will be undertaken to facilitate scaling up of effective interventions.

Enhance Diagnostics: The early diagnosis or exclusion of cancer is essential to reduce anxiety for people with cancer and their families as well as to guide clinical care. This requires timely access to the most appropriate and effective diagnostic tests, both in primary and secondary care. Further innovation and redesign of diagnostic services including diagnostic imaging, endoscopy, PET-CT and pathology will be required to facilitate timely access to tests as well as introducing new, effective diagnostic tests as they emerge. Oversight and governance are undergoing redesign with the planned launch of a Diagnostic Strategic Network, which will provide the strategic direction to ensure diagnostic services are equipped to support the recovery efforts and person-centred, sustainable and innovative future delivery. Ongoing delivery of the Endoscopy and Urology Diagnostic Recovery and Renewal Plan (2022) remains a priority.

Harness Data: Continuous improvement in the provision of timely, high-quality, transparent, and integrated data will enable an improved understanding of barriers to earlier diagnosis and variation (geographical, socio-economic, ethnicity and other equalities data). This includes having more timely staging data available for all stageable cancer types.

Invest in Innovation: Research and innovation have a key role to play in improving earlier diagnosis rates, such as biomarkers (including volatiles), artificial intelligence and multi-cancer early detection tests (MCEDs). Identifying promising research and developing a pipeline that enables innovations to be brought into NHS Scotland, to help diagnose cancer earlier and faster, will ensure improvements can be rolled out and embedded at pace. This will be supported by Chief Scientist Office and the SHIP, including the Scottish Cancer Consortium and the ANIA Pathway, and will require coordination across multiple partners, including industry and academia.

Data for success

We will measure progress through a number of sources, ensuring the inequality gap is narrowed throughout, including:

- Number of cancers diagnosed through unwarranted emergency presentations
- Cancer waiting times publications
- Independent qualitative data and insight to monitor public understanding of possible signs and symptoms of cancer
- Breakdown by Scottish Index of Multiple Derivation (SIMD) where possible

Strategy Ambitions
continued

The importance of a Rapid Diagnosis

An interim evaluation of the Rapid Dagnostic Service carried out by the University of Strathclyde found that **the one-to-one contact with dedicated healthcare staff and the timeliness of cancer or non-cancer diagnosis are particularly valued. In consequence, overall patient satisfaction with the new service is high. Patient safety and clinical effectiveness (not least in terms of cancers detected) appears to be good.**

As a user of the service said:
"It was like a whirlwind, not of destruction/confusion, but reassurance and comfort. Everything happened quickly, in a very organised way, giving me confidence that the people who would be caring for me knew what they were doing and would be there for me."

Strategy Ambitions
continued

Ambition 3: Best Preparation For Treatment ("Pre-Treatment")

Our 10-year vision

Every person diagnosed with cancer in Scotland is provided with timely, effective and individualised care to best prepare them for treatment. This begins with prehabilitation and holistic needs assessment, and continues throughout the individual's pathway of care, including appropriate follow up. A comprehensive range of cancer genomic tests is available to all those who could benefit.

Pre-treatment encompasses the stage between the point of diagnosis and the initiation of treatment. Additional information and support from the point of suspicion of cancer can improve overall experience, reduce anxiety and, in some instances, positively impact overall outcomes. Shared decision making, holistic needs assessments, information provision and signposting should be considered from the earliest point.

Collaborative working across health, care and third sectors enables early identification and access to the care and support that suits an individual's needs at the time that is right for them. Our partnership with Macmillan, and "Improving the Cancer Journey" will continue over the next 10 years to achieve future sustainability within the Health and Social Care Partnerships and Local Authorities. This programme alongside other initiatives like the Single Point of Contact optimise collaborative working. We will work with the Scottish Cancer Coalition and other relevant partners to ensure an accessible directory of support services is available for everyone affected by cancer in Scotland.

Strategy Ambitions
continued

Prehabilitation prepares people for cancer treatment and includes exercise, nutrition, psychological support, and assistance with alcohol and tobacco reduction/avoidance. It aims to improve quality of life, maximise treatment rates and minimise side effects of treatment. It should be delivered as outlined in the Key Principles – Prehabilitation for Scotland. Holistic needs assessments should be used to identify the concerns that a person with cancer has and to understand their needs. This should inform the development of a personalised care and support plan, that addresses current needs and is anticipatory for the future. That will ensure the right information is shared at the right time, and that people with cancer are signposted to relevant services.

Advances in genomic medicine should also be used to help clinicians deliver precision medicine and ensure that people with cancer receive the most appropriate treatment and avoid unnecessary side-effects. The Scottish Genomic Test Directories already include a range of genetic tests for cancer treatments, with further development of these directories anticipated in the coming years.

Data for success

We will use qualitative and quantitative data to measure experiential, clinical and system-level outcomes.

We will map prehabilitation programmes and develop a minimum dataset.

We will monitor the uptake of the Improving the Cancer Journey initiative and the number of holistic needs assessments conducted.

Strategy Ambitions
continued

The Value of Prehabilitation (Prehab)

Having never been to Maggie's before, Ian was referred by his oncologist before starting his treatment for oesophageal cancer. At that time, he felt a bit anxious and in limbo with regards to treatment, as surgery depended on chemotherapy working well. However, he was glad to receive reliable information about his role in recovery and improving treatment outcomes. As a result, Ian felt more confident managing his physical health, emotional wellbeing, and diet and nutrition. He also found it comforting to hear about another person's experience – including the ups and downs – of treatment for oesophageal cancer.

Since the prehab workshop, Ian has been back to Maggie's on multiple occasions, as have several family members who wanted to provide support to Ian and access support...

... for themselves. As Ian is now approaching his surgery, he revisits the information and techniques he's learned.

"You think, you know, I'm going for an operation here, what do I need to look at specifically for my operation? I need to keep my fitness up. I need my mindset right."

Of Prehab at Maggie's, he says: **"... It's quite strange how well Prehab fits with Maggie's... if you look at the main aspects that come out of the Prehab course in particular, every single one of your learning outcomes is something that's taught, or supported, or part of the main Maggie's ethos, in a way. It's in your curriculum. It's naturally there."**

Strategy Ambitions
continued

Ambition 4: Safe, Realistic And Effective Treatment

Our 10-year vision

All people with cancer have equitable access to treatments, with minimal variation in care. Where someone's cancer can potentially be cured, they have access to the best available treatment to achieve this. Pathways benefit from new technologies and tests allowing earlier treatment and leading to better outcomes. The Scottish Cancer Network is at the centre of this work, developing national clinical management pathways for all people with cancer.

Safe and effective treatments are critical to improving outcomes for each person with cancer and improving overall quality of life. Cancer care encompasses various treatment methods, broadly surgery, radiotherapy and systemic anti-cancer treatment (SACT) – dependent on an individual's precise diagnosis. The management of an individual's cancer may not involve any of these treatments, where that has been decided between the individual and their clinical team.

Surgery remains the single most effective treatment for solid tumour cancers. People requiring cancer surgery are increasingly benefiting from treatment in specialist centres, by teams who frequently perform a particularly complex operation and gain experience and expertise in doing so. We require service providers to collaborate and integrate regionally and nationally to ensure we maximise the potential for the most skilled and knowledgeable surgeons. Evidence shows this approach leads to better clinical outcomes for people with cancer, as well as fewer complications and less time in hospital. People with cancer requiring complex operations are usually very receptive

Strategy Ambitions
continued

to being treated by highly specialist teams, even where it involves increased travel, but it is crucial that they are appropriately supported in doing so (practically, financially and emotionally as required). Robotic assisted surgery makes significantly smaller incisions than required for traditional surgery, reducing the risk of complications, shortening recovery times and allowing hospitals to treat more patients. This will become routinely available for a wider range of operations throughout Scotland, facilitated by greater integration of services and regional working.

Radiotherapy is received by 40% of all people with cancer who are cured.[23] The National Radiotherapy Plan (2022) outlines 13 key actions to ensure that Scotland continues to have a world-class radiotherapy service. We will continue to roll out advanced treatment, including Stereotactic Ablative Radiotherapy (SABR) to those who would benefit, maximise the potential of Artificial Intelligence (AI) to support treatment planning, and agree national protocols and approaches to hypofractionation. We will continue to assess current evidence on the use of photons and proton beams and develop a long-term view of patient access to proton therapy.

SACT encompasses the treatment of cancer with chemotherapy and immunotherapy drugs. Both have the potential to cure some cancers (and can be used in combination with surgery and radiotherapy to improve outcomes) as well as providing disease and symptom control and extension of survival. Cancer medicines account for the highest proportion of new medicines introduced within NHS Scotland each year, with a fast rate of growth in their availability, a high risk of side effects and associated high costs. The pressure on SACT services to deliver these new medicines continues to increase. The number of patients receiving SACT has seen a steady increase over the last few years. In comparison, the increase in patient appointments has seen an even sharper increase over the same time period.[24]

The Scottish Medicines Consortium (SMC) is the national source of advice on the clinical and cost-effectiveness of all newly licensed medicines for NHS Scotland. The National Cancer Medicines Advisory Group (NCMAG) was established to improve equity of access to safe and effective off-label and off-patent uses of cancer medicines (i.e. used outwith their licence) through provision of national advice for cancer medicines not covered by the remit of the SMC. The work of NCMAG will continue, alongside the SMC, to improve medicines access. Alongside this there will be a renewed focus on SACT services to support sustainable delivery with appropriately increased resource. Allied to SACT delivery, and in order to maximise the opportunities of precision medicine, we aim to offer comprehensive genomic tests to appropriate people with cancer at an earlier stage in their clinical pathway.

The Cancer Medicines Outcome Programme (CMOP) helps assess the ongoing safety, effectiveness and value of cancer medicines (including off-label)

Strategy Ambitions
continued

in Scotland. Alignment of CMOP with the Scottish Medicines Consortium, National Cancer Medicines Advisory Group and the Scottish Cancer Network will ensure national cancer medicines intelligence informs clinical practice and enhances person-centred care.

There will be an ongoing need for services for people with cancer who develop an acute cancer-related illness presenting in an emergency setting or acute complications from ongoing treatments. The Acute Oncology Service (AOS) in NHS Scotland: Principles (2022) document will guide the development of new models to provide people with cancer requiring emergency care a direct route to cancer services.

Underpinning all cancer treatment is patient safety. All services in the NHS will be delivered in ways that take into account the Scottish Patient Safety Programme and meet the obligations set out under legislation, such as the Patient Rights (Scotland) Act 2011 (legislation.gov.uk) organisational duty of candour.

Data for success

We will continue to measure the number of patients receiving SACT and radiotherapy to monitor workloads, demands and requirements.

We will better measure cancer surgery workload.

We will measure outcomes through patient experience and outcome surveys as well as through the CMOP.

We will better monitor the introduction of new cancer medicines and their impact on the health service to help guide the introduction of new medicines.

We will disaggregate data as much as possible by ethnicity and equality characteristics.

Strategy Ambitions
continued

Ambition 5: Excellent Care And Support After Treatment

Our 10-year vision

Personalised support and care post-treatment are core considerations in cancer management pathways: this includes rehabilitation, early detection of recurrence, and supportive and palliative care. People affected by cancer are informed and supported to adequately manage side effects of treatment with the appropriate tools, including an electronic treatment summary.

All individuals requiring rehabilitation have access to meaningful, person-centred rehabilitation that will support them to live well and support a good quality of life, regardless of their stage on the cancer pathway. Follow-up is standardised in the SCN's clinical management pathways, is evidence-based for each cancer type and individual (including secondary cancers) and covers patient-initiated requests for review. Every person with cancer in Scotland requiring palliative care receives well-coordinated, timely and high-quality care, including care around death. Bereavement support is provided for families and carers based on their needs and preferences.

Strategy Ambitions
continued

Treatment, even with curative intent, is not always the end of care. Some people may need continued support by the NHS and others, including the third sector, to maximise their quality of life. More people are living with cancer, and treatment can cause anticipated side effects and complications that have a significant impact. Supported self-management, rehabilitation, palliative and supportive care are therefore essential, along with consistent approaches to follow up, in line with individuals' clinical needs.

Good rehabilitation is part of the whole cancer pathway to support individuals to recover or adjust so that they achieve their full potential to live well with cancer. The **Once for Scotland Rehabilitation Approach (2022)** provides a framework for good rehabilitation that puts the individual at the centre and builds on the concept of Realistic Medicine to provide a personalised approach that is outcomes-focused and supported by a shared decision making process. Rehabilitation includes activities, interventions and information resources that support self-management and facilitate access to services that address growing or complex needs, from as early as possible through to after treatment. Rehabilitation has the potential to maximise quality and quantity of life whilst reducing disease burden.

Palliative care, care around death, bereavement care, and support for carers are integral parts of the cancer journey experienced by people and their families. Palliative care includes anticipatory care planning, early supportive and palliative care in parallel with cancer treatment, symptom management, and specialist palliative care. Palliative care is integrated across health boards, Health and Social Care Partnerships and the third sector, involving primary care, hospitals, hospice care, social care and family support. Our vision for palliative care will be reflected in a new Palliative and End of Life Care Strategy.

The importance of spiritual care and the role of spirituality for health and wellbeing is becoming better understood. Spiritual wellbeing enhances and integrates all other dimensions of health, including physical, mental, emotional and social.

A Cancer Treatment Summary is a document produced by secondary cancer care professionals in collaboration with a person with cancer, for them and their GP practice. It provides information including possible treatment toxicities, side effects and consequences of treatment, signs and symptoms of a recurrence, and any actions for primary care. By co-producing and keeping a copy, the summary is also designed to support patient self-management, guide decision making, improve a sense of control, and reduce anxiety that can be particularly associated with end of treatment.

Collaborative working across health, care and the third sector can enable early identification and access to the care and support that suits an individual's needs at the time that is right for them. Cancer Patient Experience Surveys (CPES) carried out

Strategy Ambitions
continued

in Scotland indicate that this process is not universally experienced, and many feel inadequately supported following treatment. We will optimise collaborative working, meet holistic needs and improve quality of life by embedding rehabilitation and treatment summaries in cancer pathways, regularly re-assessing needs and sharing proactive care planning.

Data for success

We will measure accessibility to a broad range of tailored rehabilitation services that are outcomes-focused and centre on the individual.

We will explore how best to measure quality of palliative care in cancer using validated outcome measures for service providers, patients and carers such as the Resolve toolkit, and the Carer Support Needs Assessment Tool Intervention.

Steven's* Story about Palliative Care

"Marie* had the back pain for months until she fell and ended up in hospital. That's when they found out it was breast cancer and it had gone to her bones and her liver too. Marie was 42 and Tom* just 10. But the tests were done fast, and we got an urgent appointment with the cancer specialist. The ward staff tried hard to control the pain but Marie got worse and confused too. They sent for the palliative care team which scared us, but the doctor explained that they work with other teams to help people like us and they did. New pain killers and letting us talk – about the medicines, the cancer, and everything else.

For two years, Marie did well with the different cancer treatments, got back to work and was her usual self. Then the cancer took off again. First in the lungs and then her brain. The cancer doctors did all they could. It was our district nurse who talked about hoping for the best but thinking about what would matter if Marie got worse. So hard for us to tell Tom, but his head teacher helped. The palliative care nurses worked with our GP to get on top of the breathlessness and headaches. Marie enjoyed the day hospice, and it gave me a break. We did struggle with making plans when we didn't know exactly what would happen or when, but it was worth it.

We had to go to the hospital once when Marie had a bad chest infection, and she got better. The palliative care team visited, and everyone worked hard to get us home. Marie's sister came, friends helped, and we had the nurses, home carers, and the GP too. It wasn't easy but we managed, and it was the right place for us. Tom is doing ok. I have friends I can talk to, and my boss has been great."

*not their real names

Strategy Ambitions
continued

Ambition 6: Sustainable And Skilled Workforce

Our 10-year vision

A sustainable, skilled workforce with attractive career choices and fair work, where all are respected, supported and valued, whether they work wholly or partly in cancer services.

Strategy Ambitions
continued

Our strategy aligns with the Health and Social Care: National Workforce Strategy (2022). Our workforce is central to implementing our vision and delivering a whole system approach to improving health and wellbeing outcomes. At every stage of the journey to improve cancer survival, we need appropriately skilled and supported health and social care staff.

Strengthening our workforce means addressing the workforce journey through five pillars: plan, attract, employ, train and nurture.

The cancer workforce comprises a wide range of healthcare professionals, some of whom are cancer specialists and some for whom cancer is a component of their job. The NHS workforce has faced significant pressures and sustained actions are required – from planning for and attracting into the workforce, through to support and development of staff, including their mental health and wellbeing. We will model cancer workforce requirements taking account of where and how people with cancer most often use services, including primary care, and how these change as service delivery evolves. We will continue to grow the number of training places to expand the workforce we need for our strategic ambitions. Trainee places will be located in line with greatest need and to ensure that career opportunities within Scotland are offered to those qualifying here.

Alongside this growth, it will be vital to make fundamental changes to how our workforce is best deployed, ensuring that all professionals are doing the work they are best placed to do while recognising some tasks may be undertaken more appropriately by others. Technological advances and digital solutions will change how our workforce operates and how people with cancer access services, for example, increased use of telemedicine (clinical care provided remotely).

It will be crucial to maximise the retention of our workforce, providing support for mental health and wellbeing, providing flexibility in roles as individuals approach retirement, and increasingly collaborating and integrating roles across departmental or Board boundaries. Job plans require capacity within them for continual professional development, research (where relevant), and governance.

Data for success

We will need granular cancer workforce data to be able to complete a workforce review in oncology. We also need an understanding of where people with cancer meet the health system and how this may evolve in order to develop workforce requirements.

We will model training and staffing requirements and measure retention and retirement data.

Strategy Ambitions
continued

Ambition 7: Person-Centred Care For All

Our 10-year vision

People with cancer are at the heart of all decisions and actions involving them. They are given the opportunity to co-design their own care plan, and information including a treatment summary is readily available. A single point of contact (SPOC) is at the centre of this. Where possible, diagnostic tests and treatment are situated close to home and travel to specialist care is fully supported, making use of the continued advancement in new technologies.

Value-based health care and Realistic Medicine mean outcomes are delivered through shared decision making and discussion about the potential benefits and harms of different treatment options, including the option to do nothing. This approach allows people to make an informed choice, as well as reducing waste and potential harm. Shared decision making and informed consent are fundamental to good practice: involving people in decisions about their care strengthens their ability to self-manage. In addition, evidence shows that they value their care more and experience less regret.

People with cancer have a potentially life-changing diagnosis and immediately become 'patients' that are served by a health system. The system and its staff need to treat and care for the individual person rather than the 'patient' or 'tumour', recognising each one's preferences and needs. There are four principles underpinning person-centred care that should be central to all cancer services:

Strategy Ambitions
continued

- **Dignity, compassion and respect** ensuring all interactions are founded on kindness and our shared humanity.
- **Personalised**
  - carefully listening to the things that matter most to people
  - setting personal goals about treatment, care and daily life
  - identifying personalised action or activities to help achieve personal goals.
- **Enabling**
  - providing information in a way that is meaningful and easy to understand
  - supporting people to make the right decisions based on the things that matter most to them
  - supporting people to undertake activities and actions to help them achieve their goals helping people to live well on their own terms.
- **Coordinated**
  - supports people to get support and treatment in a timely manner
  - enables collaboration between services and professionals
  - creates opportunities to combine interactions, for example through co-location.

A single point of contact (SPOC) has the potential to improve access to care and timely reporting of results; ease navigation through care pathways; improve communication and experience, shared decision making and patient-reported outcomes; and positively impact our workforce by releasing capacity to provide more proactive and expert care.

Getting It Right for Everyone (GIRFE) reflects similar values, providing a more personalised way to access help and support with a joined-up, coherent and consistent multi-agency approach. This will be a practice model across acute, community and social services going forward.

Strategy Ambitions
continued

Data for success

We will need to develop a concise framework that outlines the key structures and processes that support a person-centred approach. We will develop metrics that measure processes such as shared decision making, and whether a 'good' personal outcome was achieved throughout the cancer journey, including supportive and palliative care.

We will continue to use PROMs and will also use the person-centred measurement framework using quantitative and qualitative data to better understand quality of care from the perspective of the person with cancer and their family.

We will monitor the availability of a single point of contact and measure the optimal model of delivery to inform future practice.

The Importance of a Single Point of Contact

A person affected by cancer shared their experience anonymously via Care Option. They highlighted the need for a single point of contact and the impact it could have:

"I was expecting to receive an appointment for a routine CT scan, before my next oncology appointment. Waiting for appointments to come through the post is on my mind for weeks around the appointment time, as I never quite know when to expect the letter or when the appointment will be. Knowing that a scan is imminent also brings to mind the what if questions, such as what if something shows up this time and the cancer is active again? So it's an anxious time...

... I had to make 5 calls to 'strangers' to finally understand why I didn't have an appointment for my CT scan. I had to be on the ball and assertive. That's a big ask for many patients who may be too ill, or lack confidence to ask for what they need. It took 2 weeks to get a resolution. That's two weeks of worry and frustration for me, and 5 calls the NHS had to manage.

We need the Single Point of Contact to be rolled out to all cancer patients. How much nicer it would be to call one person, who might even be friendly and helpful, and be able to trust that they will look into the matter and update me. What a relief!"

Strategy Ambitions
continued

Ambition 8: Tackling Inequalities

Our 10-year vision

A reduction in inequality in cancer incidence, access to services, experience and outcomes.

'Inequalities' denotes differences between groups and 'inequities' denotes unjust differences between groups. Inequalities disadvantage people and limit their chance to live longer, healthier lives.[25] If services are not provided equitably (process) then inequalities will remain (outcome). Some inequalities in cancer are more associated with specific factors (such as poorer survival in the elderly compared to younger people with cancer) whereas others are more systemic. For example, there is approximately 20% poorer uptake of cancer screening in the most deprived areas compared to the least deprived; those living in the most deprived areas are three times more likely to develop lung cancer; cancer-related deaths are 74% higher in the most deprived population than the least deprived.[26]

Both specific and systemic aspects need to be addressed.

Additional factors such as sex, age and ethnicity can influence cancer risk, access to services and outcomes, and the relationship amongst them is complex. Reducing inequalities means applying a broad, societal approach as well as targeting specific actions to disadvantaged groups along the cancer pathway. Best Start, Bright Futures (2022) aims to reduce health inequalities in the long-term by reducing child poverty now.

Scotland's geography means there are particular challenges in providing equity of access to some rural and island communities. Improving the accessibility of services through the location of services and use of digital technology,

Strategy Ambitions
continued

providing transport, maintaining support structures, ensuring affordability and increased focus on cultural competence of services are all measures likely to reduce inequalities. Speciality outreach services can improve access and self-reported health.[27]

We will reduce inequities in access, experience and outcomes for individuals and groups experiencing socio-economic inequalities, racism and discrimination. We will do so by improving the way we collect and use data and evidence to monitor equity of access, experience and outcomes for marginalised and minoritised groups, and targeting action where it is needed most. In line with our commitments under the Race Equality Framework and Action Plan (2016-2030), the Expert Reference Group on Covid-19 and Ethnicity, and the Women's Health Plan, we will have a specific, early focus on improving outcomes for minority ethnic groups, women and people living in the most deprived areas of Scotland.

We will promote healthy living by reducing alcohol, tobacco and drug use while encouraging active and healthy living, which will reduce the risk of developing cancer and enhance treatment outcomes and survival, in those at highest risk (see Preventing More Cancers).

We will improve inclusive communication and outreach to people who may not access screening although they wish to. Targeted screening (for example, for lung cancer as recommended by the National Screening Committee in September 2022) and new methodologies (such as cervical smear self-sampling) will be explored, to help reduce the screening inequalities gap (see Earlier and Faster Diagnosis). Inequalities funding has been used to develop an intelligence platform bringing together data from each screening programme to help identify common trends and identify inequality. This work will be continued to help develop processes to reach people currently excluded, by identifying and removing barriers.

Disparities in access to diagnostic and treatment services will be improved using new technology that facilitates alternative siting of services and remote consultations (see Flourishing Research and Innovation). We will make sure that efforts to add more digital elements into the health system are proportionate to ensure that nobody is left behind, while meeting the expectations of those who want to interact in this way. People with cancer will not be disadvantaged by the cost of travel or loss of paid working days.

Primary care, and especially general practice, has unique capacity and coverage in our communities to address entrenched health inequalities, and we aim to maximise its potential. Good quality prevention and early intervention in primary care are key to reducing preventable ill health, including cancer.

There will be more equal access to anticipatory care planning, palliative care, care around death and bereavement support. We will improve access to research and clinical trials

Strategy Ambitions
continued

for minority ethnic people and those that are currently underrepresented in clinical trials.

By practising Realistic Medicine, NHS Scotland can ensure we deliver the right care in the right place, reduce waste and harm, and redirect resources to where they will add the most benefit. We will promote equity of access to care and utilise a whole system approach that puts people's needs at its heart. This is a vital step in reducing health inequalities.

Data for success

We will strengthen our ability to more closely monitor and to take action to address inequalities along the full cancer pathway.

We will better identify, monitor and address the healthcare needs, experiences, access and outcomes for marginalised and minority groups.

Strategy Ambitions
continued

Ambition 9: Mental Health As Part Of Basic Care

Our 10-year vision

Dependent on need, proactive and comprehensive psychological and mental health interventions and support are available and accessible, from those trained at informed to specialist practice types, to all people affected by cancer and their families.

People recently diagnosed with cancer, those receiving treatment, those who have completed treatment, those receiving palliative care and those who are caring for people with cancer all report that the emotional aspects of cancer can be some of the most challenging. The post-treatment phase can be a particularly volatile time for mental wellbeing, and in almost half of all cancer cases, emotional effects are cited as more difficult to cope with than physical and practical effects.[28]

People affected by cancer can be better equipped emotionally and psychologically to face the challenges that lie ahead with the right psychological and spiritual support in the right place, by the right person, at the right time. The psychological and spiritual needs of the individual vary by personal circumstances and characteristics as well as cancer type and how they present. Access should be equitable regardless of geographical or socio-economic factors, ethnicity, gender, disability or other equality characteristic. By delivering person-centred care and psychologically focused care, we can empower people with cancer and potentially reduce the sense of loss of control that is commonly associated with cancer and its treatment.

Strategy Ambitions
continued

The Psychological Therapies and Support Framework for People affected by Cancer provides service providers across Scotland with guidance to enable equitable and efficient access to psychological support, and a mechanism to monitor success and challenges at local, regional and national levels. A new Mental Health and Wellbeing Strategy for Scotland and a new National Specification for Psychological Therapies and Interventions will be published in 2023, which will recognise the mental health impacts on people of all ages affected by long term conditions including cancer. These tools should be embedded in all cancer care.

Data for success

We will measure and monitor mental health in established cancer care pathways.

We will measure mental health through qualitative experiential data.

We will identify waiting times for psychological care through the psychological therapies national waiting times standard and use indicators from the new National Specification for Psychological Therapies and Interventions once published.

Strategy Ambitions
continued

Ambition 10: Flourishing Research And Innovation

Our 10-year vision

Equitable access to clinical trials has become integral to the management of treatment options. Where relevant, health professionals have allocated research time, adequate laboratory support, and are working in partnership across academia, industry and the third sector. Qualitative and non-RCT research are providing relevant, quality evidence to inform best care. Routine cancer data are available to support this.

More complex molecular tests ensure people with cancer have access to a portfolio of precision oncology and clinical research. Laboratories have capacity to support research, including clinical trials.

New technologies are being used to strengthen the full cancer patient pathway, with alternative methods for consultations and information-sharing leading to greater choice and convenience for people with cancer. The application of artificial intelligence (AI) has grown. Multidisciplinary networks are making the best use of scientific and clinical expertise to translate innovation into clinical practice. Health boards make robust, evidence-based decisions based on Scottish Health Technologies Group (SHTG) advice, leading to improved outcomes and more efficient use of resources.

Strategy Ambitions
continued

Research and innovation are a core part of the NHS. They play a key role in improving earlier diagnosis rates (see Earlier and Faster Diagnosis), enabling people with cancer to access new treatments at an earlier stage and influencing health planning and policy. Public Health Scotland (PHS) facilitates research studies through centres and the electronic Data Research and Innovation Service (eDRIS). Strong links between research in cancer and related fields such as primary care, mental health and palliative care are important, including qualitative and non-RCT research.

We live in a time of extraordinary innovation in technology that provides opportunities to diagnose and treat people with cancer. These range from the genomics revolution in diagnostics and treatment, to advances in the use of AI, 5G, Internet of Things in healthcare through to the apps, tools and products that we now use in our everyday lives. Recent health service examples include the use of video appointments such as Near Me and the use of drones in supply chains.[29] In March 2022, we reached 1.5 million Near Me appointments across Scotland, saving an estimated 49 million travel miles for patient, families and staff.

Our approach to digital health will be guided by the Digital Healthcare Strategy (2021). The Digital Front Door work will be a key development for people interacting with health and social care services in Scotland.

The SHIP aims to strengthen Scotland's innovation activities in health and social care with a focus on early-stage innovation. The CfSD's ANIA Pathway aims to fast-track proven innovations into the healthcare frontline on a Once for Scotland basis, with an early focus on innovations for delivery of care in cancer. The SHTG in Healthcare Improvement Scotland provides evidence-informed advice on the use of health technologies. It works, as others, in partnership with NHS Local Board and Regional Test Bed infrastructure to ensure that products, services and processes developed are relevant and effective for NHS Scotland.

Data for success

We will need a standardised suite of performance measures for the clinical research community and simple key performance indicators for health boards.

Service data and patient outcome data is needed to monitor new technologies.

Strategy Ambitions
continued

Ambition 11: Cancer Information And Intelligence Led Services

Our 10-year vision

There is a more integrated cancer intelligence platform along the full cancer pathway. This creates a responsive system that efficiently supports data collection, retrieval and use for clinical management, surveillance, evidence generation and policy development, which is aligned to the move towards a single electronic health record. Quality Performance Indicators will be a key driver of an overall cancer services improvement agenda, aligning with optimal pathways and national clinical management pathways. Data collection and analysis of measures including PROMs (patient-reported outcome measures) and PREMs (patient-reported experience measures) are integrated into service provision to facilitate person-centred care and shared decision making. This means:

- Improved completeness, quality, timeliness and use of data (diagnostic, clinical, inequalities and experience) along the patient pathway.
- Data definitions are consistent across Scotland, the UK and beyond.
- The Cancer Medicines Outcome Programme (CMOP) is a national, world-leading cancer intelligence asset capable of recording and analysing real-world medicines use, and disease-specific outcomes data at patient and population levels.
- Data interpretation and utilisation skills are core for the cancer workforce. The

Strategy Ambitions
continued

workforce is prepared and delivering services with the most appropriate and advanced technologies (including virtual and asynchronous appointments).

- Systems used to support the delivery of cancer services continue to have information governance assurance, and cyber and data security at their core. By working with regulators and applying agreed standards, improved data infrastructure allows greater efficiency of clinical practice and knowledge flow, and data utilisation.

Cancer data capture and use should be seamless across all health and social care settings, make best use of technology, and provide timely intelligence to those who need it, along the full cancer pathway. Data are fundamental to understanding the whole system of cancer control and care. They support service delivery and redesign including person-centred decision making, and policy and planning. They are required for audit, quality improvement, research and primary prevention. PHS operates the Scottish Cancer Registry and Intelligence Service, collects Quality Performance Indictor Data as well as reporting on a range of audits and cancer services (see Appendix 2).

The Innovative Healthcare Delivery Programme (IHDP), in collaboration with PHS and NSS, has worked over the past seven years to transform access to cancer data in Scotland, with the aim of harnessing NHS Scotland's rich data assets to improve cancer patient outcomes. IHDP is now an integral part of PHS. New data sources have been added to the Scottish Cancer Registry as well as the creation of wrap-around intelligence services. The SCRIS project has catalysed many developments in the processing and supply of national cancer data, such as the national publication of SACT utilisation data during the pandemic to allow monitoring of recovery. SCRIS provides a secure, single point of entry to an increasing number of 'joined up' national cancer datasets and broad range cancer-related information. The datasets cover 17 cancer indicators, with work ongoing to obtain further ones such as lifestyle risk factors and selective primary care data; workforce planning; diagnostics and laboratory data; multidisciplinary team (MDT) data; rehabilitation data; patient-reported outcome measures (PROMs); and data relating to recurrence and secondary cancers. The new Cancer Intelligence Platform being developed by PHS and NSS will allow all these evolving data to be hosted and accessible in the years to come. Better co-ordination and joining up of the cancer data science community, including in analytical work, will ensure the most efficient use of resources across cancer services, supported by PHS.

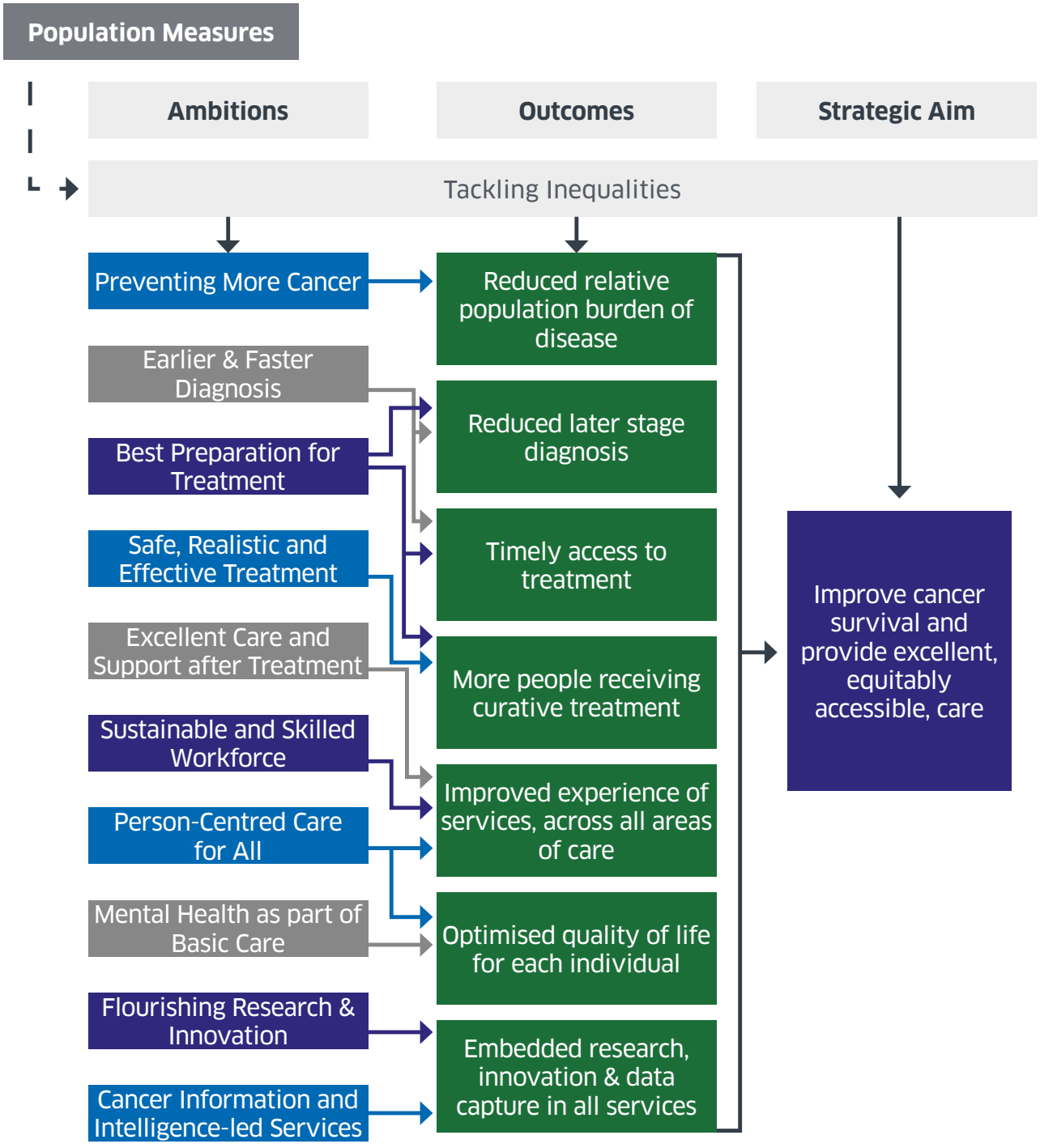
Strategy Ambitions
continued

The CMOP provides an opportunity for NHS Scotland to gather cancer medicines intelligence where there is uncertainty, about 'real world' outcomes (as opposed to those reported in clinical trials). This is done for both new and established medicines, from supporting the early health technology assessment phase of new medicines, through to the ongoing monitoring of medicines in routine use.

Quality Performance Indicators will be a key driver of an overall cancer services improvement agenda, aligning with optimal pathways and national clinical management pathways.

National Cancer Strategy 10-Year Outcomes Framework

An Outcomes Framework has been developed to identify the outcomes that matter as expressed through consultation and engagement with people affected by cancer. This Framework sets out the 11 cross-cutting ambitions that are anticipated to create change around seven key outcomes to achieve the strategic aim of improved cancer survival and excellent, equitably accessible care.



Appendix
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These seven outcomes that we expect to see at the end of 10 years connect with the overarching vision for the strategy:

More cancers are prevented, and our compassionate and consistent cancer service provides excellent treatment and support throughout the cancer journey, and improves outcomes and survival for people with cancer.

Key Principles for Evaluating the National Cancer Strategy

Evidence gathered through monitoring and evaluation will be required to assess how far the activities associated with the ambitions are progressing. A Monitoring and Evaluation Framework is being designed to cover the duration of this 10-year strategy. A strategic, evidence-based approach will assess progress towards the strategy's seven key outcomes via the 11 cross-cutting ambitions. The focus is on national (macro) level activities and how these are translated at NHS Board (meso) level to take a Once for Scotland approach to strive for consistent and sustainable services.

Given the system pressures in the NHS and economic pressure on public finance, the evaluation approach will be proportionate and connect with existing monitoring and evaluation activities in NHS Boards. It will focus on measuring actions that are fundamental to achieving the overarching vision. This includes attention to areas where less progress has been made, such as less survivable cancers, and ongoing inequalities in screening and diagnosis, as documented in the National Cancer Plan: Progress Report. It also requires attention to outcomes for people on Waiting Lists and for those who are referred for an Urgent Suspicion of Cancer, some of whom will start a cancer pathway but will not be diagnosed with cancer.

Developing high quality evidence is a fundamental principle underpinning guidance on policy evaluation as set out in The Magenta Book: Guidance for Evaluation. High quality evidence can increase our understanding of what works, maximise the chance of achieving the strategy's ambitions, and reduce delivery risk. Given the system pressures highlighted above, it will be important to use existing collection and analysis of routine datasets where possible to minimise the burden of reporting for NHS Boards. The evaluation will also use data already being gathered to support commitments in the National Cancer Plan (2020).

New evaluation activities will focus on analysing high priority data and addressing evidence gaps that can demonstrate the measurable contribution of the strategy to improving services, care and outcomes. The question of what is most significant to measure to understand success will be considered across all decisions about data and evidence. Evaluation will also engage with potential unintended consequences.

Appendix
continued

The success of the strategy will be judged on the realisation of the seven outcomes as evidenced through data and indicators. This will include quantifiable metrics for what is measurable. Qualitative data will capture evidence of experiences, why something works (or not), and the impact for people affected by cancer and the workforce. In prioritising analysis and evidence, evaluation will focus on new models of care or changes that involve significant investment, systemic change or risk.

Where gaps in evidence are identified, new data collection will be proportionate and focus on evidence that can satisfy us that progress is being made in relation to the outcomes as they connect with the strategic aim of the strategy. Consideration will be given to how any new data collection aligns with existing monitoring and surveillance requirements for other health care policies and strategies. This approach will support coordinated policy development across health conditions with the objective of delivering high quality services and care for people with cancer in Scotland.

Steps for Developing the Evaluation Framework

The work to develop an Evaluation Framework will be an iterative process that engages stakeholders in mapping out intended and potential unintended consequences of planned activities, and identifying how change can be measured using management information, research and evaluation. Stakeholders in this process include, NHS Planners, Regional Cancer Network Managers, Public Health Scotland and the Scottish Cancer Coalition. A working group of analysts, clinical advisors, managers, and planners and policy officials has been established to deliver this Evaluation Framework.

Theory of Change

'Theory of Change' describes how and why change is expected to happen and considers the evidence and assumptions underpinning the theory. It focuses on the bigger picture. A Theory of Change model will underpin the development of this Monitoring and Evaluation Framework, to understand how and why a desired change is expected to happen in a particular context. The Realistic Medicine Approach in Scotland recognises that health services alone cannot tackle all the factors that influence good population health. Therefore, evaluation activities will take account of this complexity as reflected in Guidance for Handling Complexity in Policy Evaluation.

A Logic Model can be created from a Theory of Change to map out the expected pathways or steps to realise the intended outcomes and the evidence required to demonstrate whether change has happened. A Logic Model specifies what goes in (Inputs), what is delivered (Activities), what comes out (Outputs) and what the results will be from these (Outcomes). While a Logic Model is by necessity a simplified graphic that sets out key inputs and activities that will contribute to outputs and outcomes, it is important

Appendix
continued

to recognise that pathways are not linear. With attention to inequalities across all aspects of the strategy, it will be important to understand variation within pathways for different groups of people and communities.

Mapping pathways to change will involve setting out the inputs, activities and outputs associated with the outcomes that will contribute to realising the strategy's aim. It will take time for evidence of progress to build. Therefore, outcomes will be considered in the short, medium and longer term. Short term outcomes of the 10-Year strategy will be linked to the first 3-year National Cancer Action Plan.

The following steps outline the approach that will be used to develop the Evaluation Framework:

- Setting out the short and medium term outcomes that will follow from the inputs, activities and outputs to contribute towards the long term outcomes.
- Identifying key indicators and evidence to track progress, assess whether outcomes are achieved and measure potential unintended consequences.
- Creating a visual 'Logic Model': a simplified schematic that demonstrates how inputs, activities and outputs relate to the anticipated outcomes and aim.
- Linking indicators and evidence to existing data sources, and identifying any significant gaps in evidence that are high priorities for new data collection or analysis.

This step-by-step process will involve working through the detail of how a change in outcomes is anticipated to happen in the short, medium and long term.

Definitions:

- Inputs: resources needed to deliver a programme of change (**what we invest**)
- Activities: actions required to produce the desired outcomes (**what we do**)
- Outputs: direct, tangible effects of activities that are delivered (**what we get**)
- Outcomes: desired results of this programme of change (**what we achieve**).

Appendix 2: Current Data Sources

Cancer Dataset	Source Organisation	Type
Patient and carer experiences of services	Care Opinion	Patient Experience/ Quality of Care
Focus groups	Health and Social Care Alliance Scotland	Patient Experience/ Quality of Care
Quality Performance Indicators (QPIs)	Healthcare Improvement Scotland (HIS) (Regional Cancer Networks, PHS, Scottish Cancer Network)	Patient Experience/ Quality of Care
Cancer Patient Experience Survey	Scottish Government	Patient Experience/ Quality of Care

Appendix
continued

Cancer Dataset	Source Organisation	Type
Scottish Cancer Registry Information on all new cancer cases in Scotland since 1958. Original source of most PHS cancer datasets. Breast Cancer Screening Bowel Cancer Screening Cancer Stage Distribution Cervical Cancer Screening Detect Cancer Early Staging Diagnosis Audit Diagnostic Waiting Times Cancer Waiting Times for confirmed cancers All Urgent Suspected Cancer referrals Incidence Mortality Survival Systemic Anti-Cancer Treatment (SACT) activity Waiting Times for Treatment Radiotherapy Rapid Cancer Diagnosis Service Barrett's Dataset Cytosponge Colon Capsule Endoscopy Endoscopy Surveillance Post-colonoscopy cancer rates – for symptomatic and screened bowel cancers Pathology data	Public Health Scotland (PHS)	Population/ Screening/Access/ Diagnosis/ Treatment/ Outcomes/Pathways Epidemiology of disease

Appendix 3: Development of the Strategy

The development of this new strategy began in the first quarter of 2022 looking at what the scope should be, in terms of breadth of topics as well as timelines. The vision and aims for the strategy were considered along with the principles that would underlie our strategic outlook. These early ideas were put out to consultation from April to June 2022 bringing in 257 responses from individuals and organisations including the general public, frontline workers and managers, the private sector and the third sector.

Analysis of these responses showed general agreement with what was proposed with additional suggestions.[30]

Recurrent themes were:

- **Ensuring equal access** – tackling unequal access driven by one's place of residence and socio-economic status
- **Prevention** – promoting healthier lifestyles and raising cancer awareness
- **Facilitating earlier diagnosis**
- **Person-centred approach** – placing the people with cancer and their cancer journey experiences at the centre of the new cancer strategy
- **Research and innovation** – respondents reflected repeatedly on the need to conduct more research so that innovative treatments and evidence-based approaches to care can be made available to people with cancer
- **Workforce support** – responses acknowledged the efforts and commitment of the workforce, but mentioned that the workforce needs greater support by;
  - recruiting more staff and professionals with expertise currently missing
  - providing the workforce with more training opportunities to improve skills
  - making provisions for the emotional support of staff in cancer care
- **Secondary, rare and less survivable cancers**
- **Survival** – improved survival has received large agreement as a key aim.

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We discussed these issues further at a series of roundtable focus groups over September and October, meeting with over 20 people with lived experience of cancer. We had regular engagement with the Third Sector through the Scottish Cancer Coalition and through two focus groups. These confirmed the main findings of the consultation but some new themes, issues and nuances emerged, which were taken into account in the drafting of the strategy.

Views of clinical and service providers were obtained through the public consultation and through regular engagement with our cancer networks, experts and governance groups.

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This publication is available at **www.gov.scot**

Any enquiries regarding this publication should be sent to us at
The Scottish Government
St Andrew's House
Edinburgh
EH1 3DG

ISBN: 978-1-80525-544-4

Published by The Scottish Government, June 2023

Produced for The Scottish Government by APS Group Scotland, 21 Tennant Street, Edinburgh EH6 5NA
PPDAS1246522 (06/23)

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Scottish Government
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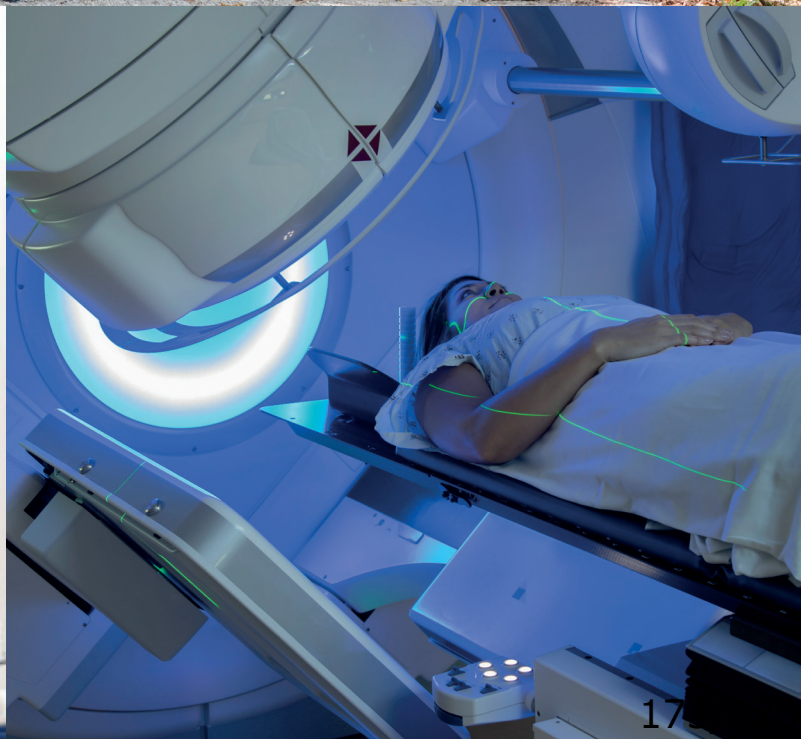
Cancer Action Plan for Scotland 2023-2026



Foreword from Cabinet Secretary for NHS Recovery, Health and Social Care

Cancer impacts us all, whether that is directly or through our family or friends. The Cancer Strategy for Scotland 2023-2033 sets out the vision and priorities of the Scottish Government for cancer over the next 10 years, with the aim to improve cancer survival and provide excellent, equitably accessible care to all. As we publish the strategy and this plan, the NHS is still under enormous pressure and so we must work through a recovery, renewal and redesign continuum over the ten years. In this initial three-year period of the strategy, success will be to **recover** and stabilise our systems and services, maintaining cancer as a priority, while the necessary recovery takes place in health systems and the wider economy.

We have developed a three-year action plan with realistic, focussed, financially prudent and achievable actions that will provide the foundation to put into place new, better and sustainable ways to deliver cancer services across Scotland. While cancer survival continues to improve across Scotland, more needs to be done and our Policy Prospectus includes a focus on improving cancer outcomes.

The strategy and plan have people living with cancer, their families and carers at their very heart, with a focus on reducing inequities in access to cancer care and cancer outcomes, recognising each person's time of need.

We look forward to working with our colleagues across NHS Scotland, and our third sector partners and their representatives on the Scottish Cancer Coalition and Less Survivable Cancer Taskforce to help implement the plan.

Michael Matheson, MSP
Cabinet Secretary for NHS Recovery, Health and Social Care

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1. Background

1.1 Context

This is the first of our action plans to accompany our 10-year Cancer Strategy for Scotland 2023-33. This plan sets out a range of actions linked to our overall strategic aim. The strategy describes the broader context of cancer in Scotland and necessary links with wider strategies.

The actions within reflect the breadth of our ambitions along and beyond the cancer pathway. This first three-year action plan 2023-2026 therefore includes actions indirectly impacting on cancer services, on which our success depends.

Cancer remains a clinical priority for the Scottish Government. Cancer survival continues to improve, but not at a satisfactory rate. Our strategic priority is to tackle this. Improving cancer survival means the number of people who have, or have had, cancer will continue to grow substantially in the coming decades, as mortality rates decline. There will also be an increasing number of people with cancer[i] due to the ageing population and Scotland's success in reducing mortality from other diseases. This will contribute to an increasing demand on the health service. Additionally, the volume of tests and treatment for each patient continues to increase, so it is vital that Realistic Medicine is embedded throughout our cancer services. People need holistic care and support throughout their cancer journey including palliative care and care around death.

Approximately 40% of cancers remain preventable[ii] with the biggest modifiable risk factors including smoking, obesity, physical activity and alcohol consumption. A clear focus and strong action will be required to address these.

As we publish this plan, the NHS is severely pressured as a result of the enormous impact of the COVID-19 pandemic and long-term challenges presented by the factors described above. Our priorities in this first 3-year action plan are therefore to **recover** and stabilise our systems and services, maintaining cancer as a priority while necessary recovery takes place in health systems and the wider economy.

Our plan is guided by broader strategies such as the NHS Recovery Plan (2021), Health and Social Care: National Workforce Strategy (2022), our Care and Wellbeing Portfolio and Digital Health and Care Strategy (2023), among others. It will link to the Re-mobilise, Recover, Re-design Framework (RRR) that was published on 31 May 2020, which set out the approach for Health Boards to safely and gradually prioritise the resumption of paused services.

In addition to working across strategies, we will be working with a number of key partners to deliver our strategic aims**.** The Scottish Cancer Network (SCN) will be at the heart of our ambitions, continuing at the forefront of defining, from diagnosis, clinical management pathways for cancer. This work will be underpinned by the Scottish Cancer Quality Programme, which will define and drive quality of care. The Centre for Sustainable Delivery (CfSD) will pioneer and deliver new, better and more

sustainable ways of delivering services including improving service access for people with cancer across Scotland.

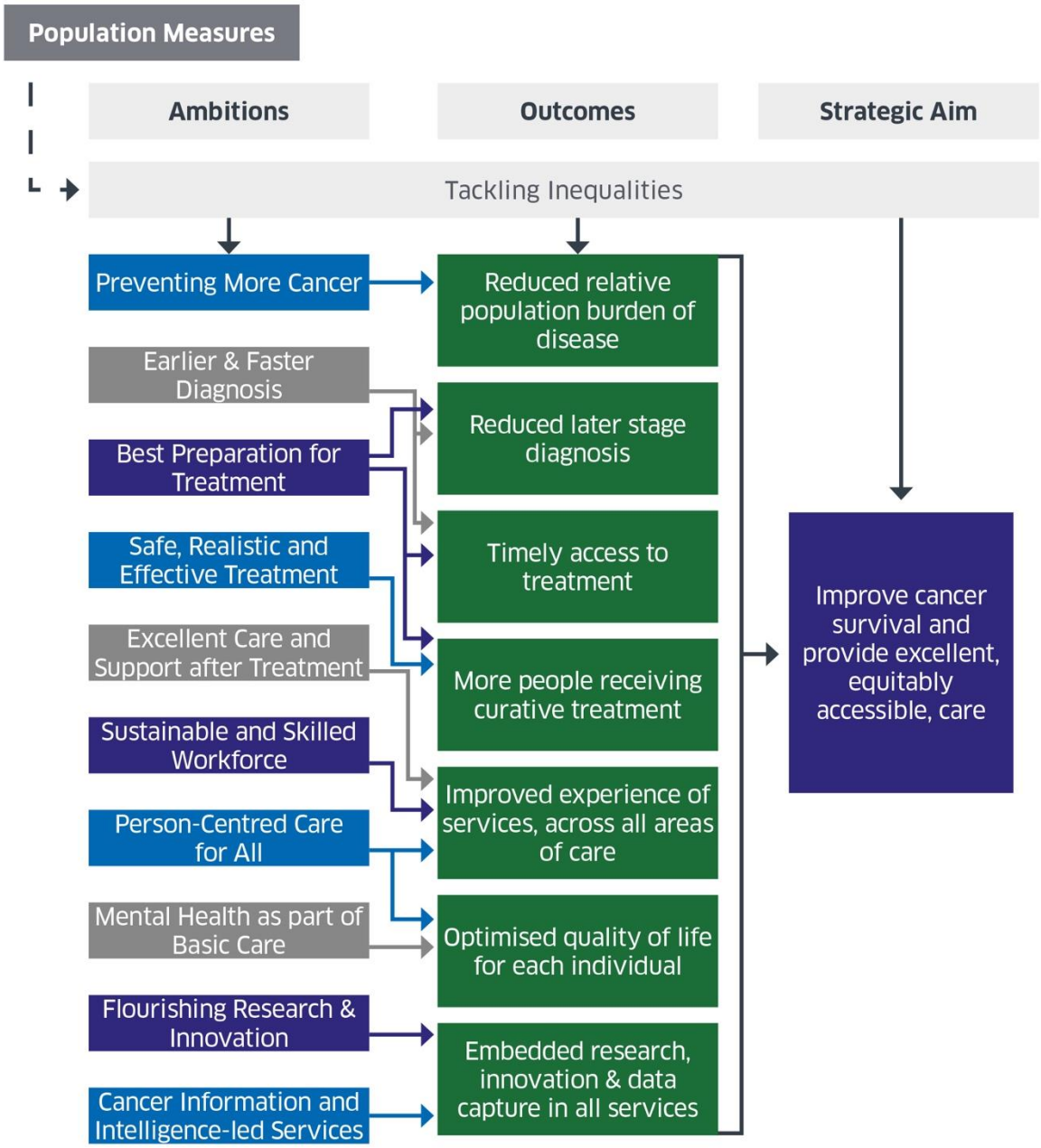
Evidence for this plan also comes from the National Cancer Plan: Progress Report (2022) that showed good progress in the four flagship actions (single point of contact, prehabilitation, rapid cancer diagnostic services (formerly Early Cancer Diagnostic Centres), and the Scottish Cancer Network), which will continue. There was progress in most other actions, with some delays due to the pressures COVID-19 continues to place on the health service and those working in it. Several actions are now completed, and a number will be taken forward here.

'What matters' to people with cancer must be reflected in our delivery. Evidence from people with cancer is that while clinical outcomes are clearly important, so too are treatment and care that reflect their personal preferences and what matters to them. Value-based health care and Realistic Medicine mean outcomes are delivered through shared decision-making and discussion about the potential benefits and harms of different treatment options, including the option to do nothing. This allows people to make an informed choice, as well as reducing waste and potential harm.

Person-centred care means putting people at the heart of what we do. We will continue to measure and act upon patient-reported experience and outcome measures, using tools such as Care Opinion and the Scottish Cancer Patient Experience Survey, while exploring new methods through collaboration with our third sector partners, such as the Scottish Cancer Coalition.

1.2 Our 10-year strategy

The Cancer Strategy for Scotland 2023-2033 sets out our vision and priorities for cancer over the next 10 years with the aim to **improve cancer survival and provide excellent, equitably accessible care.** It identifies associated outcomes and ambitions on how to reach them.



Our vision is that in 10 years time more cancers are prevented, and our compassionate and consistent cancer service provides excellent treatment and support throughout the cancer journey and improves outcomes and survival for people with cancer.

We have put people living with cancer and their families and carers at the centre of the strategy with a primary aim to reduce inequities in access to cancer care and in cancer outcomes. These are reflected in 11 priority areas that outline our ambitions:

Pathway

1. Preventing More Cancers
2. Earlier and Faster Diagnosis
3. Best Preparation for Treatment
4. Safe, Realistic and Effective treatment
5. Excellent Care and Support after Treatment

Cross-cutting

6. Sustainable and Skilled Workforce
7. Person-Centred Care for All
8. Tackling Inequalities
9. Mental Health as part of Basic Care
10. Flourishing Research and Innovation
11. Cancer Information and Intelligence led Services

Actions to tackle inequalities are addressed through each of the ambitions, for example reducing smoking rates among our most deprived communities; ensuring equitable direct access to imaging for primary care for those with non-specific symptoms suspicious of cancer; looking at where further use of robotic assisted surgery would be of most benefit; and undertaking novel analytical work to support a better understanding of survival, outcomes, demographics and inequalities.

We will focus on the cancer types that are the largest burden and have poorer survival. These include lung cancer and other less-survivable cancers (brain, liver, oesophagus, pancreas, stomach) that have seen very little progress in the last five decades. Lung cancer remains Scotland's single biggest cause of cancer mortality and continued focus and action to address this are paramount.

A focus on lung cancer

At the time of publication, lung cancer is the single biggest cause of cancer mortality in Scotland and will require the focus applied to it in the National Cancer Plan 2020 to continue with vigour in the long term. Improved survival will require leadership, prioritisation, resourcing and strong action. The required actions will be set out in each plan accompanying this strategy and include preventative measures such as smoking cessation services and robust tobacco control; earlier and faster diagnosis, including targeted screening and delivering Scotland's optimal diagnostic pathways; access to specialist treatment; and ongoing research, investment in innovation, and further data and intelligence gathering.

2. The Actions

2.1 Preventing More Cancers

Our 10-year vision is that Scotland is a place where the new generation of young people do not want to smoke. It is a place where everyone eats well and has a healthy weight, underpinned by a population that is more physically active. Alcohol is no longer a major cause of cancer. The incidence of preventable cancers, such as cervical cancer, is reduced.

Tobacco remains the single biggest preventable cause of cancer in Scotland. By March 2026 we will:

1. achieve further reductions in smoking rates due to ongoing implementation of comprehensive tobacco control measures in line with international best practice, particularly among our most deprived communities;
2. be making strong progress on our refreshed Tobacco Action Plan, due to be published in Autumn 2023; and
3. complete the implementation of recommendations from the Rapid Review of Smoking Cessation Services 2023

Maintaining a **healthy weight** can help to reduce the risk of cancer and increases the chances of positive outcomes. By taking the wide range of action set out in our Diet and Healthy Weight Delivery Plan (2018), we will seek to reduce diet-related health inequalities. This includes progressing legislation to restrict promotions of less healthy food and drink at the point of sale and developing proposals to strengthen outdoor advertising restrictions for food that is high in fat, sugar or salt.

Being **physically active** is one of the most important steps people of all ages and abilities can take for cancer prevention, treatment, and control. We support the WHO ambition to reduce physical inactivity by 15% by 2030. We will implement the Active Scotland Outcomes Framework that provides a common structure for the wide range of actions we are taking across transport, education, environment, health and sport sectors.

Alcohol as a risk factor for certain cancers remains a key challenge, particularly the development of liver disease and subsequent liver cancer. In taking action to prevent alcohol-related harms, we follow the international World Health Organisation recommended approach - these are known as the three A's – making alcohol less available, less affordable and less attractive. By March 2026 we will:

4. if our overall evaluation supports a continuation of minimum unit pricing (MUP) and a change in price, lay Orders in Parliament in late 2023 to continue MUP beyond the initial 6-year period and set a new unit price;
5. subject to the outcomes of a consultation on potential restrictions to alcohol advertising and promotion, develop more detailed proposals ensuring full consultation around these;
6. give consumers useful health information on product labels and discuss plans for calorie labelling on alcohol products; and
7. increase awareness of the link between cancer and alcohol through Scottish Health Action on Alcohol Problems.

Efforts to reduce incidence and survival of **cervical cancer** are on a positive trajectory, in most part due to the introduction of the HPV vaccine.

8. We will in 2023 introduce a one-dose schedule of the HPV vaccine, with high coverage maintained.
9. We will continue to take steps towards the World Health Organisation's targets to eliminate cervical cancer, and also progress work to address inequalities that population level targets would not.

2.2 Earlier and Faster Diagnosis

Our 10-year vision is that later stage disease (stages III and IV) has reduced by 18 percentage points. A focus will remain on reducing the health inequality gap, particularly those from areas of deprivation.

Finding and diagnosing cancer as early as possible has a key role to play in further improving cancer survival in Scotland which, despite progress in the last 10 years, continues to lag behind international counterparts. Ensuring NHS Scotland has a skilled and sustainable service model to support the full cancer pathway and delivery of the Earlier Diagnosis vision, is critical – **see 2.6 Sustainable and Skilled Workforce.**

In order to focus on the greatest need, we developed an evidence-based framework to determine where efforts should be focused over the next 10 years and 3-year action plans within. This included reviewing incidence, stage at diagnosis, deprivation and survival data along with the impact of Covid-19 and pathway pressures. This process concluded that the focus of the first 3-year action plan will be lung, head and neck and colorectal cancers, with the focus then shifting to other cancer types in future action plans.

Whilst applying focus to these areas across the initial 3-year action plan, we will also deliver improvements that will benefit all cancer types, including rarer cancers, throughout the lifespan of the cancer strategy, such as primary care cancer education and reviewing and updating the Scottish Referral Guidelines for Suspected Cancer.

The framework will be reviewed in line with development of the next 3-year action plan to reflect any emerging new evidence.

By March 2026 we will have delivered the following actions across several workstreams:

Improve Public Education and Empowerment

10. Activate targeted Detect Cancer Earlier (DCE) campaigns aimed at those from areas of deprivation.
11. Undertake continuous independent evaluation of DCE campaigns to ensure they deliver Key Performance Indicators (KPIs).
12. Review and develop DCE campaign assets to improve symptom awareness for all cancer types, including non-specific symptoms.
13. Expand the Detect Cancer Earlier Programme's website functionality and scope.
14. Support the Scottish Cancer Coalition's awareness-raising efforts.

Support Primary Care

15. Carry out a clinically led review of emerging and existing data to update the Scottish Referral Guidelines for Suspected Cancer.
16. Explore opportunities to develop algorithms/decision support tools to improve timely referral for patients with suspected cancer and facilitate adoption if benefits realised.

17. Offer a sustainable earlier detection of cancer education solution for NHS Scotland's primary care clinicians (GPs, trainee doctors, ANPs, pharmacists etc).
18. Explore the role of community pharmacists in earlier diagnosis efforts.
19. Identify people who are at high risk of poorer health, including cancer, yet have no or low use of health care, and encourage them to seek help at an earlier stage.
20. Support targeted actions in primary care to improve access to care and support for people who experience multiple inequalities and who are at high risk of cancer or who have cancer.

Optimise Screening

21. Modernise the breast screening programme, improving access and availability; optimising equipment in procurement and use; improving workforce understanding, satisfaction and processes; and streamlining and improving access to data.
22. Take forward the UK National Screening Committee (NSC) recommendation on targeted screening for adults aged 55–74 identified as being at high risk of lung cancer. This will be inclusive of the commissioning, building community engagement and formation of a multidisciplinary working group and governance structure to take forward key explorations highlighted in the recommendations: to set out pathways and milestones on a structured route to ensure an equitable launch and uptake.
23. Consider opportunities around self-sampling for cervical cancer screening in line with UK NSC guidance: ensuring due consideration of its risks; sharing knowledge and experience with other nations to ensure a learned and informed approach; and working across agencies to align systems and technology, promoting accurate reporting and monitoring processes.
24. Deliver the Equity in Screening Strategy's action plan to reduce screening inequalities for under-served groups, such as people living in socioeconomic deprivation, minority ethnic population groups including Gypsy Traveller communities, women, disabled and LGBTQ+ people, through targeted screening communication materials and engagement, easier access to the whole screening pathway, enhanced data collection and monitoring and prioritisation of inequalities at a whole system level.

Enhance Diagnostics

25. Expand and evaluate Rapid Cancer Diagnostic Services to ensure population-based coverage.
26. Deliver Scotland's Endoscopy and Urology Diagnostic Plan, which includes expanding the network of Urology Diagnostic Hubs and adoption of alternatives to traditional endoscopy (including colon-capsule endoscopy, transnasal endoscopy and Cytosponge).
27. Support implementation of Scotland's new optimal lung cancer diagnostic pathway.
28. Publish optimal diagnostic pathways for head and neck and colorectal cancers and monitor their implementation.
29. Support and contribute to the new Diagnostic Strategic Network.
30. Ensure equitable direct access to imaging for primary care, for those with non-specific symptoms suspicious of cancer.

31. Continue to invest and expand diagnostic services across NHS Scotland including workforce, for example, advanced practice and digital solutions such as digital pathology.

Invest in Innovation

32. Work with the Scottish Cancer Innovation Consortium to identify and prioritise new and emerging earlier diagnosis/detection technologies from innovation to implementation.
33. Support the Accelerated National Innovation Adoption (ANIA) collaborative to focus on fast-tracking the adoption of proven technological innovations across NHS Scotland, for example the use of Artificial Intelligence in reading chest x-rays for earlier diagnosis of lung cancer.
34. Work collaboratively with the third sector to drive service redesign efforts, including Cancer Research UK's Test, Evidence, Transition Programme that aims to accelerate the effective spread and adoption of innovative pathways, whilst working to reduce inequality in access to proven interventions.

Harness Data

35. Publish more timely staging data for additional cancer types, starting with head and neck cancers.
36. Routinely publish cancer diagnosis through emergency presentation data via PHS.
37. Publish validated urgent suspicion of cancer (USC) referral data via PHS.
38. Clarify any additional measurements for monitoring improvements in blood and neurological cancer pathways.
39. Improve the availability and quality of primary care cancer data to enable service improvement.
40. Improve availability of cancer diagnostic datasets.

Diagnose Faster

41. Support adoption of Once for Scotland clinical pathways developed by CfSD's specialty delivery groups.
42. Carry out a clinically led review of latest data and evidence and determine whether there is merit in specific additional or alternative cancer waiting times standards for different types of cancer and cancer treatment.
43. Review and support full adoption of the Framework for Effective Cancer Management including the Once for Scotland Cancer Regrading Framework and Effective Breach Analysis standard operating procedure.
44. Invest up to £30m to support cancer waiting times improvements.
45. Invest in improving the pathways of less survivable cancers, particularly hepatocellular carcinoma and pancreatic cancer. This will shorten the time to staging and agreeing treatment options.
46. Test and evaluate patient direct or rapid access to the USC pathway.

2.3 Best Preparation for Treatment ('Pre-treatment')

Our 10-year vision is every person diagnosed with cancer in Scotland is provided with timely, effective and individualised care to best prepare them for treatment. This begins with prehabilitation and holistic needs assessment and continues throughout the individual's pathway of care, including appropriate follow up. A comprehensive range of cancer genomic tests is available to all those who could benefit.

Pre-treatment encompasses the stage between the point of diagnosis and the initiation of treatment. Shared decision making, holistic needs assessments, information provision and signposting should be considered from the earliest point.

Prehabilitation is the first step in the rehabilitation continuum and includes exercise, nutrition, psychological support and assistance with alcohol and tobacco reduction/ avoidance. It aims to improve quality of life, maximise treatment rates and minimise side effects of treatment. It should be delivered applying a person-centred approach, as outlined in the Key Principles – Prehabilitation for Scotland.

By March 2026 we will:

47. Develop a partnership with CfSD that will explore the potential for digital innovation in supporting the delivery of prehabilitation and strengthen partnerships with existing stakeholders.
48. See a universal prehabilitation programme offered through each Maggie's centre in Scotland with an additional investment of up to £80,000 to ensure future sustainability. We will work with other willing providers to deliver a similar offer, ensuring nationwide coverage of face-to-face universal prehabilitation.
49. Review the impact of the Nutrition Framework for people affected by cancer and continue to develop tools that aid implementation and adequately assess the nutritional needs of people affected by cancer.
50. Work with the Scottish Cancer Network, Regional Cancer Networks, Macmillan Cancer Support and other key stakeholders to further test and embed successful prehabilitation approaches within both management guidelines and pathways of care, whilst also evidencing impact of outcomes.
51. Work with NHS Education Scotland to ensure the tools that support the development and delivery of high quality prehabilitation services are available and accessible to all staff working across Scotland.

Genomics

The adoption of new genomic technologies, tests and earlier treatment for individuals will lead to more precision medicine, more effective and potentially more cost-effective treatments with better outcomes. By March 2026 we will:

52. Develop the Scottish Strategic Network for Genomic Medicine (SSNGM) to act as a front door for genomic healthcare in Scotland and a means of linking together expertise across the NHS, academia and industry.

53. Publish a Genomics Strategy and Implementation Plan in 2023.
54. Continue to update the Scottish Genomic Test Directories and support standardised genomic cancer testing and treatment pathways.
55. Develop, in conjunction with the SSNGM, a plan for the expansion of genomic testing and the development of molecular tumour boards.

2.4 Safe, Realistic and Effective Treatment

Our 10-year vision is that all people with cancer have equitable access to treatments, with minimal variation in care. Where someone's cancer can potentially be cured, they have access to the best available treatment to achieve this. Pathways benefit from new technologies and tests allowing earlier treatment and leading to better outcomes. The Scottish Cancer Network is at the centre of this work, developing national clinical management pathways for all people with cancer.

Safe and effective treatments are critical to improving outcomes for each person with cancer, improving overall quality of life and survival. Cancer care encompasses various treatment methods dependent on an individual's precise diagnosis. Surgery is the single best treatment for solid tumour cancers. Radiotherapy is received by 40% of all people with cancer who are cured. Systemic anti-cancer therapy (SACT) encompasses the treatment of cancer with chemotherapy and immunotherapy drugs. The management of an individual's cancer may not involve any of these treatments, where that has been decided between the individual and their clinical team. The demand for SACT treatments is rising at a rate of around 10% annually, placing severe pressures on current services and their workforce. Financial investment and reform will both be vital to their sustainability.

The Scottish Cancer Network (SCN) will be at the heart of defining best practice for treatment and care. Its clinical management pathways will include guidance on follow up, high risk surveillance and best supportive care for specific cancer types. It will support greater national collaboration and agreement about treatment and care for all people with cancer in Scotland.

By March 2026 we will:

56. Invest up to £5 million into the Scottish Cancer Network, National Managed Clinical Networks and the Managed Service Network for Children and Young Adults.
57. Ensure clinical management pathways include guidance, where appropriate, on the minimum number of times any individual clinician should be providing any specific treatments each year to ensure best possible outcomes and safe, effective treatment.

Strengthen **surgical services** by:

58. Upskilling clinicians to access the new robots available for Robotic Assisted Surgery (RAS)
59. Work with the Robotic Assisted Surgery group to consider where further use of RAS would be of clinical benefit, or where other treatments would be more beneficial and practical.

Strengthen **radiotherapy** services by:

60. Delivering the 13 actions in our National Radiotherapy Plan including
    - Continue to develop the Scottish Oligometastatic SABR Network and invest up to £2.8 million in the continued roll out of SABR.
    - Assess current evidence on use of photons vs proton beam and develop a long-term view of patient access in Scotland.
61. Continue to invest in our capital radiotherapy replacement programme, investing up to £67.4 million over the next 3 years.

Strengthen **systemic anti-cancer therapy (SACT)** services by:

62. Increasing national resourcing of SACT service across Scotland, alongside developing Acute Oncology services, reaching up to £10 million per annum of additional funding.
63. Establishing and delivering the Oncology Transformation Programme.
64. Providing sustainable investment in CMOP to ensure there is a single national capability to assess the effectiveness, safety and value of cancer medicines in Scotland, including benefits, harms and public value, and generate evidence to support the Scottish Medicines Consortium (SMC) and the National Cancer Medicines Advisory Group (NCMAG). We will continue to invest in the work of CMOP.
65. Reviewing the decision making processes and criteria for both new and existing cancer medicines.
66. Ensuring SMC and NCMAG advice is consistently implemented in NHS Scotland, including integrating NCMAG's approval process into the medicines landscape and formalising their relationship with the SMC and CMOP. We will invest up to £690,000 to continue the work of NCMAG.
67. Supporting the transition to a single national way of working and electronic chemotherapy prescribing system.

Strengthen our **models of care** by:

68. Working to improve alignment between SMC approval and available capacity and infrastructure within NHS Scotland to ensure that new medicines are available to people with cancer.
69. Continuing and strengthening quality improvement through the Cancer Quality Programme, focussing actions relating to agreed priority Quality Performance Indicators in line with strategic aims and national clinical agreement of Quality in cancer services.

2.5 Excellent Care and Support after Treatment

Our 10-year vision is that personalised support and care post-treatment are core considerations in cancer management pathways: this includes rehabilitation, early detection of recurrence, and supportive and palliative care. People affected by cancer are informed and supported to adequately manage side effects of treatment with the appropriate tools, including an electronic treatment summary.

All individuals requiring rehabilitation have access to meaningful, person-centred rehabilitation that will support them to live well and support a good quality of life, regardless of their stage on the cancer pathway. Follow-up is standardised in the SCN's clinical management pathways, is evidence-based for each cancer type and individual (including secondary cancers) and covers patient-initiated requests for review. Every person with cancer in Scotland requiring palliative care receives well-coordinated, timely and high-quality care, including care around death. Bereavement support is provided for families and carers based on their needs and preferences.

By March 2026 we will:

Rehabilitation

70. Establish a national rehabilitation Governance Board to lead and advise on actions required nationally.
71. Create and support a network of local rehabilitation leads to champion development in their local Health Boards.
72. Support rehabilitation services to complete a self-assessment to audit their rehabilitation services and benchmark themselves against the Six Principles of Good Rehabilitation as outlined in the Once for Scotland Approach.

Palliative and end of life care

73. Publish a Palliative and End of Life Care Strategy that takes a whole system, population and public health approach.
74. Ensure that supportive care, palliative care, care around death and bereavement are integral parts of the cancer journey that people and their families and carers experience.
75. Ensure that people can access holistic care and support to help them with physical, psychological, social and spiritual needs they may have.

Follow up

76. Standardise patient follow up in SCN's clinical management pathways that are evidenced-based for each cancer type and individual (including secondary cancers) and will reflect people's preferences.

2.6 Sustainable and Skilled Workforce

Our 10-year vision is for a sustainable, skilled workforce with attractive career choices and fair work, where all are respected, supported and valued, whether they work wholly or partly in cancer services.

We recognise the significant pressures that the NHS workforce has faced and that sustained actions are required – from planning for and attracting into the workforce, through to support and development of staff, including their mental health and wellbeing. Our Health and Social Care: National Workforce Strategy (2022) sets out a national framework to achieve our vision of a sustainable, skilled workforce. This will be achieved through the five key pillars of the workforce journey: plan, attract, employ, train and nurture. Recommendations of the Improving Medical Retention Advisory Group are being considered by NHS employers, trade unions, professional organisations and where appropriate for other staff groups.

The cancer workforce comprises dozens of healthcare professionals, some of whom are cancer specialists and some for whom cancer is a component of their job. We will model workforce requirements across all professions vital to oncology services, continue to grow the number of training places and ensure that all professionals are doing the work they are best placed to do. We will maximise the retention of our workforce, providing support for mental health and wellbeing, providing flexibility in roles as individuals approach retirement, and increasingly collaborating and integrating roles across departmental or board boundaries.

By March 2026 we will:

Plan

77. Complete a workforce review of key professions in cancer services, including modelling, to inform recruitment, training and allocation.

Attract

78. Introduce new models of care and service improvements in oncology, working with the Scottish Cancer Network and Scotland's five cancer centres, and other cancer networks as appropriate.
79. Apply the deliverables within the Nurture Pillar of the National Workforce Strategy to the cancer workforce, committing to drive a supportive and enabling culture for people working in health, social care and social work.

Employ

80. Recruit an additional 800 GPs by the end of 2027.
81. Apply the recommendation of the Allied Health Professions (AHP) Workforce and Policy Review to the cancer workforce. It will consider the actions necessary to deliver a national education and workforce plan for AHPs.

Train

82. Accelerate training to increase endoscopists. This includes a national faculty of trainers, the remobilisation of basic endoscopy courses, and immersion courses to enable Joint Advisory Group on GI endoscopy (JAG) accreditation.
83. Increase the number of medical undergraduate places by 100 per annum and double the number of Widening Access places to help address existing inequalities.
84. Create 30 new reporting radiographer training places.
85. Create 3 new Medical Oncology and 4 Clinical Oncology training places in 2023.
86. Continue to consider increases to training places in medical and clinical oncology, in line with medical workforce modelling data.
87. Consider the development of national training pathways where they may be beneficial, in the first instance looking at the rehabilitation continuum.

Nurture

88. Support and, where appropriate, lead development and implementation of new skills and expertise frameworks, ensuring correct skill mix and use of administrative and support staff to ensure all professionals can focus on the work they are best placed to undertake.
89. Support NHS Health Boards to utilise local flexibilities within NHS Pension arrangements, including the option of 'pension recycling'
90. Implement the NHSScotland Interim National Arrangement on Retire and Return developed by the 'Once for Scotland' Workforce Policies Programme to support retiring employees who wish to continue in employment.
91. Support staff mental health and wellbeing through national initiatives such as the National Wellbeing Hub and Helpline, confidential mental health treatment through the Workforce Specialist Service, Coaching for Wellbeing and funding for additional local psychological support.
92. Promote spiritual care for staff, including those providing palliative and end of life care across all settings, through the Spiritual Care Framework and Palliative and End of Life Care strategy.
93. Promote and support guidance for potential clinical leaders in cancer including through the Leading to Change programme development and Cancer Workforce: Clinical Leadership guidance.

2.7 Person-Centred Care for All

Our 10-year vision is that people with cancer are at the heart of all decisions and actions involving them. They are given the opportunity to co-design their own care plan, and information including a treatment summary is readily available. A single point of contact (SPOC) is at the centre of this. Where possible, diagnostic tests and treatment are situated close to home and travel to specialist care is fully supported, making use of the continued advancement in new technologies.

Value-based health care and Realistic Medicine mean outcomes are delivered through shared decision making and discussion about the potential benefits and harms of different treatment options, including the option to do nothing.

Person-centred care is facilitated by good communication and collectively enables informed and shared decision making, including discussions about the benefits and potential harms from any treatment and from no treatment. By placing this standard at the heart of all we do, we will improve the safety, efficiency, efficacy, quality and experience of care.

Shared decision making training can support health and care professionals to have meaningful conversations that will lead to appropriate, evidence-based practice that delivers outcomes that matter to the people they care for.

A single point of contact (SPOC) improves access to care and timely reporting of results; eases navigation through care pathways; improves experience, shared decision making and patient-reported outcomes; and positively impacts our workforce by releasing capacity to provide more proactive and complex care.

Improving the Cancer Journey (ICJ) helps us keep the person with cancer and their family or supporters at the centre of their care. The service integrates psychosocial care into the cancer pathway and, through the holistic needs assessment and care planning process, individuals can access timely support that is relevant, appropriate, and sufficient for their needs.

Getting It Right for Everyone (GIRFE) reflects similar values, providing a more personalised way to access help and support with a joined-up, coherent and consistent multi-agency approach. This will be a practice model across acute, community and social services going forward.

By March 2026 we will:

94. Launch the final Improving the Cancer Journey (ICJ) service, in partnership with Macmillan, giving everyone diagnosed with cancer in Scotland access to a key support worker.
95. Continue to invest in the 12 pilot single point of contact (SPOC) sites, evaluate the impact of the programme and expand its reach.
96. Complete the Scottish Cancer Patient Experience Survey (SCPES), working with Macmillan Cancer Support.

97. Work with Macmillan alongside other third sector organisations and Health Boards to determine any new actions required to improve the experience of people diagnosed with cancer and how best to measure this.
98. Support the development of a person-centred measurement framework that will generate continuous data on person-centred processes and person-centred outcomes, and test this within cancer services.
99. Work with the West of Scotland Cancer Network to scale up the treatment summary (TSUM) pilot and support work to encourage wider introduction across Scotland.
100. Work with the third sector and the NHS to ensure everyone affected by cancer is aware of support services available and how to access them.
101. Work with NHS inform to review and update their cancer information provision to best meet patient needs.
102. Promote the use of Care Opinion and continue to monitor all comments to inform service improvement.
103. Develop education, training and tools that support health and care professionals to practise Realistic Medicine and deliver person-centred care.
104. Increase awareness and use of patient resources (such as the Choosing Wisely questions and BRAN questions[iii]) to support Realistic Medicine throughout cancer services, for example by increasing availability of Realistic Medicine leaflets in clinical settings.
105. Promote shared decision making training (such as under TURAS https://learn.nes.nhs.scot/63069) to health and care colleagues involved in delivering cancer services to help them deliver care based on what matters most to the people they care for.

2.8 Mental Health as part of Basic Care

Dependent on need, proactive and comprehensive psychological and mental health interventions and support are available and accessible, from those trained at informed to specialist practice types, to all people affected by cancer and their families.

There is strong evidence that psychological distress is a significant problem for people affected by cancer. Through the provision of the right psychological support in the right place, by the right person, at the right time, people affected by cancer can be better equipped emotionally and psychologically to face the challenges that lie ahead[iv]. This is not a one-time process. The Psychological Therapies and Support Framework helps those working with people affected by cancer to confidently and proactively identify, discuss and address psychological support needs. Where necessary, it helps signpost and refer people to the services that best meet an individual's needs.

By March 2026 we will:

106. Implement the Psychological Therapies and Support Framework and the new National Specification for Psychological Therapies and Interventions.
107. Develop our cross-sector, multi-disciplinary trauma-informed workforce to deliver care that is psychologically informed and centred around good communication. We will ensure the workforce is supported to manage their own emotional needs.
108. Complete the first national benchmarking exercise to help understand the demand and capacity for psychological care and support.
109. Develop an action plan for improvement of psychological support and an options paper for future service provision linked to the Psychological Therapies Matrix, National Specification and data/performance recording indicators.
110. Publish a refreshed Mental Health and Wellbeing Strategy in 2023 to ensure that people with long term physical conditions, including some cancers, have access to mental health and psychological services and spiritual care, including community and third sector support, to achieve positive mental health outcomes. The strategy will have a focus on tackling inequalities.

2.9 Flourishing Research and Innovation

Our 10-year vision is that equitable access to clinical trials has become integral to the management of treatment options. Where relevant, health professionals have allocated research time, adequate laboratory support and are working in partnership across academia, industry and the third sector. Qualitative and non-RCT research are providing relevant high quality evidence to inform best care. Routine cancer data are available to support this.

More complex molecular tests ensure people with cancer have access to a portfolio of precision oncology and clinical research. Laboratories have capacity to support research, including clinical trials.

New technologies are being used to strengthen the full cancer patient pathway, with alternative methods for consultations and information-sharing leading to greater choice and convenience for people with cancer. The application of artificial intelligence (AI) has grown. Multidisciplinary networks are making the best use of scientific and clinical expertise to translate innovation into clinical practice. Health Boards make robust, evidence-based decisions based on Scottish Health Technologies Group (SHTG) advice, leading to improved outcomes and more efficient use of resources.

Research and innovation are a core part of the NHS. They play a key role in improving earlier diagnosis rates (**see Earlier and Faster Diagnosis**), enabling people with cancer to access new treatments at an earlier stage and influencing health planning and policy.

We live in a time of extraordinary advances in technology that provides opportunities to improve access to cancer, diagnostics and treatments, including supportive care and early palliative care. Our approach to digital health will be guided by the Digital Healthcare Strategy (2021), including the development of the Digital Front Door. The Scottish Health and Industry Partnership Group (SHIP) aims to strengthen Scotland's innovation activities in health and social care with a focus on early-stage innovation. The CfSD's ANIA Pathway aims to fast-track proven innovations into the healthcare frontline on a Once for Scotland basis, with an early focus on innovations for delivery of care in cancer. The Scottish Health Technologies Group (SHTG) in Healthcare Improvement Scotland provides evidence-informed advice on the use of health technologies.

The Improving Equity of Access to **Cancer Clinical Trials** in Scotland Report was produced by an expert advisory group and sets out 51 recommendations for the future.

By March 2026 we will:

111. Establish a delivery group to consider the viability and prioritisation of all recommendations and agree actions for the short, medium and long term.
112. Continue to support the early phase clinical trial work of the Edinburgh and Glasgow adult Experimental Cancer Medicine Centres (ECMC), and the paediatric Experimental Cancer Medicine Centre in Glasgow. We will match

Cancer Research UK funding for the Scottish ECMCs over the next funding period 2023-28.

113. Through UK-wide funding arrangements, continue to facilitate access for researchers based in Scotland to the majority of the National Institute for Health and Care Research (NIHR) research project funding schemes.
114. Continue to support the work of the NHS Research Scotland Cancer Research Network in running innovative, high quality research studies across Scotland.

Wider Innovations

115. Develop efficient pipelines to translate the potential benefits discovered through research into clinical practice for those with cancer, particularly in the area of genomic medicine.
116. Utilise cancer genomic datasets to harness research opportunities where possible.
117. Ensure SHTG provides evidence-informed advice that is tailored to the underlying question and context, that is sufficient, relevant, timely, reliably of high quality, and easily understood by a wide audience[v] by:
    - advice being sought in time to inform key decision-making processes and systems, and
    - improving a collective understanding of what constitutes 'good evidence' across health and care in Scotland.
118. Release the first iteration of Digital Front Door by 2024.
119. Review the use of Near Me within cancer services to inform consideration of how it could be offered more routinely, where appropriate for both the person with cancer and their condition.

2.10 Cancer Information and Intelligence Led Services

Our 10-year vision is of a more integrated cancer intelligence platform along the full cancer pathway. This creates a responsive system that efficiently supports data collection, retrieval and use for clinical management, surveillance, evidence generation and policy development, which is aligned to the move towards a single electronic health record. Quality Performance Indicators will be a key driver of an overall cancer services improvement agenda, aligning with national clinical management and optimal pathways. Data collection and analysis of measures including PROMs (patient-reported outcome measures) and PREMs (patient-reported experience measures) are integrated into service provision to facilitate person-centred care and shared decision making.

Cancer data capture and use should be seamless across all health and social care settings, make best use of technology, and provide timely intelligence to those who need it, along the full cancer pathway, including those with a cancer diagnosis. Data are fundamental to understanding the whole system of cancer control and care. They support service delivery and redesign including person-centred decision making, policy and planning. They are required for audit, quality improvement, research and primary prevention.

By March 2026 we will:

Data collection and intelligence system

120. Strengthen national cancer intelligence systems with up to £800,000 of investment at a regional level and ensure that new clinical software systems consider standardisation and interoperability of data.
121. Invest up to £3 million in the Scottish Cancer Registry Intelligence System (SCRIS) to strengthen and expand the Scottish Cancer Registry and to enhance the Cancer Intelligence Platform through the addition of relevant cancer datasets including radiotherapy, SACT and QPI audit data.
122. Embed the CMOP within PHS to strengthen and build intelligence on whole system real world medicines use and outcomes to inform clinicians and patient choice.
123. Develop standardised nomenclature and laboratory data to enable genetic laboratories to implement a genomics module as part of the national Laboratory Information Management System (LIMS) and to work effectively as part of a Once for Scotland approach.
124. Standardise data outputs for cancer genomics tests to enable their incorporation into cancer registry datasets where possible.
125. Contribute to and learn from data analysis being conducted through the International Cancer Benchmarking Partnership (ICBP).
126. Develop and agree on a Once for Scotland basis, core principles for the collection of cancer PROMs (patient-reported outcome measures), influenced by our investment in the regions and Scottish Cancer PROMs Advisory Group.

Data analysis

127. Prepare a cancer data roadmap to address identified data gaps, secure wider stakeholder commitment/sponsorship and invest in new data collection that aligns with strategic aims and clear translation into improved equitable treatment and care for people with cancer, for example, surgical, diagnostic and inequalities data.
128. Undertake novel analytical work to support a better understanding of survival, outcomes, demographics and inequalities.
129. Build on COVID-19 specific work such as: emergency and non-emergency routes to diagnosis including survival outcomes; evaluate the validity of pathologically confirmed cancers as measures of cancer incidence; and join up data on waiting times, routes to diagnosis and outcomes.
130. Continue validation of the SACT datasets and build on the work of CMOP integration with other cancer information to better understand the benefits from SACT data to support clinical decision making.
131. Improve data collection on metastatic cancers, collating data nationally for the first time to help drive service improvement, with an initial focus on metastatic breast cancer.

Data use

132. Strive to improve current clinical systems to allow easier cross-boundary care (such as in radiology) with a single sign on for the cancer workforce.
133. Make data readily available for research purposes through trusted research environments.

3. Governance

Our overall strategic progress and direction will be overseen by the Scottish Government. The Scottish Cancer Strategic Board will own the strategy and associated action plans, and review progress against them. Beyond this, ownership of actions will be held at national to regional and local levels as appropriate. NHS Scotland approaches will be a core principle to all our work. We will:

134. Review cancer governance and structures with the purpose of simplifying the overall landscape, ensuring appropriate links with wider services, and reducing duplication of discussion and decision making at all levels.
135. Commission the Scottish Cancer Network to carry on its delivery of new Clinical Management Pathways and hosting national networks, also adopting new responsibilities to support further Once for Scotland working where there are clear benefits to treatment and care, and effective use of clinical time.
136. Work with the Cancer Managers' Forum to support delivery of all aspects of this plan relevant to their work.

4. Monitoring and Evaluation

Information on the key principles and approach to evaluation is provided in the 10-year Cancer Strategy for Scotland.

A Monitoring and Evaluation Framework for each 3-year action plan will be developed using the steps outlined in the Cancer Strategy for Scotland 2023-2033. Setting up a framework for each action plan will provide the flexibility to design the best evaluation methods to address evidence and learning requirements as they emerge across the timeline of the 10-year strategy.

The objectives of the 3-year action plans will represent the building blocks needed to make progress towards the longer-term strategic aim of the 10-year strategy. The first action plan is concerned with stabilising systems and services. The second action plan will seek to renew services and cancer control, and the third action plan aims to redesign services and harness innovations. Given the wider systems and financial pressures outlined in relation to evaluation of the 10-year strategy, evaluation of the first action plan will focus on the outputs and outcomes that we can expect to be delivered within three years as systems and services are stabilised.

The Monitoring and Evaluation Framework for this first action plan will incorporate measures to assess progress in relation to short-term outcomes for the 10-year strategy, in other words the progress that is expected to be made in years 1-3 to recover and stabilise systems and services. In addition to evaluating outcomes, this framework will generate learning from the experience of implementing the plan: what is known as 'process' evaluation; as well as understanding the outcomes of activities. Data indicators and evaluation questions will be set out to monitor and evaluate the processes and outcomes linked with implementing and delivering the action plan. Where possible, in order to take a proportionate approach that minimises burden, questions will be addressed through routine data collection.

Monitoring of data, such as waiting times, will continue to be important in the measurement of metrics to assess performance and to understand variation in the system. We will apply Healthcare Improvement Scotland's concept of learning systems to understand progress and share learning. Approaching evaluation from the perspective of Learning Systems enables us to consider what variation tells us about the system, specifically what is working and not working, and to share this learning across the system. Specific approaches for supporting Learning Systems will be developed with stakeholders for each action plan.

In connecting with existing monitoring and evaluation activities that are taking place in NHS Boards, this approach will draw on transferable, scalable and well-evidenced learning that is available from the local ('micro') level. While national monitoring and evaluation is not directly about local improvement or local data needs, it aims to capture and share good quality evidence as learning emerges within the system.

As part of monitoring and evaluating the action plans, a set of core evaluation questions will be developed to share with local programmes and projects that wish to develop evaluation methods that support learning against key indicators of success.

[i] Public Health Scotland (2021) Cancer incidence in Scotland: Cancer Incidence and Prevalence in Scotland to December 2019
[ii] Cancer Risk Statistics (no date) Cancer Research UK.
[iii] About choosing wisely UK (no date) Choosing Wisely UK.
[iv] The Scottish Government (2022) Psychological therapies and support framework for people affected by cancer. rep.
[v] Scottish Health Technologies Group (no date) Range of advice products, Scottish Health Technologies Group.

Scottish Government
Riaghaltas na h-Alba

This publication is available at **www.gov.scot**

Any enquiries regarding this publication should be sent to us at

The Scottish Government
St Andrew's House
Edinburgh
EH1 3DG

ISBN: 978-1-80525-545-1 (web only)

Published by The Scottish Government, June 2023

Produced for The Scottish Government by APS Group Scotland, 21 Tennant Street, Edinburgh EH6 5NA
PPDAS1246602 (06/23)

NHS Fife

Cancer framework

For the population of Fife we will deliver effective cancer prevention, early diagnosis and high quality sustainable cancer services for those living with and beyond cancer.

2022–2025

Published April 2023

www.nhsfife.org

Contents

Executive overview

It is my pleasure to present the Strategic Cancer Framework for NHS Fife. This framework sets out how we will deliver effective cancer prevention, early diagnosis and high quality sustainable cancer services for those living with and beyond cancer. We want to ensure that we deliver excellent cancer services which we would be happy for our family, friends and loved ones to access and experience a positive journey.

The Cancer Framework 2022–2025 has been developed to ensure there is a full system approach to the delivery of sustainable cancer services to support the increased incidence in cancer and those living with and beyond a cancer diagnosis in NHS Fife.

To support writing of this document extensive public, patient, staff and third sector engagement was undertaken to share thinking and incorporate their priorities on what is important to them. The framework will align with the Scottish Government Cancer Strategy, Recovery Plan post COVID and our local Health and Population Wellbeing Strategy. It will be underpinned by the 6 principles of realistic medicine and will link in with national and regional services to ensure our patients receive the best care and are at the heart our services. Assessment of health inequalities provided an understanding of population groups and factors contributing to poorer health and health inequality.

The impact of COVID will be seen for some time with a notable reduction in cancers diagnosed during the pandemic of approximately 9% across Scotland. Furthermore the temporary pause of screening is expected to affect earlier diagnosis.

A cancer governance structure to support both leadership and accountability is in place to ensure strategy and operational delivery, along with innovation will combine leadership, continuous improvement and achievement throughout services.

Eight strategic commitments have been established supported by key priorities

1. Prevention, early diagnosis and reduction in inequalities
2. Person-centred
3. Optimal pathways and integrated care
4. Research, innovation and knowledge
5. Digital and information
6. Workforce
7. Property and asset management
8. Quality and performance improvement

To ensure the framework remains contemporary, a delivery plan will be agreed on an annual basis to ensure our priorities remain relevant and will continue to engage with public, patients and staff.

Key priorities for 2022-2023

- Reduction of health inequalities
- Single point of contact
- Rapid cancer diagnosis service expansion
- Cancer estate review
- Improving access to clinical trials
- Pathway review/best supportive care
- Cancer workforce review

This framework will ensure cancer services remain high profile within NHS Fife and allow us to have oversight and be assured that the complexity of cancer services are in line with national and local strategy.

Dr Christopher McKenna
Medical Director

Meet the cancer framework leadership team

Christopher Mckenna

Dr McKenna - started his career in NHS Fife in 2011, when he was employed as one of the first consultants in Acute Medicine. He trained as an Acute Physician in the South East of Scotland and is a Fellow of the Royal College of Physicians Edinburgh. He was appointed as the Clinical Director for the Emergency Care Directorate within the Acute Services Division in 2015 and has played a key role in the improvement of unscheduled care delivery within the Victoria Hospital. Dr McKenna completed the IHI Improvement Advisor training programme in 2012 and has been involved in a number of quality and safety initiatives across the Acute Division. In 2018 Dr McKenna took part in the Leading for the Future programme and he is passionate about the development of Medical Leadership. He took up his position as Medical Director for NHS Fife in March 2019.

Gemma Couser

Gemma is the Associate Director for Quality and Clinical Governance. Part of her portfolio includes responsibility for Cancer Strategy, Audit and Performance. Gemma began her career in the NHS as a graduate management trainee. Over the past decade she has held senior manager posts across a variety of clinical specialties including Clinical Services Manager for the Edinburgh Cancer Centre. Gemma is committed to making a positive contribution to the population of Fife and to ensuring that healthcare professionals and patients are at the heart of how our services are designed.

Kathy Nicoll

Kathy is the Cancer Transformation Manger for NHS Fife. Alongside the strategic development of the Cancer Framework, she has responsibility for the management of Cancer Waiting Times performance and the Cancer Quality Performance Indicators. Kathy chairs the National Cancer Managers' Forum and works closely with Scottish Government. She is a member of various groups at a national level supporting cancer delivery through the Early Cancer Diagnosis Programme Board, Cancer Delivery Board, Early Cancer Diagnostic Oversight Group and Cancer Prehabilitation Implementation Group. She moved from Derbyshire to Fife 27 years ago, where she still lives.

Murdina MacDonald

Murdina is the Lead Cancer Nurse for NHS Fife. She trained as a cancer nurse in 1990 at the Royal Marsden Hospital (UK) and worked within Oncology in several fields: radiotherapy, Systemic Anti Cancer Treatment (SACT), supportive care, gastrointestinal (GI) and urology for over a decade. As the Lead Cancer Nurse Murdina provides forward thinking clinical and professional leadership to the tumour site cancer nursing teams. She also provides support, guidance and represents the broad views of nurses involved in the delivery of cancer, working collaboratively with a wide range of partner charities, cancer network teams and is a member of national nursing bodies. Murdina acts as advocate for our patients, to ensure they remain central to designing how we deliver cancer care.

Nick Haldane

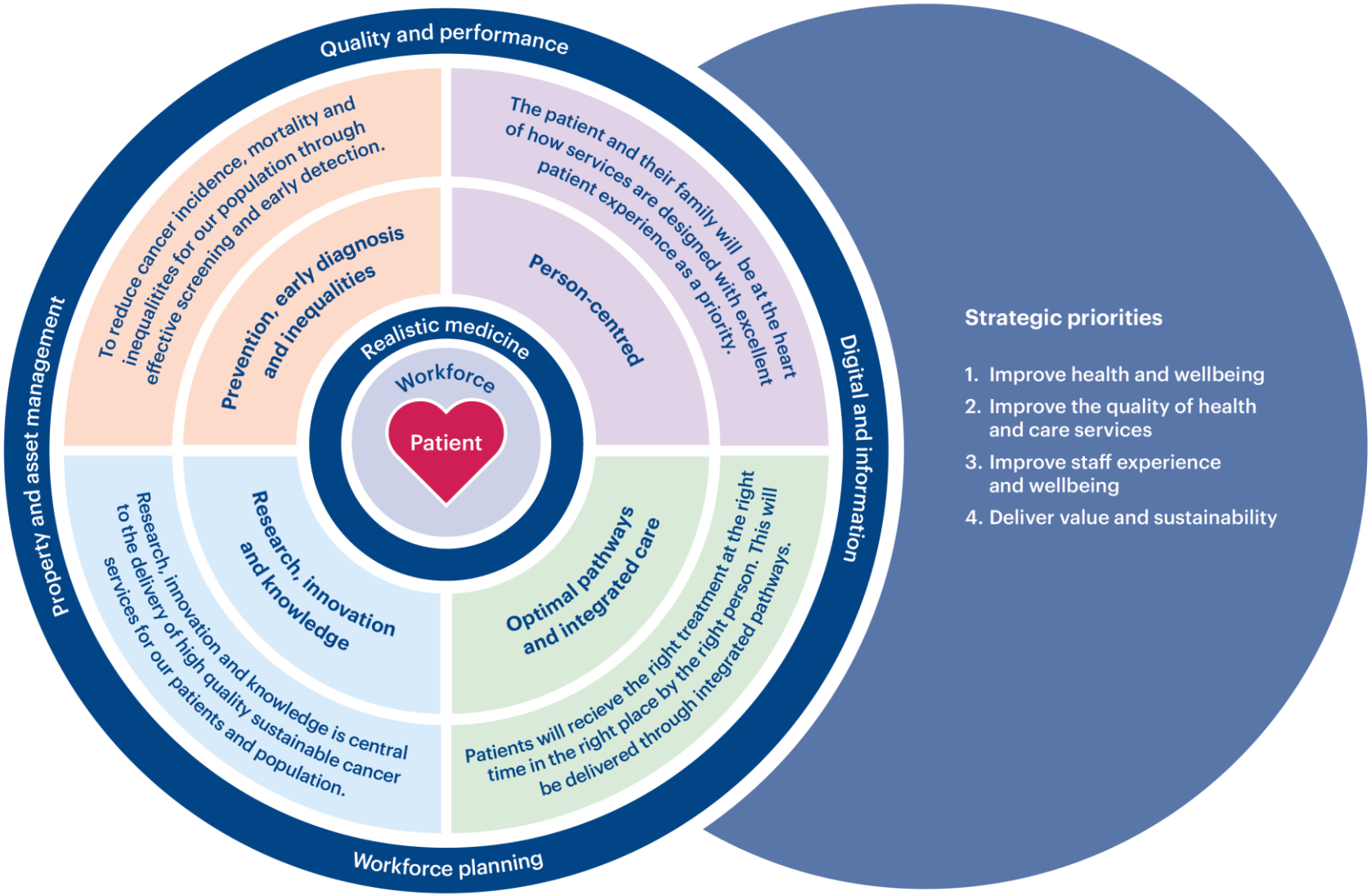
Nick is a General Practitioner (GP) in St Andrews. Along with his GP workload he currently plays an active part in the in-patient care at St Andrews Community Hospital including medical cover to the Palliative Care beds. Nick enjoys his role as an Educational Supervisor helping to train the GPs of the future. Nick is the NHS Fife Lead GP for Cancer and Palliative Care providing a Primary Care voice within Fife and representing Fife Primary Care both regionally and nationally within the Cancer Networks. He grew up in Burntisland and was educated in Kirkcaldy. He graduated from the University of Dundee in 1999 and completed his GP training in Tayside before returning to Fife to take up a partnership in 2004. As a proud Fifer Nick is delighted to be able to contribute to this exciting work.

John Robertson

John is a Consultant Colorectal Surgeon working at the Victoria Hospital Kirkaldy and is the Lead Cancer Clinician for Surgery in Fife. He originally grew up and was educated in Glasgow, training there before undertaking a research degree in cancer metastases at University College London. Subsequently John completed his training in the South East of Scotland rotation prior to being appointed a consultant in August 2015 in Fife. He is very keen to ensure optimal care for all cancer patients having had significant exposure in various surgical specialties throughout his training.
He continues to have daily involvement with colorectal cancer patients in clinic, endoscopically and surgically and is part of the local SCAN network. John is heavily involved in teaching and is an Honorary Senior Clinical Lecturer at the University of Edinburgh and has regular interactions with surgical colleagues in both NHS Lothian and Tayside.

Acknowledgement of thanks to Dr Neill Storrar, Consultant Haematologist and Lead Cancer Clinician for Oncology and Medicine for his contribution to the framework.

Our framework



Introduction

National context

The aim of the framework is to deliver a system-wide ambitious strategic plan to provide high quality, person-centred cancer care to every patient across the NHS Fife healthcare system, from prevention and early diagnosis to survivorship and end of life care.

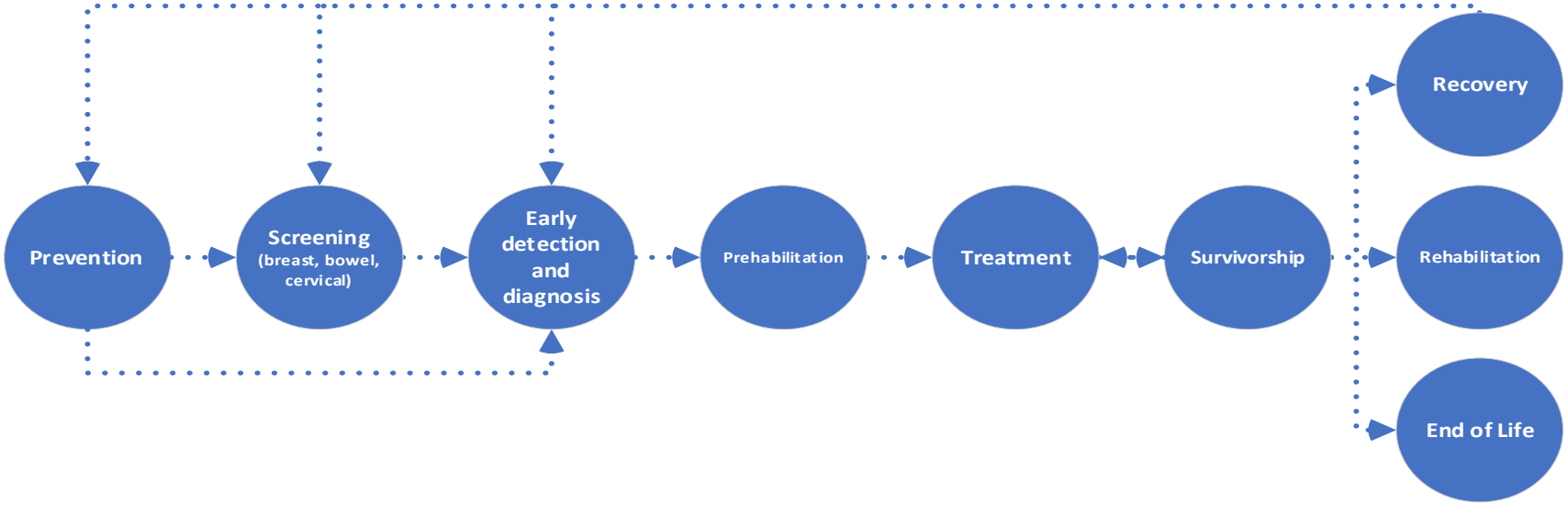
Cancer is everyone's business with cancer touching all parts of our healthcare system. This framework puts our patients and people (population and staff) at the heart.

This framework aligns with the NHS Fife Population Health and Wellbeing Strategy and with the National Recovery & Design: An Action Plan for Cancer Services and will be supported by national and public health initiatives. Underpinning this framework are our organisational values and the 6 principles of Realistic Medicine. We will have good conversations with patients and will be prudent about the care that is delivered. Through implementation of the framework, we will work with colleagues to ensure we are cognisant of more sustainable and greener healthcare.

Incidence of cancer is rising and more people are living with and beyond a cancer diagnosis. NHS Fife continues to prioritise cancer care and recognise that a full system approach is required to deliver clinically sustainable cancer services. In order to achieve this, we will ensure that the voices of those affected by cancer are listened to and are at the heart of this framework.

Our hope is that this framework creates improvements for how we can help support our local population to be more cancer aware and improve care for those living with and beyond cancer.

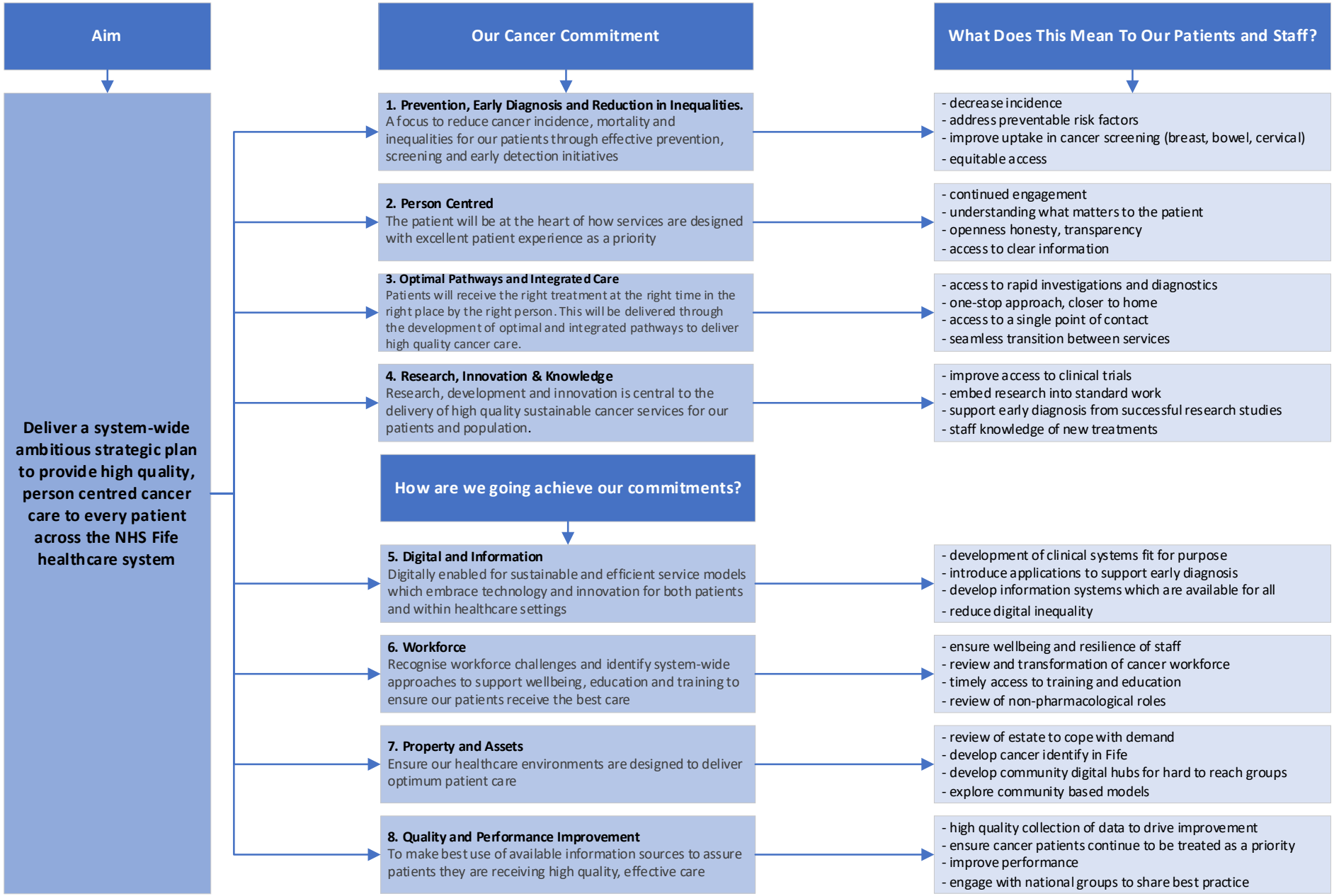
The patient journey



Delivering this framework

The purpose of this framework is to make a difference; a delivery plan will be agreed on an annual basis which will set out key workstreams for delivery in year to ensure this remains contemporary and reflects any strategic changes decided by the Cancer Governance and Strategy Group along with changes in national priorities.

Cancer services are dynamic and ever evolving and as such an annual review of this framework will be completed to ensure that our priorities remain relevant.


Aim
Our Cancer Commitment
What Does This Mean To Our Patients and Staff?
Deliver a system-wide ambitious strategic plan to provide high quality, person centred cancer care to every patient across the NHS Fife healthcare system
1. Prevention, Early Diagnosis and Reduction in Inequalities.
A focus to reduce cancer incidence, mortality and inequalities for our patients through effective prevention, screening and early detection initiatives
- decrease incidence
- address preventable risk factors
- improve uptake in cancer screening (breast, bowel, cervical)
- equitable access
2. Person Centred
The patient will be at the heart of how services are designed with excellent patient experience as a priority
- continued engagement
- understanding what matters to the patient
- openness honesty, transparency
- access to clear information
3. Optimal Pathways and Integrated Care
Patients will receive the right treatment at the right time in the right place by the right person. This will be delivered through the development of optimal and integrated pathways to deliver high quality cancer care.
- access to rapid investigations and diagnostics
- one-stop approach, closer to home
- access to a single point of contact
- seamless transition between services
4. Research, Innovation & Knowledge
Research, development and innovation is central to the delivery of high quality sustainable cancer services for our patients and population.
- improve access to clinical trials
- embed research into standard work
- support early diagnosis from successful research studies
- staff knowledge of new treatments
How are we going achieve our commitments?
5. Digital and Information
Digitally enabled for sustainable and efficient service models which embrace technology and innovation for both patients and within healthcare settings
- development of clinical systems fit for purpose
- introduce applications to support early diagnosis
- develop information systems which are available for all
- reduce digital inequality
6. Workforce
Recognise workforce challenges and identify system-wide approaches to support wellbeing, education and training to ensure our patients receive the best care
- ensure wellbeing and resilience of staff
- review and transformation of cancer workforce
- timely access to training and education
- review of non-pharmacological roles
7. Property and Assets
Ensure our healthcare environments are designed to deliver optimum patient care
- review of estate to cope with demand
- develop cancer identify in Fife
- develop community digital hubs for hard to reach groups
- explore community based models
8. Quality and Performance Improvement
To make best use of available information sources to assure patients they are receiving high quality, effective care
- high quality collection of data to drive improvement
- ensure cancer patients continue to be treated as a priority
- improve performance
- engage with national groups to share best practice

Cancer within our population

Incidence and prevalence			
Cancer in Scotland		**Cancer in Fife**	
34,000 new cancers diagnosed per year. **Lung cancer** is the most common cancer in Scotland.	**44** people every day die from cancer.	**2446** In 2019, 2446 Fife residents were registered as having a new cancer (all cancers) - rates are slightly higher in men.	**Cancer** Lung, prostate, breast and colorectal are the most common cancers in Fife and in the rest of Scotland.
3.7% of the population are estimated to be living with cancer (**250,000** people).	**1/3** Around one third of people with a new cancer diagnosis in Scotland lives less than one year from diagnosis.	**Cancer** One of the most common causes if ill health and mortality in Fife.	**Cancer** Cases of cancer in Fife have been increasing which reflects the growing and ageing population.
Cancer in older age Numbers are increasing due to the increasing average age of our population and the increased likelihood of cancer in older age.	**9%** The total projected percentage increase in the population from 1983-1987 to 2023-2027 is **9%.**		
29% Cancer deaths represent **29%** of all deaths	**4%** The percentage increase in the timeframe of 2013-2017 to 2023-2027 is **4%** in the population and **20%** in cancer cases.		

Mortality

Cancer in Scotland

16,366
Cancer (all types) is the most common cause of mortality. In 2019 there were 16,366 cancer deaths (excluding NMSC) registered in Scotland.

16,184
Draft Cancer data shows that in 2020 there were 16,184 deaths from cancer in 2020 (2.5 times greater than deaths from Covid-19 in 2020).

7,991
Female (in 2019).

8,375
Male (in 2019).

4 in 10
of us get cancer.

85-89
Risk of cancer peaks between 85 and 89 years of age.

Cancer in older age
Numbers are increasing due to the increasing average age of our population and the increased likelihood of cancer in older age.

9%
The total projected percentage increase in the population from 1983-1987 to 2023-2027 is **9%.**

29%
Cancer deaths represent **29%** of all deaths.

4%
The percentage increase in the timeframe of 2013-2017 to 2023-2027 is **4%** in the population and **20%** in cancer cases.

21%
Mortality rates are projected to fall by 21% in the UK between 2014 and 2035.

Cancer in Fife

1,206
In 2019 there were 1,206 deaths from all cancers in Fife and cancer was the most common cause of death.

Cancer
Lung cancer is the most common cancer in Fife and Scotland with higher mortality rates.

31%
Female.

28%
Male.

Under 75
Half of these were persons aged under 75 years of age.

Cause of death
Colorectal, prostate, oesophageal, and breast cancer are the next most common cause of death.

A focus on lung cancer

Cancer in Scotland

Lung cancer

Lung cancer is the most common cause of cancer deaths which has a considerably higher mortality rate than the next four most significant causes of mortality, which are colorectal cancer, oesophageal cancer, prostate cancer and breast cancer.

Cancer in Fife

Lung cancer

Lung cancer is the most common cause of cancer mortality for both sexes.

75 per 100,000

Mortality rate of 75 per 100,000 in Fife slightly higher than the South East region.

Treatment

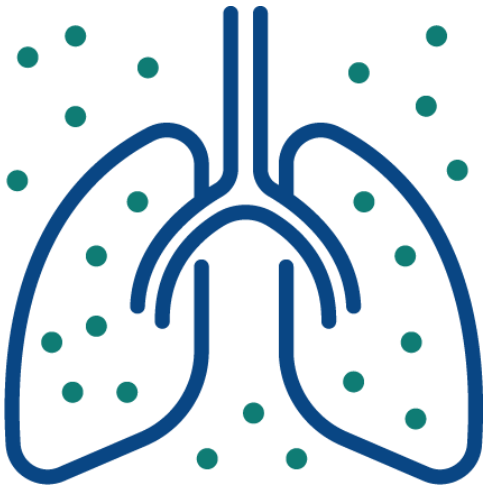
A significant proportion of people with lung cancer cannot, or choose not to, have treatment. Their survival is typically measured in weeks or short months

Smoking

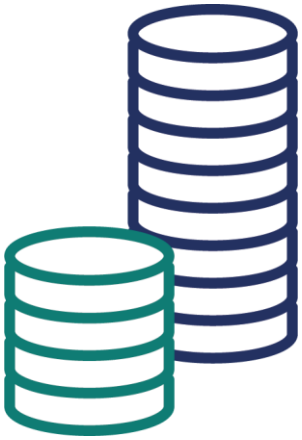
Smoking is a major risk factor for lung cancer.

2018

The numbers of deaths have remained the same in 2018 compared to 2008.



Inequality and deprivation[1]		
Cancer in Scotland	**Cancer in Fife**	
Inequalities There are stark inequalities in cancer incidence and mortality between the most and least deprived populations. A definition for health inequalities is **'the unjust and avoidable differences across our population and between groups within it'**	**30% higher** Incidence of cancer is 30% higher in the most deprived areas compared to the least deprived areas.	**Mortality** Mortality is more than double the rate in the most deprived areas compared to the least deprived areas.
Inequalities The inequalities we experience can be down to where we are born, live, socialise and work over the course of our life and are faced by people because of income and wealth and also inequalities in power, agency and opportunity.	**Inequalities** There are wide inequalities in incidence and mortality for all types of cancer.	**Inequalities with lung cancer** There are particularly marked inequalities associated with lung cancer.
	Deprived areas Late stage diagnosis is more common for people living in the most deprived areas.	**Screening programmes (breast, bowel, cervical)** The causes are complex but one factor may be lower rates of participation in the screening programmes.



1 http://www.healthscotland.scot/health-inequalities/what-are-health-inequalities#:~:text=Health%20inequalities%20are%20the%20unjust,denote%20unjust%20differences%20between%20groups.

Screening[2] and HPV Vaccination

Cancer in Scotland

Cancer screening

Cancer screening for breast, bowel and cervical cancer is the process for identifying people who appear healthy but may have a higher chance of developing the disease.

It aims to detect cancers at an earlier stage when treatment will be more effective. It also aims to prevent some cancers occurring.

For cervical screening, younger people are less likely to come forward than older people.

HPV Vaccination

S4 females (2019/20) - 88.2% of those first offered 1st dose in 2016/17 had received 1st dose; 81.7% had received 2nd dose.

15%

There is a substantial socioeconomic gradient - almost 15% difference in 2nd dose uptake between the least and most deprived quintiles at S4.

Those vaccinated against HPV are more likely to take up the offer of screening than the unvaccinated population

Cancer in Fife

Uptake of screening in Fife

Uptake in Fife in line with Scotland.

Mental health

Collaborative project in Fife to support those experiencing severe and enduring mental health conditions to engage with screening programmes.

Uptake of screening in Fife

Bowel 65.2%

Breast 73%

Cervical 70.3%

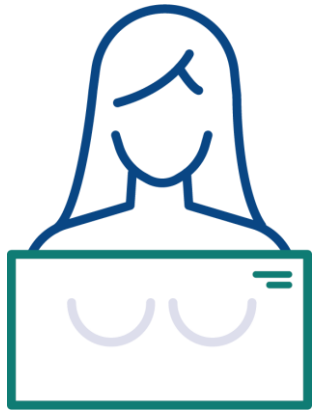
Uptake of screening in Fife

Uptake is much lower in most deprived areas in Fife compared to least deprived areas:

Bowel – 18.5% lower

Breast – 18.4% lower

Cervical – 11.5% lower (for the 25-64 age group)



[2] Cancer Framework Documents\NHS Fife Integrated Screening Report 2022 v4 25.10.22 CGC.docx

Prevention and early diagnosis

Cancer in Scotland

Around 40% of cancers are thought to be preventable. There is a large opportunity to prevent many of the commonly occurring cancers in Scotland through lifestyle changes by preventing smoking, improving diet and reducing obesity and alcohol consumption. Many of these risk factors for health are influenced by the wider standards of living, including experience of poverty and influencing change requires whole system and in some cases national collaboration and change:

- 79% of lung cancers would be prevented if people did not smoke
- 65% of adults are overweight and obesity causes 6% of cancers
- 4-6% of cancers can be attributed to poor diet
- Drinking alcohol contributes 3-4% of cancers.
- Overexposure to ultraviolet radiation contributes 3-4% of skin cancers
- Exposure to certain infections contributes 3-4%.

Exposure to certain substances at work continues to contribute to cancer cases.

Research shows that regular physical activity reduces the risk of a variety of cancer types.

Cancer in Fife

1,206

Whilst smoking has been declining, 1 in 5 of the population over 16 in Fife reports that they smoke– similar to Scotland.

Cancer

Highest rate of smoking is in the 16-34 age group amongst whom 24% of people smoke, higher than the rate in Scotland (20%).

Two thirds

Around two thirds of people in Fife are overweight (including obese).

Overweight

Patterns of overweight, obesity and physical activity is similar to Scotland.

1/4

Over a quarter of people report having low or very low activity levels.

11.2 units

On average, people in Fife drink 11.2 units of alcohol per week.

1 in 4

Just over 1 in 4 people (22%) in Fife drink more than the weekly recommended level of 14 unit for women and 21 units per week for men

Alcohol

Patterns of alcohol consumption in Fife is similar to Scotland.

Deprived areas

In the most deprived areas of Fife, smoking rates are 4 times higher along with alcohol consumption and obesity with physical activity and good diet being lower than in the least deprived areas and show similar patterns with the rest of Scotland.

The impact of COVID-19 on cancer and screening services

Much of the data presented in the cancer framework pre-dates the COVID-19 pandemic. We know that the pandemic may change the picture presented here. For example, reduced primary care face to face appointments, constraints on performing aerosol generating procedure, reduced health service capacity due for example to social distancing, cleaning etc and redeployment are all likely to have influenced cancer related appointments and diagnosis and thus cancer registrations. Overall in Scotland, the rate of new cancers fell by 9% and the number by 8% between 2019 and end of 2020. Most of the decrease is estimated to be due to under-diagnosis caused by the pandemic:

- Reduction in lung cancer by 7%.
- Reduction in female breast cancer by 11%.
- Reduction in colorectal cancer by 19%.
- Reduction in cervical cancer by 24%.
- Reduction in prostate cancer of 10%.

Furthermore a temporary pause and reduced capacity in screening is expected to have affected our ability to detect some cancers early. The proportion of early detected breast cancers appears to have reduced significantly as a consequence of the pausing of screening programmes (under diagnosis of early-stage breast (-20%), colorectal (-33%) and cervical (-45%) cancers compared with the number of early detected cancers in 2019.) There were also in some cases, changes to treatment to reduce risk during the pandemic.

At this stage it is difficult to assess the precise and lasting impact of COVID-19 on cancer incidence and outcomes and deprivation, but it is clear there has been a significant and potentially lasting effect on services and rate of diagnosis which we will need to monitor and respond to over time.

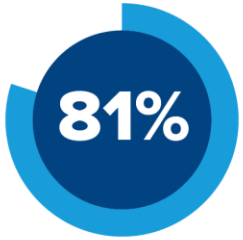
For more information, visit
https://publichealthscotland.scot/media/12645/2022-04-12-cancer-incidence-report.pdf

Cancer activity in Fife – a brief summary

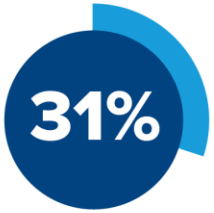
Number of urgent suspected referrals recieved in 2021

Percentage of cancers diagnosed from an urgent suspected cancer referral

Number of cancers diagnosed in 2019

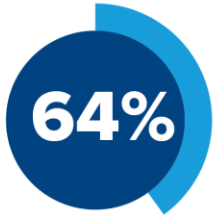


Percentage of patients who recieve their first treatment in Fife



Percentage of patients with surgery as a first treatment

Number of SACT episodes delivered in 2021



Percentage increase of SACT episodes from 2017–2021

5 year average 62 day cancer waiting times performace

5 year average 31 day cancer waiting times performance

Radiotherapy attendances for Fife patients in 2019

Percentage of patients treated with best supportive care

Early cancer diagnosis centre conversation rates

National context

Scottish Government vision

"To improve cancer services and patient outcomes and ensure equitable access to care wherever a patient may live, especially while the risk to COVID-19 persists. To do this, we will make the best use of workforce skills, technology and service innovation to drive earlier cancer diagnosis and treatment, and champion person-centred care"

The Remobilise, Recovery and Re-design Framework published in December 2020 aims to effectively mobilise the NHS to a better health and care system through:

- innovation and integration
- ensuring equity of access
- achieving better outcomes for people in Scotland, and their families.

Our framework supports relevant actions identified within the recovery plan.

The revised Effective Cancer Management Framework was published December 2021. As the cancer journey continues to be challenging, this plan aims to incorporate new ways of managing cancer pathways and services in response to the pandemic in order to effectively manage cancer patients, their experience and improve their outcomes. The key elements align with our commitments.

To drive cancer up the strategic agenda a National Cancer Governance structure has been agreed.
See Appendix 1

Regional context

NHS Fife is part of the South East Scotland Cancer Network (SCAN) along with NHS Borders, NHS Dumfries & Galloway and NHS Lothian. Services are delivered locally where possible with specialist interventions delivered regionally. Reprovision of the Edinburgh Cancer Centre for the SCAN network is planned and a regional transformation programme has been initiated to support the development.

We work closely with our regional partners to ensure a coherent strategy (Appendix 4) is developed through the Regional Cancer Strategy Group which will provide a forum that will support the SCAN boards to collaboratively develop their respective cancer strategies ensuring they complement and align. A regional strategy will support the Regional Cancer Planning Group to ensure that an equitable approach is taken to the development and provision of cancer services across the South East of Scotland and that national and local standards are met. Appendix 2 shows the regional governance structure.

We also work closely with NHS Tayside which supports cancer services in the North East of Fife. In addition to specifically delivered services, there are circa 400 patients from North Fife directly referred from GPs to NHS Tayside for cancer care each year. NHS Fife will engage with NHS Tayside's aim to design, plan and deliver a new build modern cancer centre for the population of Tayside and North East Fife based at Ninewells Hospital Dundee.

For more information on where our cancer services are delivered across the region, see
Table 4 Regional Services Provided to NHS Fife (December 2021)

Local context

An ambitious Population Health and Wellbeing Strategy is in development. The Strategy will describe the vision and future direction of health and care services in NHS Fife with a focus on health and wellbeing of citizens in Fife. Innovation and changes in models of care and staffing will be critical to enable NHS Fife to continue to deliver modern, high quality care for the next 5 years and beyond.

As a significant employer in Fife, embedded within the NHS Fife strategy plan is our aim to establish ourselves as an Anchor Institution playing a recognised role in the community, contributing to the local economy and aims to optimise on local employment opportunities. This is key in our cancer framework to help develop our strategic thinking and strengthen our approach to partnership working both within and outwith Fife.

This framework will align with the NHS Fife Population Health and Wellbeing Strategy and will build on the successes of the previous Cancer, Palliative Care and Last Days of Life Strategy. The priorities within the strategy, set out here, also endeavour to support delivery of NHS Fife's 4 strategic aims:

- Improving the quality of health and care services.
- Improving health and wellbeing.
- Improving staff experience and wellbeing.
- Delivering value and sustainability.

Accomplishments from the previous Cancer Strategy – Cancer, Palliative Care and Care in the Last Days of Life	
• Development of a clinical nursing team defined as a point of contact and subsequent employment of clinical support workers to support patient centred care • Implementation of Improving the Cancer Journey, in alliance with Macmillan Cancer Support • Dermatology initiative with GP practices using dermatoscopes to improve early referral of suspicious skin lesions. • The introduction of qFIT for bowel screening has led to a significant increase in screening uptake. Fife piloted a project to assess the use of qFIT for symptomatic patients by GPs to improve early diagnosis. • Development of the acute oncology service within Fife to provide urgent access to specialist cancer advice, treatment and care, for patients without a clearly defined cancer pathway.	• Local campaign last year on the benefits of sun protection. • Health and Social Care support for patients returning to work following successful treatment. • Maggie's Centre Cancer in the Workplace course. • Review of Specialist Palliative Care services to improve provision of supportive care and palliation. Expansion of the Specialist Palliative Care Outreach team which is consultant led and provides increased support in the community. • The Lead GP for Cancer and Palliative Care was involved in the review of the Scottish Referral Guidelines for Suspected Cancer.

We have developed a governance structure to support both leadership of and accountability for cancer overseen by the Medical Director (Responsible Executive for Cancer); this model ensures that strategy, operational delivery and innovation combine to ensure leadership, continuous improvement and achievement are maintained throughout services. Cancer Services Governance Structure for NHS Fife is shown in Appendix 3.

For more information on cancer services delivered in Fife please see Table 5: Local Cancer Services Provided in NHS Fife (December 2021)

Developing this framework in collaboration with our patients, staff and population

In order to develop the framework a full system approach to engagement was adopted. The objective of the engagement work is to ensure that the Framework has meaning and ensures that those who are responsible for the delivery of the cancer services are connected to the priorities that are identified. The development of the NHS Fife Cancer Framework has involved extensive engagement with a wide range of stakeholders and included approximately 35 services. A big thank you to all of our staff and teams who engaged to develop this Framework, without your input this would not have been possible. For a full list of those teams who engaged to develop the Framework please see Appendix 5

This is what our staff told us

It is of the upmost importance that this Framework connects with our workforce delivering cancer care. As part of the engagement sessions, services were asked to complete a Strength, Weaknesses, Opportunity and Threat (SWOT) analysis.

Strengths	Weaknesses	Opportunities	Threats
• A person-centred approach is taken There are strong, resilient, supportive and unified teams throughout the organisation demonstrating flexibility, cohesion and multi-professional working both within Fife and interfacing with our regional partners. • Continuous development of its workforce to allow personal growth through innovation,	• Staffing resources are stretched due to increasing demand and ageing population with limited cover arrangements, particularly seen in nursing and single-handed specialist practitioners. • National workforce shortages impact on ability to provide sustainable services. • Management of succession planning. Limited opportunity for	• Establishment of a cancer identity in Fife with a view to developing a 'Cancer Unit' for Fife. • Development of roles and review of staffing across cancer services, introducing advanced practice models to reduce the specialist burden, work with regional partners. • To establish fully nurse-led services.	• Dual site working for systemic anti cancer treatment therapies (SACT). • Intermittent clinical and medical oncology support due to site specific pressures due to resource, increasing demand and complexity. • Expanding and tolerable SACT treatments leading to better survival and increasing return of patients with resource issues.

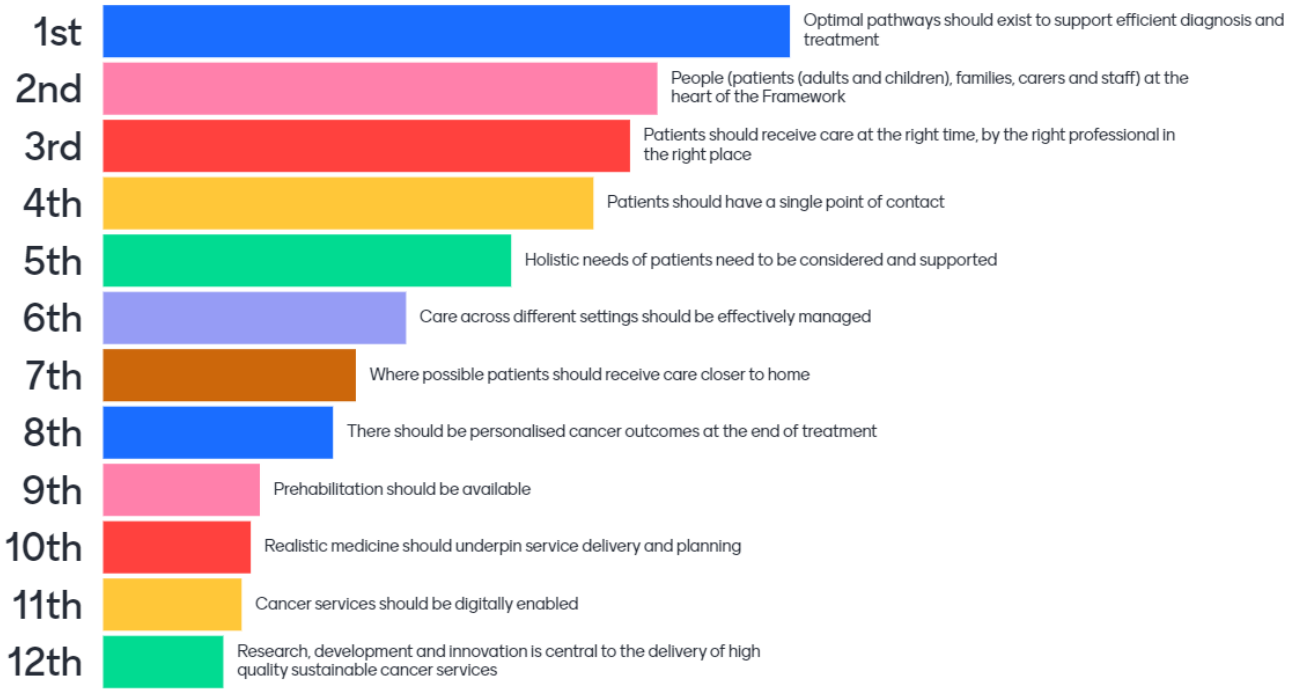
Strengths	Weaknesses	Opportunities	Threats
education and training to maximise skills within the workplace. • The workforce is knowledgeable and skilled, with specialist expertise in complex diagnostics, interventions and treatments. • A progressive approach is taken optimising on the availability of new innovations and technologies to ensure patients receive timely information and the best treatment available. • Accreditation and quality assurance ensures that patients receive safe care.	continued professional development, education, learning and teaching due to workforce constraints. • Links between services could be more efficiently optimised to ensure a whole system approach is taken to timeously manage our cancer patients, including use of the wider workforce, e.g. AHPs, palliative care, spiritual care. • Outdated estate and perceived under-utilisation of wider estate, including of community hospitals. • Minimise cross-site working. Space a factor in relation lack of EOL beds, with no room for growth and expansion. • Requirement for additional equipment to meet demand, e.g. CT, MRI. • Delivery of Cancer Waiting Times performance standards. • Lack of Information systems and digital enablement.	• Non-medical prescribing of oral SACT and delivery in the community. • Maximise use of estate in Fife for care closer to home wherever possible. • Improve interfaces between all services across Fife to provide an optimal pathway. • Develop staff training programmes to provide education to ensure a skilled generalist workforce. • Provide prehabilitation for all patients diagnosed with cancer • Continued development of digital resources and introduction of new and emerging technologies. • Understand and maximise on the offer that can be provided by wider workforce to 'make every contact count' to spread the burden of support.	• Staffing restraints due to recruitment and retention, an ageing workforce with vulnerability of and reliance on retired members of staff to undertake significant proportions of work. • Projected increase in cancer cases with an anticipated increase in presentation with advanced disease. • Lack of permanent funding impacts on the ability to continue with successful pilots or test of change initiatives. • Lack of opportunity to educate the workforce in respect to services that transcends all care, e.g. Palliative Care, Allied Health Professionals (AHPs), Realistic Medicine. • Equity of access to services, including where services are offered in tertiary centres.

This is what our patients told us

Engagement was also carried out in collaboration with the public, people affected by cancer, our 3rd sector colleagues and through an Equality Impact Assessment (EQIA); this was achieved by virtual consultation as summarised below.

The patient and public engagement session was set the context of the Framework, listening to patients who have experienced cancer. Discussion led to agreement of emergent and priority themes and this is how our patients and population ranked our cancer priorities:

Ranking priorities



Care Opinion

Comments from Care Opinion in 2020-2021 regarding cancer experiences in Fife also provided useful insights.

There were 20 positive stories:

1. Prompt tests/diagnosis
2. Exemplary care and treatment from all disciplines
3. Professionalism
4. Communication
5. Treatment during height of pandemic

And one negative around Communication

Complaints

Complaints can be a measure of quality service provision and themes identified through Patient Liaison shows issues with:

- Coordination of care
- Communication relating to all areas of care
- Late or misdiagnosis
- Waiting times
- Support at home

Equity framework

An Equality Impact Assessment (EQIA) was carried out to set out the impacts of the cancer framework to determine key recommendations and amendments to enable a more equitable and adjusted service to meet the needs of all.

The aim of the EQIA was to understand population groups and factors contributing to poorer health/health inequality, the potential impacts and to determine recommendations to reduce or enhance such impacts.

Potential impacts to patients	EQIA recommendation	Framework objective
• Location of services can present a challenge to patients in attending appointments and treatments including: – travel to/from appointments both within and outwith Fife – availability of patient transport – coordination of public transport – cost of travel.	• Consideration of where services are – it can be stressful to go out of Fife to go to an appointment or get treatment. • We need to look at our expenses budget and who gets the support.	**2.8** Ensure care is close to home where possible, repatriating care from out with Fife, where appropriate. **2.9** Review transportation for patients to access services both within and out with Fife. **3.8** Focus on equality when planning and designing new cancer related services to avoid and reduce the impact of social inequalities in accessing cancer services including screening, diagnosis, treatment, information, support and clinical trials. **4.1** Explore a Hub and Spoke model of care to ensure equitable access to clinical trials with care closer to home. **5.4.1** Ensuring the reduction of digital exclusion in the design of solutions (with particular consideration of people without access to data, devices, digital literacy and disabilities which may affect use of digital options. **7.2** Explore community-based models of care, such as community dispensing or supportive therapies. **7.4** Assess digital requirements in relation to development of Hubs for hard to reach groups.

Potential impacts to patients	EQIA recommendation	Framework objective
• Non-smoker living in a smoking environment – smoke free homes project. • Accessibility to green space, parks. • Promotion of healthy lifestyles, such as walking.	• Restart the Smoke Free Homes Project. • Link in with initiatives to enable access to parks and leisure. • Promote physical activity through existing initiatives.	**1.1** Reduce the harms associated with preventable risk factors for cancer, with a focus on supporting healthy communities, early and targeted intervention, effective and integrated harm reduction and reducing inequalities.
• Returning to work after a cancer diagnosis.	• Signpost for financial support from charities, such as Marie Curie. • Explore opportunities to retrain if not able to return to job.	**2.10** Make returning to work after a cancer diagnosis a health outcome, including signposting and awareness of public and 3rd sector organisations that support return to work after illness such as Access to Work/FEAT/Health Working Lives.
• Access to advice, including digital access.	• A combination of access to services should be available for those who do not have use of digital resources.	**5.3.1** Development of a cancer webpage for staff and patients to access up to date, relevant information. **5.2.4** Introduce patient access to information and patient initiated review. **7.4** Assess digital requirements in relation to development of Hubs for hard to reach groups.
• Access to services for protected groups.	• Improve community messaging. • A holistic approach, including spiritual care, for Palliative Care and not just medicines.	**1.2** Protect people from cancer through screening and HPV vaccination with high rates of uptake and address inequalities in uptake. **2.6** Patient choice, spiritual belief and understanding must be central to the care received and delivered.

Our cancer commitments

Prevention early diagnosis and reduction in inequalities

Commitment 1: To reduce cancer incidence, mortality and inequalities for our population through effective prevention, screening and early detection initiatives.

There are striking inequalities in cancer incidence and outcomes in Fife, largely due to the unequal distribution of social factors that influence health. In order to reduce cancer incidence and mortality we need to focus on the known modifiable risk factors for cancer, reducing inequalities and addressing the broader 'upstream' factors that contribute to inequalities in our health. Preventing cancer in Fife will be a complex and a long-term endeavour and whole system collaboration with partner organisations is critical to achieving our priorities.

Where we live has a direct impact on health and wellbeing. Our ambition is to make sure the fundamental building blocks needed for good health are in place for Fife. A Plan for Fife | Our Fife - Creating a successful, confident and fairer Fife sets out our joint ambitions within Fife Partnership over the next 10 years.

Existing workstreams in Fife are underway and support broader strategies to reduce harms and inequalities associated with cancer, and directly align with broader recommendations in relation to the NHS Fife Population Health and Wellbeing Strategy and Prevention & Early Intervention Strategy planned by the Health and Social Care Partnership (HSCP).

To deliver this commitment the priorities identified for reducing cancer incidence, mortality and inequalities in Fife are:

- **1.1.** Reduce the harms associated with preventable risk factors for cancer, with a focus on supporting healthy communities, early and targeted intervention, effective and integrated harm reduction and reducing inequalities. Key priority areas are:
  - 1.1.1. Develop a system wide approach in collaboration with Health Promotion to focus on promoting holistic assessments of patient's risk for the cancers which are attributable to life style across hard to reach groups e.g., Making every contact count.
  - 1.1.2. Promote good community orientation through improving awareness.
  - 1.1.3. Support the public, patients and staff to eat well, have a health weight and be physically active.

1.1.4. Reduce harm associated with tanning practices in our community.

1.2. Protect people from cancer through HPV vaccination, maintaining immunisation coverage rates and reducing inequalities in coverage in line with the Fife Immunisation Strategic Framework 2021-24.

1.3. Review the impact of the Fife Rapid Cancer Diagnosis Service (formerly known as Early Cancer Diagnosis Centre (ECDC)) for those with vague symptoms with a view to expanding to other specific tumour sites

1.4. Work with partner organisations across the whole system to address the broader upstream determinants of health that contribute to cancer inequalities.

1.5. Embed a culture of 'prevention' and 'mitigating inequalities' into routine services, increasing staff awareness and capacity to intervene early with regards to risk factors for cancer.

1.5.1. Increase health professionals' awareness to promote the Health and Social Care Partnership (HSCP) Reduce the Risk of Cancer initiative by providing key messages to share and signpost information of the key preventable risk factors for cancer.

1.5.2. Build on work to increase advice and support relating to income maximisation for cancer patients.

1.6. Ensure screening is easy to access, local and supported by appropriate resources to support patients to participate, with a focus on populations that have difficulty accessing screening to address inequalities in uptake.

1.7. Ensure Primary Care Healthcare Professionals have appropriate and equitable access to diagnostic imaging and triage to support urgent suspected cancer referrals.

Person-centred

Commitment 2: The patient will be at the heart of how services are designed with excellent patient experience as a priority.

Patients have told us their top three priorities are to experience an optimal pathway for rapid diagnosis and treatment, that people should be at heart of the Framework and they should receive the right care at the right time in the right place.

To achieve this commitment we will:

2.1 Actively include the views and experiences of patients, families and unpaid carers through continued engagement to ensure shared decision making, including Care Opinion.

2.2 Services will be designed to ensure there is a dedicated Single Point of Contact to provide information points for appointments, advice, clinical and other support.

2.3 Improve sharing of quality information with patients and care providers through digitally enabled systems, e.g., Holistic Needs Assessments (eHNA) and Treatment Summaries, Digital Patient Hub. electronic Key Information Summaries (eKIS) in primary care including Palliative Care summaries

2.4 Develop a Cancer Services website dedicated to helping *people* who face *cancer* learn about patient services

2.5 Ensure patients have access to prehabilitation and rehabilitation for optimum fitness prior and post treatment

2.6 Patient choice, spiritual belief and understanding must be central to the care received and delivered.

2.7 Ensure optimal pathways exist to ensure efficient diagnosis and treatment of patients.

2.8 Ensure care is close to home where possible, repatriating care from out with Fife, where appropriate.

2.9 Review transportation and financial support for patient access to services both within and out with Fife.

2.10 Make returning to work after a cancer diagnosis a health outcome, including signposting and awareness of public and 3rd sector organisations that support return to work after illness such as Access to Work, FEAT and Healthy Working Lives.

2.11 Continue to offer patients support through the Macmillan Improved Cancer Journey (ICJ) pathway to ensure they can access support as their circumstances change.

Optimal pathways and integrated care

Commitment 3: Patients will receive the right treatment at the right time in the right place by the right person. This will be delivered through the development of optimal and integrated pathways to deliver high quality cancer care.

There is a recognised need to improve timely access for our patients and use of patient pathways and integrated models of care will be a key priority. Variation across pathways should be reduced and underpinned by optimum referral pathways to deliver timely access to diagnostics and treatment. To do this, services need to be integrated to ensure the patients' care is coordinated from referral to end of life care.

Due to the growing and ageing population we need to recognise the full multi professional teams to support patients during diagnosis, treatment and beyond treatment including care for people with cancer who do not receive cancer treatment (best supportive care). Central to meeting changing demand is the embedding of a greater sense of 'shared responsibility' for all steps in the pathway between patients, secondary, primary, community health services and other partner agencies with accountability for timely communication between services and the availability of accessible plans of care.

NHS Fife places great emphasis upon preventing avoidable deaths, however, when preventing death is no longer an option, we will continue to treat and support our patients, including those affected by cancer, throughout their last months and weeks of life.

To achieve this commitment, we will:

3.1 Implement sustainable optimal cancer pathways with review of timed cancer pathways to improve cancer waiting times performance and to ensure clear timelines for appointments, diagnostics, decisions and treatments, including direct patient navigation for the most complex patient pathways from initial referral through to palliative and end of life care.

3.2 To embed a new model for Specialist Palliative Care, to optimise generalist palliative care access and provision in acute and community settings; to develop a Best Supportive Care (BSC) pathway with care that is multidisciplinary, integrated and coordinated; improving Primary Care, Acute Care and Specialist Palliative Care linkages.

3.3 Develop Systematic Anti Cancer Treatment (SACT) models to ensure patients are treated in the most appropriate setting.

3.4 Review the contribution of the wider workforce for continuing care and utilise all the workforce to ensure that every contact counts.

3.5 Ensure effective design of Multidisciplinary Team (MDT) meetings to optimise on early diagnosis and timely treatment and care, fostering a culture of strong leadership and teamwork across all services.

3.6 Ensure that prehabilitation and rehabilitation are embedded in care pathways.

3.7 Actively engage with Edinburgh Cancer Centre in relation to opportunities in Fife.

3.8 Focus on equality when planning and designing new cancer related services to avoid and reduce the impact of social inequalities in accessing cancer services including screening, diagnosis, treatment, information, support and clinical trials.

Research, Innovation & Knowledge

Commitment 4: Research, innovation and knowledge is central to the delivery of high quality sustainable cancer services for our patients and population.

A positive research culture in health care is associated with better job satisfaction for staff and better outcomes for patients. NHS Fife Research, Innovation and Knowledge Department hosts and sponsors a large and growing number of research studies ranging from international multi-centre drug trials to short term student projects. They work with a variety of commercial and non-commercial sponsors and funders, investigators and researchers with a wide range of interests and experience, members of the public and service users and colleagues from across Scotland and the UK. NHS Fife will make every effort to ensure cancer patients have access to the most up to date technology and innovative diagnostics and treatments.

To achieve this commitment, we will:

4.1 Explore a Hub and Spoke model of care to ensure equitable access to clinical trials with care closer to home.

4.2 Improve links with East Region Innovation Hub.

4.3 Understand the cost benefits of improved clinical trial participation.

4.4 Embed research into standard work through the research, innovation and knowledge programme of education.

4.5 Ensure staff have the appropriate time allocated to acquire knowledge of new treatments.

4.6 Support healthcare professionals to be innovative in pursuing continuous quality improvement, prioritising tests of change to support early diagnosis and wider best practices from successful research studies.

4.7 Align with the NHS Fife Innovation governance Framework to ensure new innovations are appropriately planned, resourced and monitored.

4.8 Seek opportunities to test innovative solutions with the McKenzie Early Diagnosis Institute and the South East Health Innovation Hub (HISES).

4.9 Work closely with our educational partners.

4.10 Align work with Public Health to reduce inequalities in research

Our enablers

Digital and Information

Commitment 5: Digitally enabled for sustainable and efficient service models which embrace technology and innovation.

Digital and Information Department have a strategy and programmes service area which collaborates across Digital, NHS Fife, NHS Scotland, suppliers and partners to develop strategy and deliver service change that is focussed on improved patient care through digital transformation. Existing strategic priorities currently being undertaken which supports cancer patients are:

- Near Me
- Digital Patient Hub
- Electronic Patient Record Development

To provide staff and patients with access to digitally enabled health it is imperative that the use of the Scottish Approach to Service Design is considered to ensure systems are efficient and effective. Digital and Information Department will require service commitment when adopting existing and implementing new digital capability in support of the Cancer Framework.

To achieve this commitment, we will:

5.1. Develop cancer clinical information systems that:

- **5.1.1.** Track patients referred with urgent suspected cancer or diagnosed with cancer.
- **5.1.2.** Provide a Multidisciplinary Team (MDT) solution which is fit for purpose.
- **5.1.3.** Manage and monitor activity, for example inpatient SACT and HPB surveillance.

5.2. Support the improvement of the cancer referral process through:

- **5.2.1.** Implementation of Fife Referral Organisational Guidance (FROG).

5.2.2. Introduction applications ('Apps') to support referral, e.g. photo triage, in a secure and compliant manner.

5.2.3. Prepare for the implementation of nationally provided artificial intelligence (AI) to support early detection.

5.2.4. Implementation of Acute Clinical Referral Triage (ACRT) and Patient initiated review (PIR).

5.3. Ensure information is available to patients and staff to improve their patient journey and outcomes:

5.3.1. Development of a cancer webpage for staff and patients to access up to date, relevant information.

5.3.2. Development of information resources, e.g. electronic treatment summaries, palliative performance scale.

5.3.3. Implementation of Electronic Patient Record.

5.4. Support the change by:

5.4.1. Ensuring the reduction of digital exclusion in the design of solutions, with particular consideration of people without access to data, devices, digital literacy and disabilities which may affect use of digital options.

5.4.2. Ensuring the availability of the Digital Enablement team to support both patients and staff with their adoption and use of digital systems.

5.4.3. Ensuring the solutions are safe and secure by meeting both clinical and information governance standards.

5.4.4. Ensuring appropriate cancer data is available for reporting in support of operational improvement and strategic planning.

Workforce

Commitment 6: Recognise workforce challenges and identify system-wide approaches to support in relation to wellbeing, education and training to ensure our patients receive the best care.

To deliver this Framework we recognise that our staff are our biggest asset. The NHS is the biggest employer in Europe, and the world's largest employer of highly skilled professionals. There is evidence that staff are feeling the strain, particularly since the pandemic and there is some evidence that many of those leaving the NHS would remain if employers could reduce workload pressures, offer improved flexibility and professional development. Staffing gaps are already present, in particular in diagnostics, such as radiology, pathology and the specialist nursing workforce. Consideration of alternatives is required where there are national shortages such as oncology, and specialist consultant posts. There are also concerns around the ageing workforce and we therefore need to take the opportunity to look at how we resource the cancer workforce differently to ensure it is balanced, resilient and fit for the future. Table 3 shows the current cancer specific workforce. Any workforce implications will align with the NHS Fife Workforce Strategy.

To achieve this commitment, we will:

6.1. Review the cancer workforce, including skill mix and supporting roles, to inform future service delivery models and succession planning.

6.2. Work towards the national agenda to transform roles with consideration of Senior Professional Leadership, Management of CNS, ANP and AHP workforce being aligned to support the broader vision and developments.

6.3. Review wider roles, such as AHPs and palliative care to complement an integrated cancer care pathway. Ensure the wellbeing and resilience of the cancer workforce including improved access to Spiritual Care and other wellbeing services as part of the approach to staff wellbeing.

6.4. Identify gaps in medical workforce working with regional partners to develop a regional plan to ensure resilience and equity of care.

6.5. Take forward leadership opportunities across the workforce to highlight opportunities available to cancer workforce colleagues, encouraging new talent to take up leadership roles.

6.6. Make sure all staff have the time to undertake appropriate training and development in order to carry out their role and to equip them for future roles.

6.7. Optimise on education and training from others in the workforce to ensure patients receive the most appropriate care, for example Realistic Medicine, Occupational Medicine and Palliative Care.

6.8. Take a holistic approach to the management of patients with cancer to include those treating patients who are not in cancer roles, for example inpatients.

6.9. Introduce a cancer awareness programme in teaching of junior doctors to educate and ensure early understanding.

Property and Asset Management

Commitment 7: Ensure our healthcare environments are designed to deliver optimum patient care

Review of our current estate is crucial for optimal patient care, with the design of patient pathways informing configuration of our estate, both currently and in the future to ensure we can accommodate future demand and growth. As cancer prevalence increases and people are living longer, current accommodation is an issue. The Framework aims to address these challenges, now and in the longer term, and it is therefore imperative we review estate throughout Fife with the aim of increasing capacity and to give the ability to offer care closer to home, where appropriate.

To achieve this commitment, we will:

7.1. Review the estate in line with the Board's Property & Asset Management Strategy to accommodate new ways of working and new technologies so that capacity can cope with demand now and in the future.

7.2. Explore community-based models of care, e.g., community dispensing, supportive therapies and the non-hospital based services, for the palliative phase of illness to ensure services are accessible for all, including people living in the most deprived areas of Fife where incidence and mortality of cancer is higher.

7.3. Develop the case for a Cancer Unit in Fife in line with the developing Population Health and Wellbeing Strategy.

7.4. Assess digital requirements in relation to development of Hubs for hard-to-reach groups.

Quality and Performance Improvement

Commitment 8: To make best use of available information sources to assure patients are receiving timely, high quality, effective care.

Performance data on the current Local Delivery Plan (LDP) standards set priorities between the Scottish Government and NHS Boards to provide assurance on NHS Scotland performance. In October 2008, Better Cancer Care – An Action Plan was published and stated that 95% of all patients diagnosed with cancer will begin treatment within 31 days of decision to treat, irrespective of route of referral and 95% of those referred urgently by their GP with a suspicion of cancer will begin treatment within 62 days of date of receipt of referral. Graph 6 shows quarterly 62 and 31 day performance from 2017 to 2021.

To strengthen the commitments made in in the 2008 publication, Quality Performance Indicators (QPIs) were introduced to improve safe, effective and person centred care (CEL06 (2012)).

Cancer has remained a priority through the pandemic and the refresh of the Effective Cancer Management Framework provides teams with tools to effectively manage patients from the point of referral to first treatment and aims to improve patient experience as well as cancer waiting times performance.

To achieve this commitment, we will:

8.1. Embed the Effective Cancer Management Framework into the cancer team's workplan, supported by senior management to ensure full adoption.

8.2. Ensure cancer patients continue to be seen and treated as a priority.

8.3. View national 62 day and 31 day Cancer Waiting Times targets as a minimum standard.

8.4. Continue to drive and improve quality performance through robust governance of the Quality Performance Indicators and local use of data to improve service delivery.

8.5. Full engagement with the Cancer Managers' Forum and other national groups to share good practice.

8.6. Ensure consistent, good quality data collection through formal education for the cancer data collection team and through the formal Quality Assurance programmes.

Risk to delivery

Title	Description	Risk Profile
Cancer workforce issues	There is a risk that we will be unable to deliver the Cancer Framework within the stated timescales due to: lack of succession planning, inability to recruit suitably trained staff to vacant posts, national shortages of specialist posts and posts not being funded substantively, resulting in sub optimal patient experience and outcomes, increased pressure on staff, staff wellbeing and services and adverse publicity.	
Financial delivery of cancer framework	There is a risk that we will be unable to deliver the Cancer Framework due to insufficient financial investment in Cancer Services and funding being provided on a non-recurring basis resulting in disruption to / loss of services, sub optimal patient experience and clinical outcomes, and adverse publicity.	
Digital and information challenges	There is a risk that lack of digital and information support for cancer services will impact on our ability to delivery key commitments identified in the Framework in relation to: • Lack of robust quality and performance improvement data collection systems resulting in disparate data collection impacting optimal pathways and integrated care. • Digital exclusion for those without access resulting in inequalities to person-centered care.	TBC
Cancer services property Infrastructure	There is a risk that we will be unable to deliver the cancer framework due to inadequate space/capacity to accommodate the expected increase in patients with a cancer diagnosis and with extended active treatment times, resulting in sub optimal patient care, experience, outcomes and safety.	
Expansion of Edinburgh Cancer Centre (ECC)	There is a risk to delivery of the Cancer Framework if there is inadequate regional collaboration and funding to support the repatriation of patients should the Edinburgh Cancer Centre (ECC) expansion Initial Agreement (IA) and Outline Business Case (OBC) be successful in terms of staffing and recruitment, estate, patient experience, pathways.	

Risk profile

Likelihood	Consequence				
	Negligible 1	**Minor 2**	**Moderate 3**	**Major 4**	**Extreme 5**
Almost certain 5	LR **5**	MR **10**	HR **15**	HR **20**	HR **25**
Likely 4	LR **4**	MR **8**	MR **12**	HR **16**	HR **20**
Possible 3	VLR **3**	LR **6**	MR **9**	MR **12**	HR **15**
Unlikely 2	VLR **2**	LR **4**	LR **6**	MR **8**	MR **10**
Remote 1	VLR **1**	VLR **2**	VLR **3**	LR **4**	LR **5**

In terms of grading risks, the following grades have been assigned within the matrix.

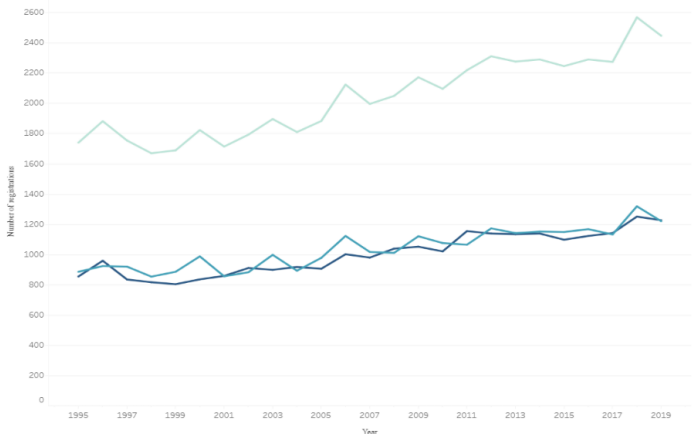
- Very Low Risk (VLR)
- Low Risk (LR)
- Moderate Risk (MR)
- High Risk (HR)

Descriptor	Remote	Unlikely	Possible	Likely	Almost Certain
Likelihood	Can't believe this event would happen – will only happen in exceptional circumstances (5-10 years)	Not expected to happen, but definite potential exists – unlikely to occur (2-5 years)	May occur occasionally, has happened before on occasions – reasonable chance of occurring (annually)	Strong possibility that this could occur – likely to occur (quarterly)	This is expected to occur frequently / in most circumstances – more likely to occur than not (daily / weekly / monthly)

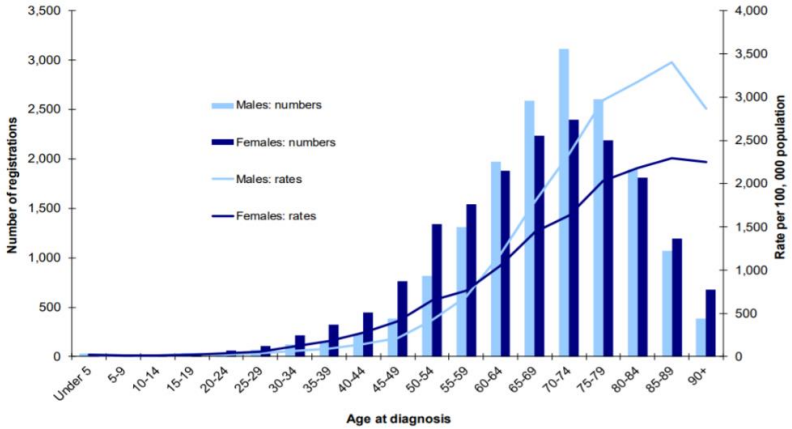
Data and information

Public health data

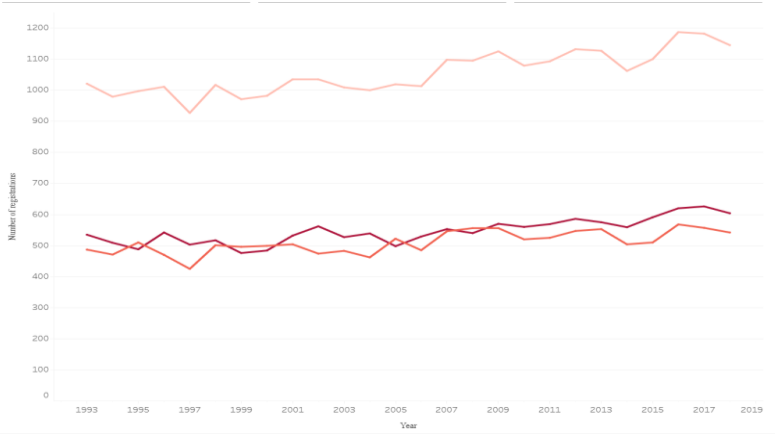
The table below shows new cases of cancer in Fife from 1995–2019



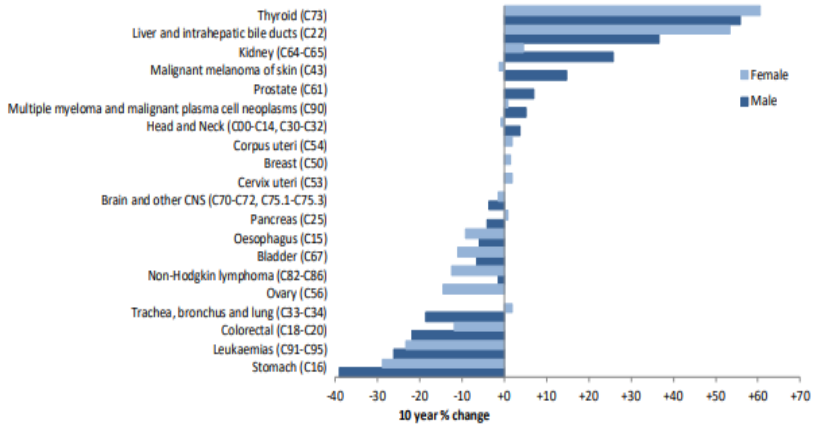
Numbers diagnosed male/female



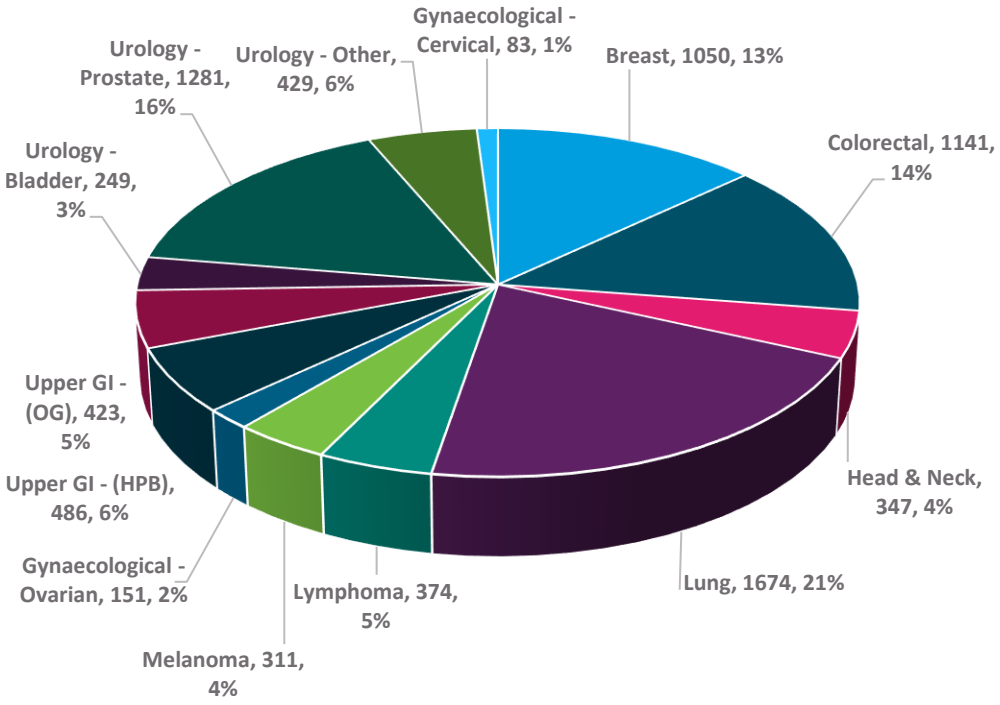
The graph shows number of deaths due to cancer in Fife from 1993 to 2019.

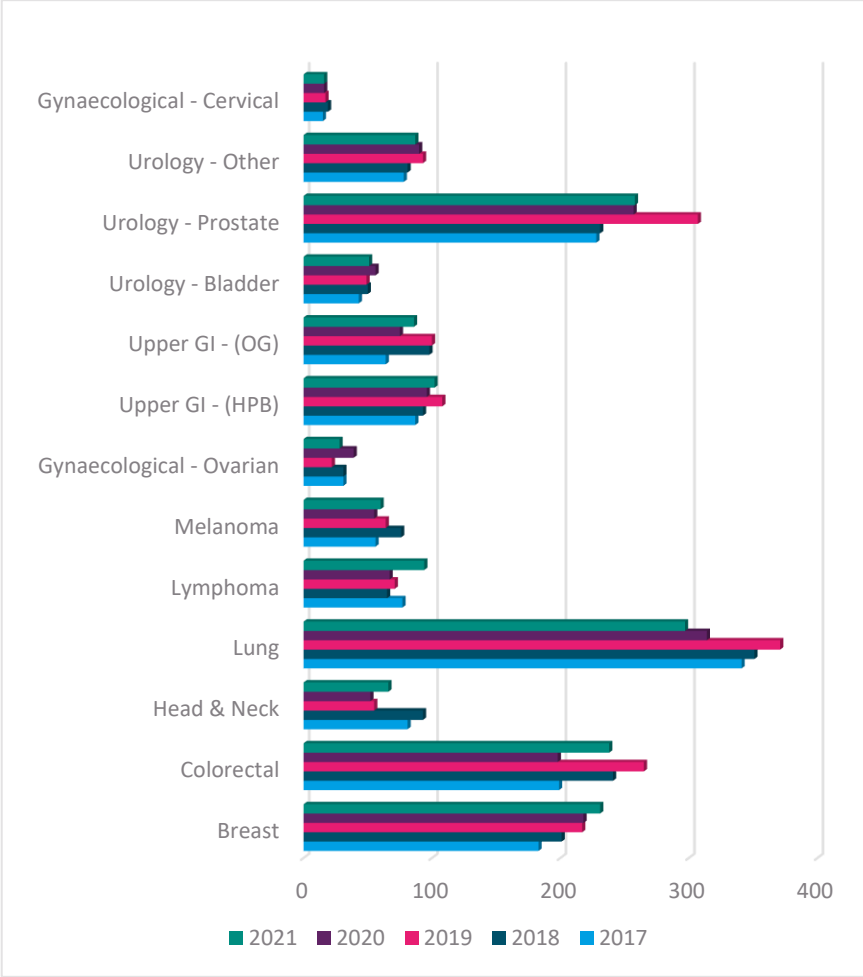


10 year percentage change in age-adjusted incidence rate for 20 most common cancers

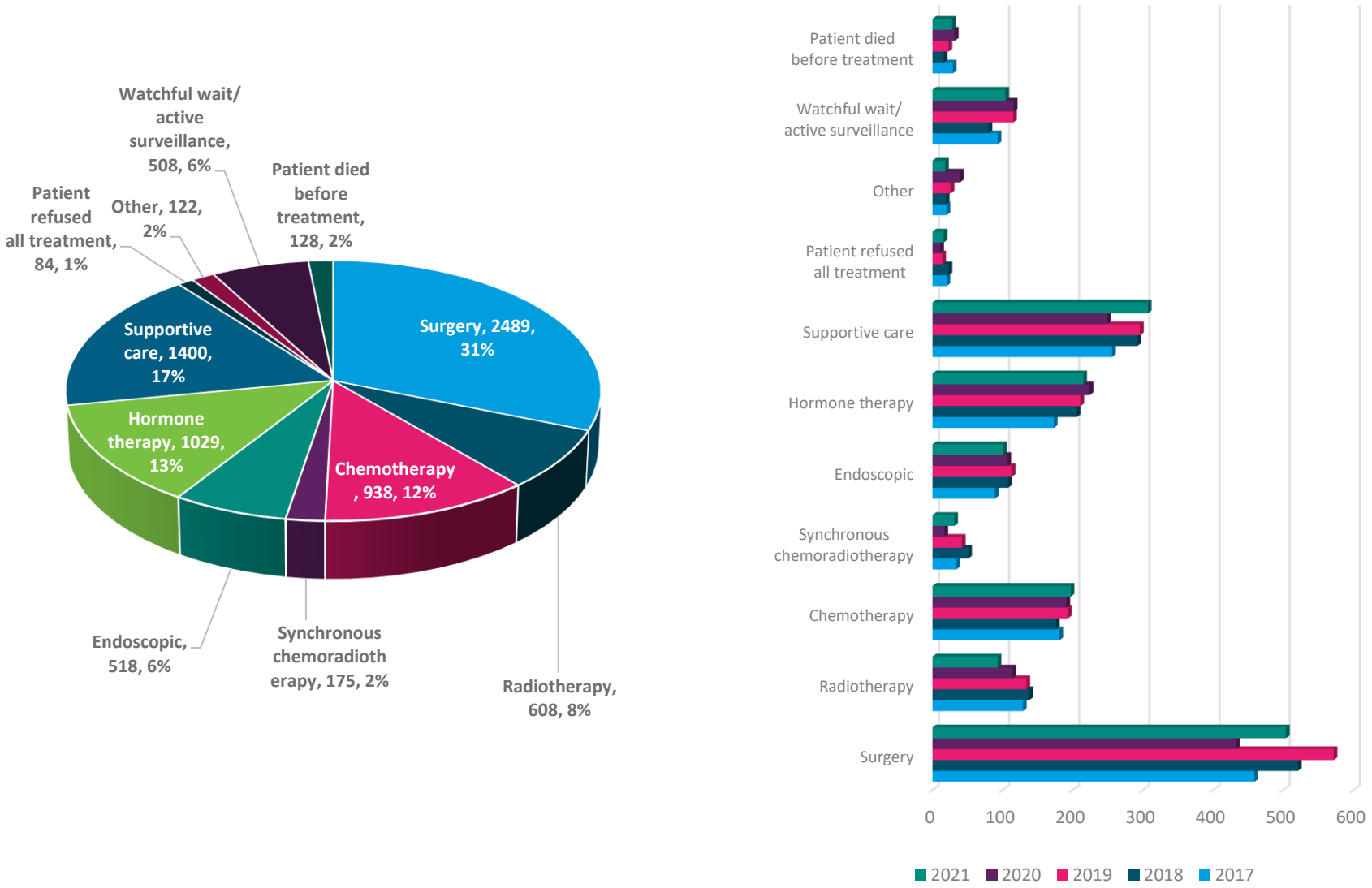


Graph 1: Number of New Cancers Diagnosed (reportable cancers January 2017–December 2021)

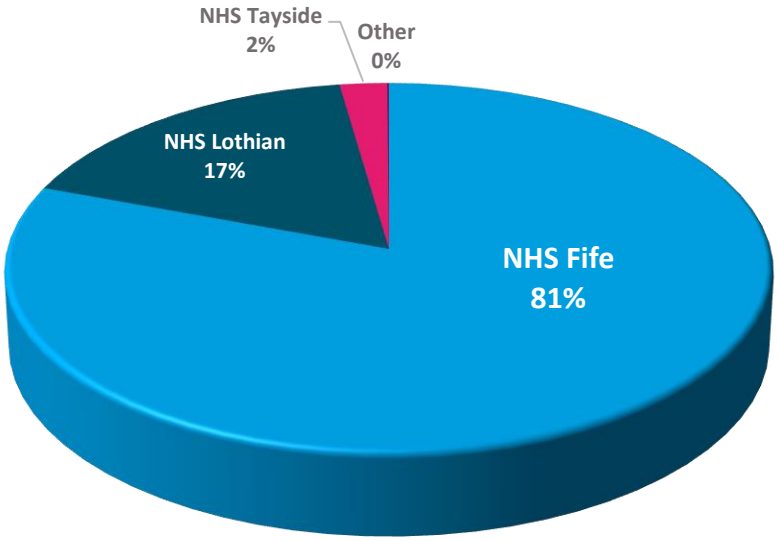




Graph 2: Number of New Patients Treated by Treatment Type (reportable cancers) January 2017–December 2021

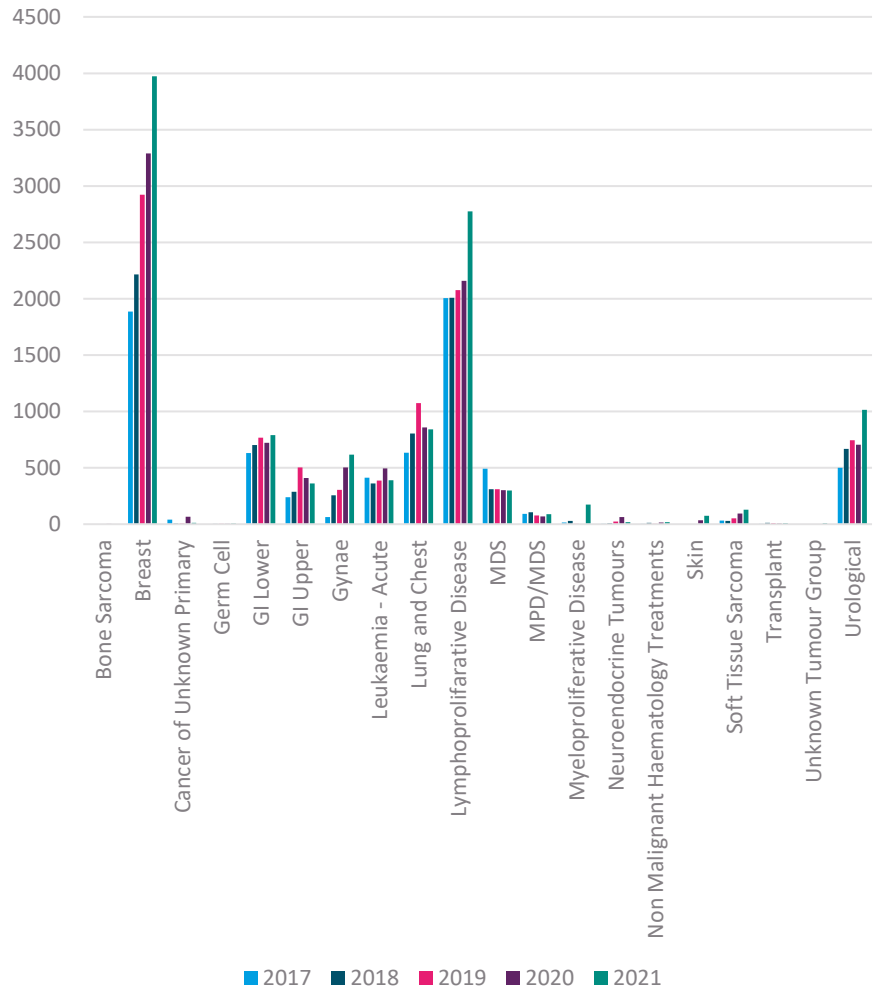


Graph 3: Proportion of New Patients Treated by Board (1st Treatment – reportable cancers) January 2017–December 2021



Board of treatment	
Board of treatment	**No pts**
NHS Fife	6448
NHS Lothian	1368
NHS Tayside	176
Other	7
Grand total	**7999**

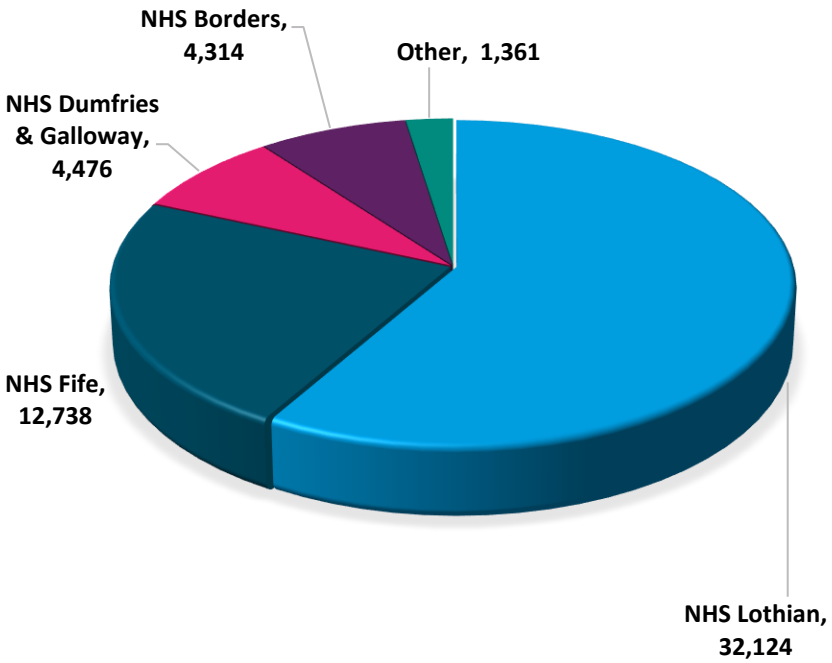
Graph 4: Systemic Anti-Cancer Treatment (SACT) Episodes January 2017–December 2021



Tumour type	2017	2018	2019	2020	2021
Bone Sarcoma				<5	
Breast	1886	2215	2923	3290	3974
Cancer of Unknown Primary	41	5	6	65	11
Germ Cell		<5	<5	>5	<5
GI Lower	630	701	767	723	790
GI Upper	240	287	503	410	360
Gynae	63	256	305	503	618
Leukaemia - Acute	413	362	386	494	390
Lung and Chest	633	805	1073	859	841
Lymphoproliferative Disease	2005	2009	2075	2160	2775
MDS	493	311	310	302	300
MPD/MDS	92	105	77	69	89
Myeloproliferative Disease	14	28	<5		174
Neuroendocrine Tumours	<5	9	22	64	19
Non-Malignant Haematology Treatments	>5	13	<5	16	19
Skin				35	74
Soft Tissue Sarcoma	33	28	53	93	128
Transplant	<5	13	8	6	8
Unknown Tumour Group					9
Urological	501	668	744	705	1015
Grand total	**7050**	**7816**	**9263**	**9799**	**11601**

	2017	2018	2019	2020	2021
Non SACT Interventions	1408	1639	3112	3492	4064
SACT given as Intervention	183	220	507	369	718
Total interventions	**1591**	**1859**	**3619**	**3861**	**4782**

Graph 5: South East Cancer Network (SCAN) Radiotherapy Treatment Episodes 2019



NHS Board	Number of attendances
NHS Lothian	32,124
NHS Fife	12,738
NHS Dumfries & Galloway	4,476
NHS Borders	4,314
Other	1,361

Graph 6: Quarterly Cancer Waiting Times Performance from Q1 2017 to Q4 2021

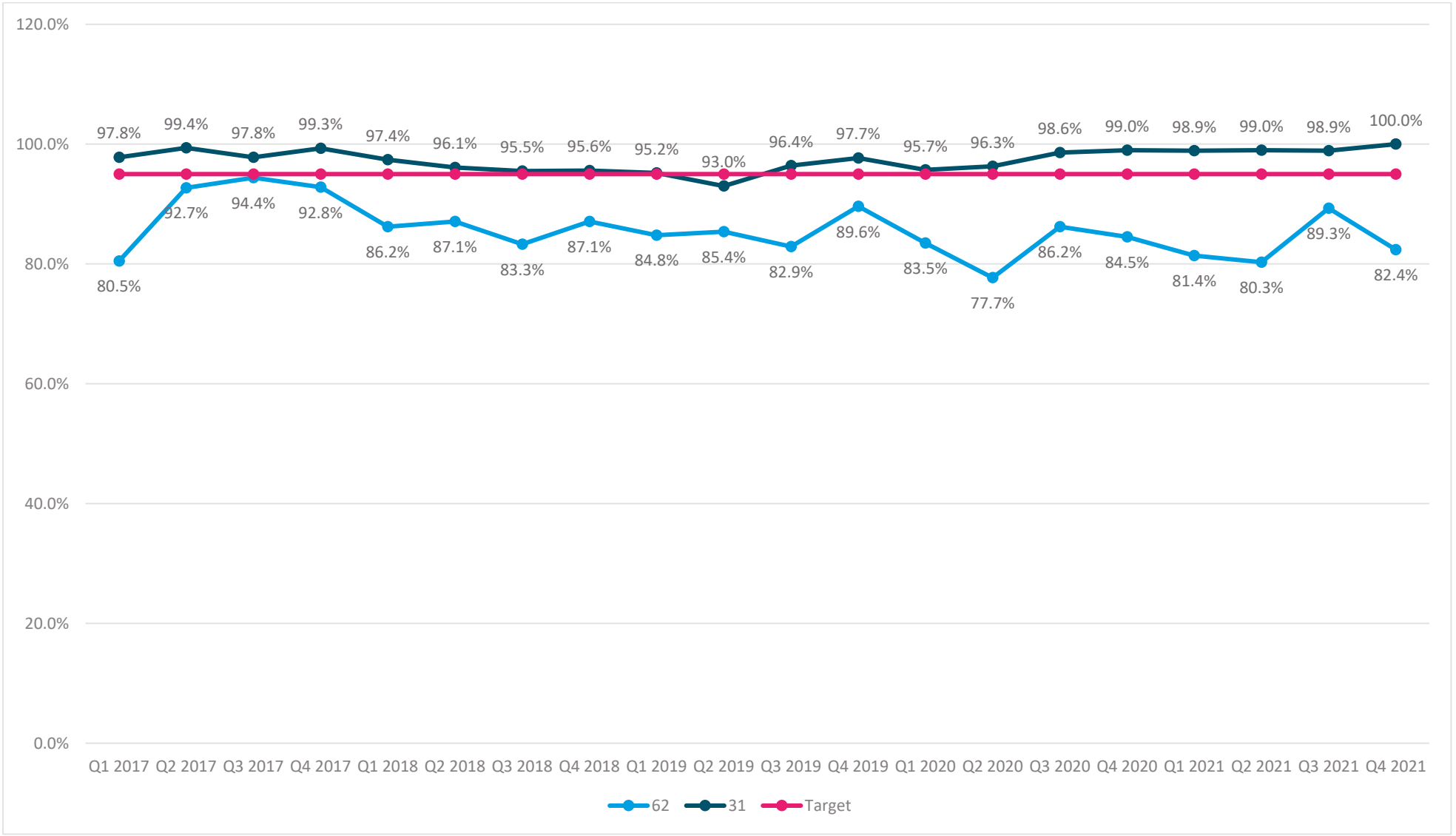


Table 1: Referral vs Diagnosis – Conversion 2017–2021

NHS Fife	Conversion Rates (USC Referral/Diagnosed)														
Tumour Site	2017			2018			2019			2020			2021		
	Referrals	Treated	Conversion	Referrals	Treated	Conversion	Referrals	Treated	Conversion	Referrals	Treated	Conversion	Referrals	Treated	Conversion
Breast	836	109	**13%**	1281	139	**11%**	1375	133	**10%**	1541	175	**11%**	1873	167	**9%**
Colorectal	836	43	**5%**	1048	68	**6%**	1226	89	**7%**	887	95	**11%**	1447	81	**6%**
Head & Neck	464	32	**7%**	747	34	**5%**	959	32	**3%**	753	35	**5%**	750	41	**5%**
Lung	427	130	**30%**	473	154	**33%**	466	173	**37%**	373	112	**30%**	397	114	**29%**
Lymphoma	27	22	**81%**	54	12	**22%**	72	15	**21%**	77	9	**12%**	121	14	**12%**
Melanoma	929	22	**2%**	1918	42	**2%**	2082	41	**2%**	1382	37	**3%**	1908	35	**2%**
Ovarian	63	14	**22%**	61	16	**26%**	77	11	**14%**	51	14	**27%**	77	9	**12%**
Upper GI - (HPB)	38	15	**39%**	52	23	**44%**	75	25	**33%**	63	20	**32%**	95	30	**32%**
Upper GI - (OG)	484	27	**6%**	658	31	**5%**	680	32	**5%**	390	31	**8%**	525	29	**6%**
Bladder	317	13	**4%**	434	29	**7%**	486	19	**4%**	398	29	**7%**	565	24	**4%**
Prostate	230	84	**37%**	333	139	**42%**	358	147	**41%**	309	114	**37%**	402	132	**33%**
Urology - Other	86	20	**23%**	112	24	**21%**	131	27	**21%**	84	22	**26%**	127	15	**12%**
Cervical	50	3	**6%**	91	5	**5%**	118	4	**3%**	117	8	**7%**	173	5	**3%**
Grand total	**4787**	**534**	**11%**	**7262**	**716**	**10%**	**8105**	**748**	**9%**	**6425**	**701**	**11%**	**8460**	**696**	**8%**

Table 2: SCAN Clinical Trial Performance: Clinical Trial Quality Performance Indicator

Target = 15% for all Tumour sites.

Tumour Site	Cohort	Fife		Borders		D&G		Lothian		SCAN	
		%	No Pts	%	No Pts	%	No Pts	%	No Pts	%	No Pts
Lymphoma	2019-20	0%	0/73	0%	0/31			2.1%	4/187	1.4%	4/293
Acute Leukaemia	2019-20	5.9%	1/17	0%	0/4			16.1%	5/31	22%	6/51
Bladder	2019-20	1.7%	1/60	5.3%	1/19	6.3	2/32	5.6	7/125	4.7	11/236
Renal	2020	4.8%	3/62	40%	8/20	21.2%	7/33	33.3%	49/147	25.6%	67/262
Testis	2019-20	0%	0/12	0%	0/3	0%	0/6	0%	0/36	0%	0/57
Prostate	2019-20	0%	0/253	0%	0/107	0%	0/122	4%	21/525	2.1%	21/100
Oesophago-gastric	2020	2%	2/99	13.2%	5/38	4.3%	2/46	10.1%	18/178	7.5%	27/361
HPB	2020	3.8%	4/104							1.5%	7/445
Colorectal	2020-21	1.6%	4/243	11.2%	11/98	5.9%	7/119	17.2%	90/523	11.4%	112/983
Gynaecology (Cervical)	2019-20	6.8%	1/15	0%	0/6	0%	0/6	7.6%	2/26	5.7%	3/52
Gynaecology (Endometrial)	2019-20	3.8%	2/53	0%	0/13	0%	0/25	9.9%	10/101	6.2%	12/192
Gynaecology (Ovarian)	2019-20	41.4%	12/29	11.1%	1/9	40%	6/15	122.2%	77/63	82.8%	96/116
Breast	2020	2.4%	5/209	24.7%	18/73	1.9%	2/108	32.5%	299/921	24.7%	324/1311
Head and Neck	2019-20	18.8%	13/69	23.6%	5/19	20%	7/35	19.3%	37/192	19.7%	62/315
Lung	2019	1.1%	4/354	0.9%	1/106	0%	0/155	2%	15/7612	1.5%	20/1377
Melanoma	2019-20	0%	0/71	0%	0/37	0%	0/34	1%	2/188	0.6%	2/325

Table 3: Current Cancer-Specific Workforce (December 2021)

	Role	Establishment
Cancer Specific Workforce	Cancer Lead, Surgery	1 PA/Week
	Cancer Lead, Medicine & Oncology	1 PA/Week
	Cancer Lead GP & Palliative Care	2 PA/Week
	Cancer Lead Nurse	1.0wte
	Cancer Transformation Manager	1.0wte
	Cancer Audit & Performance Manager	1.0wte
	Cancer Audit Facilitators	3.6wte
	MDT Coordinators/Trackers	4.2wte
	Tracker	0.5wte
	Central Referral Unit	1.55wte

Cancer Workforce Specialty	Cancer Consultant/Lead	Staff			
		WTE			
		Band 8A	Band 7	Band 6	Band 5
Pharmacy	Principle Pharmacist 1.0wte	2.8	2.0 fixed + 0.5 rotational	nil	2.0
Oncology (Visiting)	50 PA/week				
Allied Health Professionals					
Dietetics				1.0	
Occupational Therapy			3.2		
Physiotherapy			1.6		
Speech & Language		0.6	0.6	0.6	
Radiology	No cancer-specific workforce				
Other	Specialty Doctor 1.0wte				

Cancer Workforce Specialty	Consultant/Lead	Advanced Nurse Specialist (ANP) Clinical Nurse Specialist (CNS)			Clinical Support Workers (CSW) Administrative Support			
		WTE						
		Band 8A	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2
Acute Oncology	Yes		1.0	1.0				
Breast	Yes		1.0	2.0				
Colorectal	Yes		1.0	2.0	1.5		1.0	
Head & Neck (ENT & OMFS)	Yes		1.0	0.6			0.8	
Lung	Yes		2.0					
Haematology	Yes		1.0	1.0				
Haematology Day Unit	Yes		1.0	2.0	15.2		2.0	1.2
Haematology Ward 34	Yes		1.0	1.8	13.0			7.8
Gynaecology	Yes		1.0			1.0		
Dermatology	Yes			3.8				
Upper GI (HPB & OG)	Yes		2.0					
Urology	Yes		1.0	2.0	0.4	1.0	0.6	
Early Cancer Diagnosis Centre	Yes		1.0			1.0		
SACT	Yes (Nurse Consultant)	1.0						

Table 4: Regional Services Provided to NHS Fife (December 2021)

Area	Service provided	Cancer types	Services Provided	Cancer Types
	Lothian	Lothian	Tayside	
Outpatients	Oncology (visiting)	All (seen in Fife)		
Specialist Interventions	Speech & Language	Head & Neck		
Specialist Diagnostics	PET Molecular Testing ERCP Mediastinoscopy Staging Laparoscopy	All (except Lung) All Upper GI/HPB Lung Upper GI	PET	Lung
Treatment	Chemotherapy Chemoradiation Surgery Robotic Surgery Radiotherapy (including specialist) Brachytherapy Proton Beam Immunotherapy VATS CHART Radiofrequency Ablation (RFA)	Head & Neck Head & Neck (ENT) Lung, Upper GI, HPB Complex Breast. Prostate All Prostate, Cervical Lymphoma All Lung Lung, Liver, Kidney, other abdomen	Chemoradiation Plastic Surgery	

Area	Service provided	Cancer types	Services Provided	Cancer Types
	Lothian	Lothian	Tayside	
Other	Genetics		Fertility Sparing	
Regional Multidisciplinary Team (MDT) Meetings	MDT	Head & Neck (ENT) Haematology Gynaecology Skin Upper GI HPB		

Table 5: Local Cancer Services Provided in NHS Fife (December 2021)

Area	Service provided		Cancer types
Early Cancer Diagnosis Centre	A service to refer patients with vague symptoms who do not meet the Scottish Cancer Referral Guidelines.		Vague but concerning symptoms
Outpatients	All first outpatient appointments take place within NHS Fife. (within 14 days of referral) Follow Up appointments Post treatment care/appointments Oncology (visiting Oncologists)		All
Diagnostics	**Radiology** Xray Ultrasound CT MRI Mammography Bone Scan Skeletal survey **Other** ECHO	**Endoscopy** Bronchoscopy Colonoscopy OGD Colposcopy Cystoscopy Flexible sigmoidoscopy Flexible cystoscopy Hysteroscopy Microlaryngoscopy Nasendoscopy Ureteroscopy	All

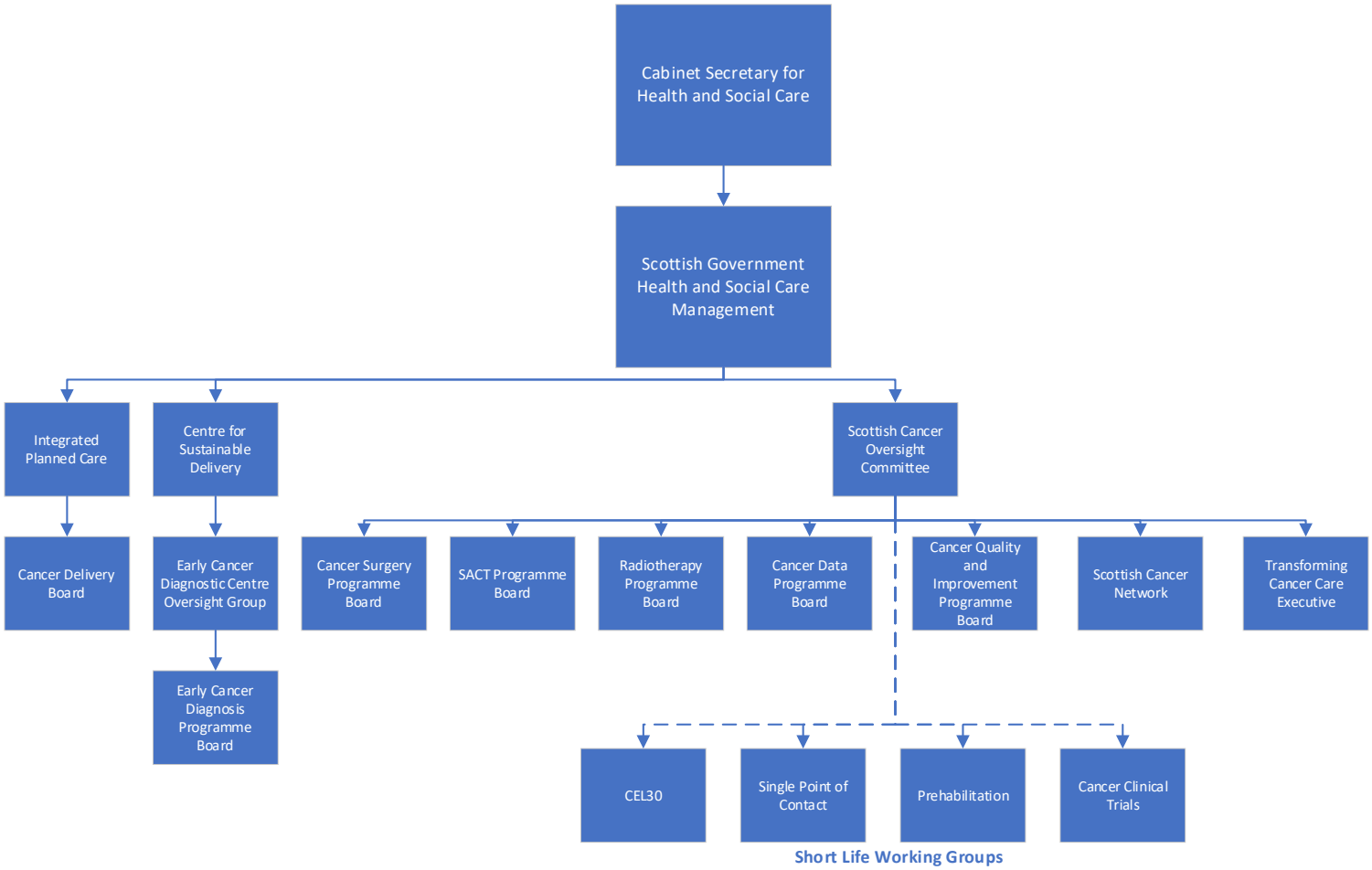
Area	Service provided	Cancer types
Specialist Diagnostics	CT guided biopsy	All
	Ultrasound guided biopsy	
	CT Colon	Colorectal
	MRCP	
	Cytosponge	
	Colon Capsule	
	EUS	Upper GI
	ERCP/MRCP	
	EBUS	Lung
	Thoracoscopy	
	VATs	
	TRUS	
	Trans perineal Biopsy	Prostate
	Template Biopsy	
	Bone Marrow Aspirate/Trephine	Haematology
	Biopsy (incision, excision, lymph nodes, etc)	All (except HPB)
	Cellular Pathology	All (except where treatment done out with Fife)
	Nuclear Medicine	Breast
Pre Treatment	Prehabilitation	Colorectal, Urology
	Maggies Prehabilitation	All

Area	Service provided		Cancer types
Treatment	Surgery (including complex) Robotic Surgery Chemotherapy Hormones LLETZ TURBT Pharmacy Pharmacy Aseptic Services		Breast, Colorectal, Head & Neck, Skin, Gynaecology, Urology (bladder, kidney, testes, penile) Colorectal, Renal, Gynaecology All (except Head & Neck and very specialist) Breast, Prostate Gynaecology Bladder
Specialist Interventions	Speech & Language Dietetics Physiotherapy Occupational Therapy	Podiatry Spiritual Care Psychology Cancer of Unknown Primary	All
Post Treatment Care	Acute hospital Acute Oncology Hospice Palliative Care Health & Social Care GP		All
Multidisciplinary Team Meeting	Local MDT		Breast, Colorectal, Lung, Urology, Complex Pelvic Surgery, SCC

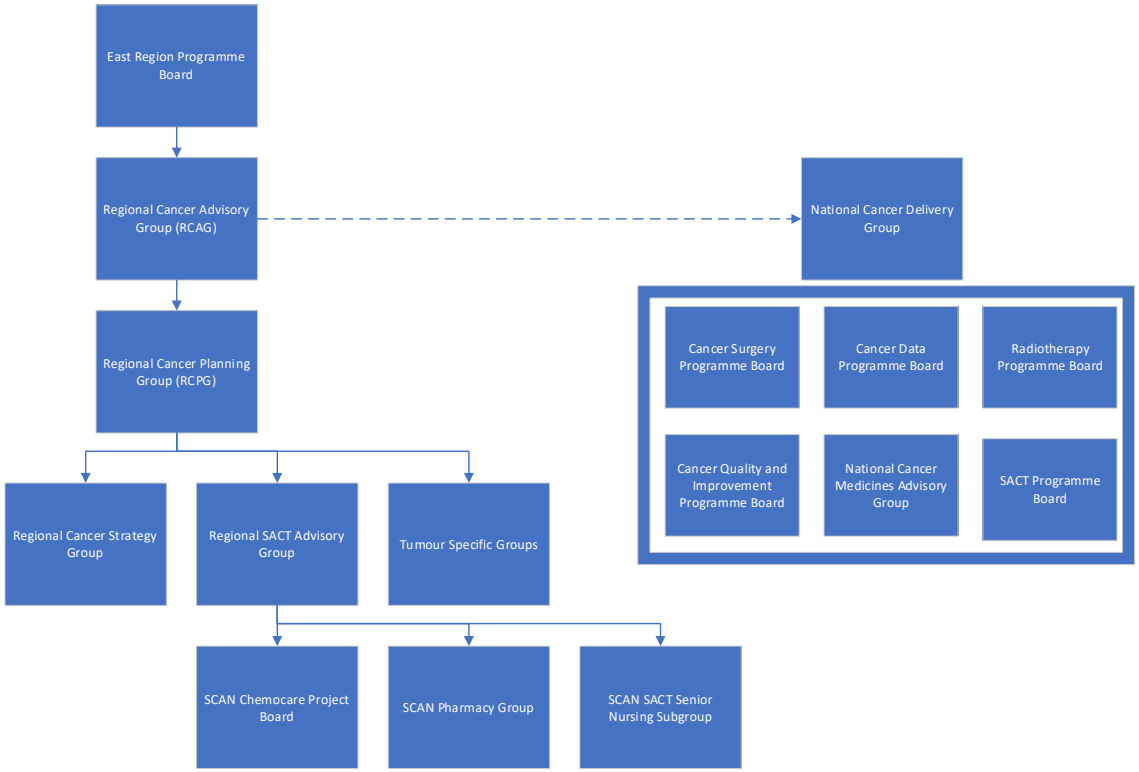
Area	Service provided	Cancer types
Other	Maggies ICJ pathway 3rd sector	

Appendices

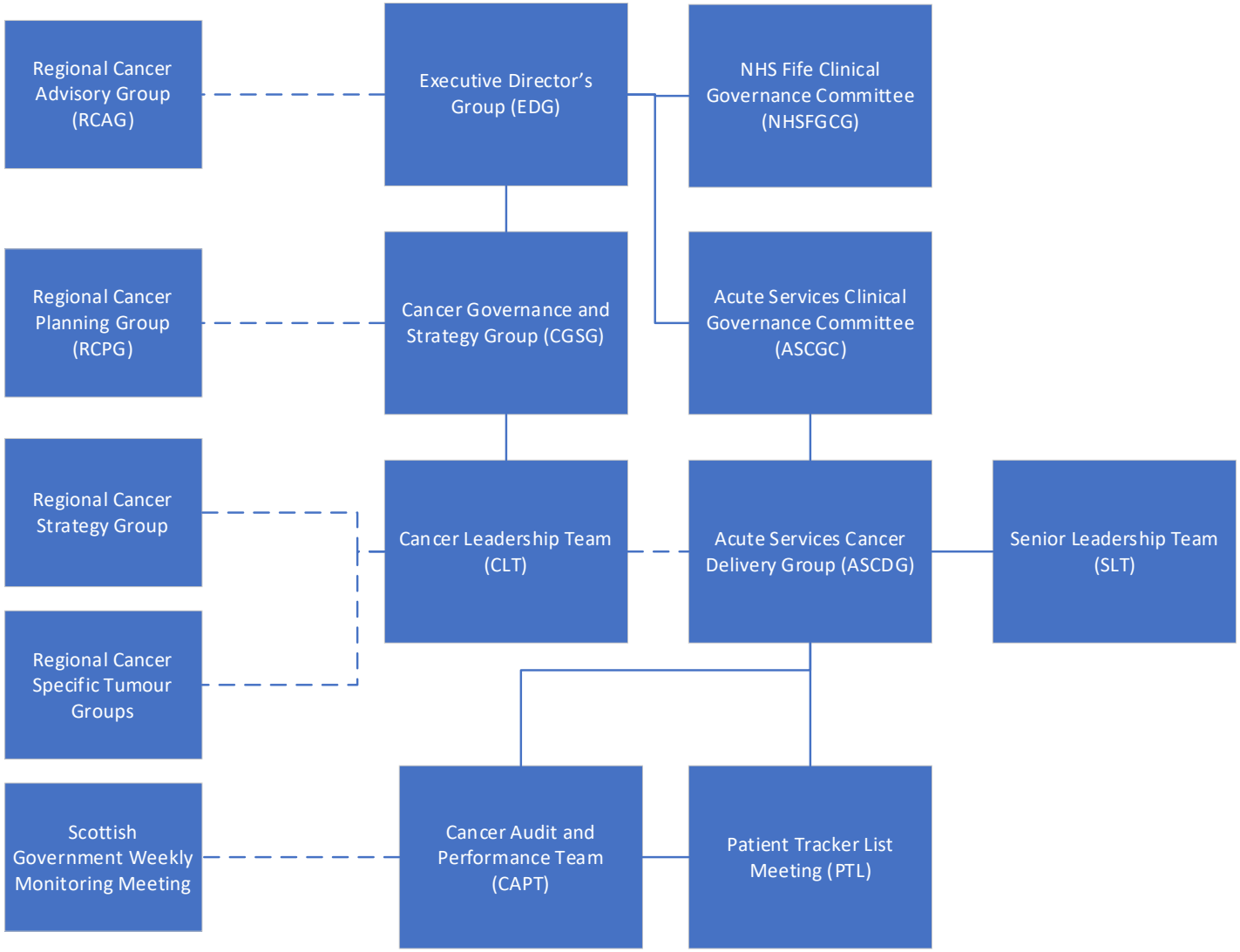
Appendix 1. Scottish Government Cancer Governance Structure (2021)



Appendix 2: Regional Governance Structure (2021)



Appendix 3: NHS Fife Cancer Services Governance Structure (2021)



Appendix 4: SCAN Regional strategic priorities

Remobilisation of services

- Workforce sustainability.
- Rapid Cancer Diagnosis Service (formerly known as Early Cancer Diagnosis Centre (ECDC).
- Review of cancer pathways across the region in order to improve patient journeys and implement improvement opportunities.
- Regional approach to Acute Oncology services.
- Reprovision of the Regional Cancer Centre and potential transformation opportunities with alignment between the boards' emergent local cancer strategies.

SCAN Regional Services SWOT analysis – top 5

Strengths	Weaknesses	Opportunities	Threats
1. Desire to do as much locally as possible. Majority SACT delivered at cancer units. Only specialist and combined treatment at Edinburgh Cancer Centre. Outreach at Dumfries & Galloway (D&G). 2. Good use of SACT planning tool (Borders and D&G) for capacity planning. 3. Tumour group specific support workers in Fife. Planned in D&G. 4. Supportive therapies within ambulatory care; D&G community hospital and Borders, keen to increase locations in Fife 5. D&G able to maintain 100% capacity during COVID due to modern build and spaces.	1. Acute oncology model has limited/ no medical cover at Borders and variable for Fife. D&G no oncologist but via specialist palliative care. Sub optimal model of acute oncology units compared to Centre – lack of senior decision making increases the likelihood of admission. 2. IT – limited use of Near Me and requirement to revert to face to face but improved in D&G. 3. Seen as Edinburgh and not an East service. 4. Not all staff able to work at top of license, limited skill mix, limited staff pools. 5. Number of manual processes in place where technology could support, e.g. SACT 'ready check'.	1. Potential for regional workforce model re medical input to acute oncology service and Cancer Treatment Helpline with rotational posts; virtual resource to enable 7 day service to all units. 2. Shift supportive therapies into community settings, e.g. Borders community hospital sites; other sites in Fife and elements to community/primary care, e.g. phlebotomy; use of home models, e.g. Hospice @ Home. 3. Wider opportunities (both sites) IVT biologics, OPAT, supportive therapies to be combined and provided outwith cancer unit. 4. Maximise use of IT – virtual consulting; automate SACT 'ready', patient portal, access to off-site medical cover. 5. Palliative Team part of MDT in future, more joined up earlier in the process.	1. Regional Aseptic service may limit what can be delivered in the Borders. 2. Workforce – unable to advertise due to wider Board issues. 3. Radiotherapy patients: previously accessed accommodation (pre COVID) on site, use of hotels/self-catering. Currently out of tender. 4. Service models based on individuals rather than standardised processes adopted consistently by teams are unsustainable longer term and create disparities shorter term.

Appendix 5: Staff and public engagement – who we engaged with

Staff and public engagement	

• Patients
• Public Health & Health Promotion
• Primary Care
• Patient Centred Care
• Palliative Care
• Health and Social Care Partnership
• Research Development and Innovation
• Psychology
• Specialist Nursing Teams
• Tumour Group Multi-Professional Teams
  – Breast
  – Colorectal
  – Dermatology
  – Respiratory
  – Oncology/Acute Oncology/Cancer of Unknown Primary
  – Systemic Anti Cancer Treatment (SACT)
  – Haematology
  – Ears, Nose & Throat (ENT)
  – Hepatopancreatobilary (HPB)
  – Urology
	• Allied Health Professionals
	  – Dietetics
	  – Occupational Therapy
	  – Physiotherapy
	  – Speech and Language Therapy
	• Pharmacy and Medicines
	• Digital and Information
	• Property and Asset Management
	• Realistic Medicine Team
	• Spiritual Care Team
	• Radiology
	• Pathology
	• Organisational Development and Workforce
	• Laboratories
	• Cancer Audit & Performance Team
	• 3rd Sector
	• Occupational Health
	• Dental

Appendix 6: Measuring success

Measure	Standard	Target
Cancer Waiting Times (CWT) Performance	62 day standard from Referral to Treatment. 31 day standard Decision to Treat to Treatment.	95%
Rapid Cancer Diagnosis Service (formerly known as Early Cancer Diagnosis Centre (ECDC)	Patients referred urgent suspected cancer with vague symptoms will have a cancer diagnosis or had cancer excluded within 21 days of date of receipt of referral.	21 days
First Urgent Suspected Cancer (USC) Appointment	Aim to see all patients within 14 days of receipt of an urgent suspected cancer referral.	14 days
Multidisciplinary Team (MDT) Meeting	All patients with a diagnosis of cancer will be discussed at a multidisciplinary team meeting.	100%
Quality Performance Indicators (QPIs)	Quality Performance Indicators will drive improvement in clinical care and inform cancer recovery.	Specific
Data Quality Assurance (DQA)	Continue to comply with the Data Quality Assurance (DQA) programme.	95%
Detect Cancer Early (DCE)	To increase the proportion of people diagnosed with early stage disease (stage 1) by 25% for Breast, Colorectal and Lung.	25% from 2010 baseline
Access to Clinical Nurse Specialist (CNS)	Aim to assess all patients within 48 hours of a cancer diagnosis.	48 hours

Glossary of terms

Acronym	Meaning
AHP	Allied Health Professional
AI	Artificial Intelligence
ANP	Advanced Nurse Practitioner
AO	Acute Oncology
BSC	Best Supportive Care
CHART	Continuous Hyperfractionated Accelerated Radiation Therapy
CLL	Chronic Lymphocytic Leukaemia
COVID-19	Coronavirus Disease 2019
CT	Computerised Tomography
CWT	Cancer Waiting Times
DCE	Detect Cancer Early
EBUS	Endobronchial Ultrasound
ECC	Edinburgh Cancer Centre
ECHO	Echocardiogram
eHNA	Electronic Health Needs Assessment
ENT	Ears, Nose and Throat
EQIA	Equality Impact Assessment
ERCP	Endoscopic Retrograde Cholangiopancreatography
EUS	Examination Under Anaesthetic

Acronym	Meaning
FiCTS	Fife Cancer Tracking System
GP	General Practitioner
HPB	Hepatopancreatobilary
ICJ	Improved Cancer Journey
IR	Interventional Radiotherapy
LDP	Local Delivery Plan
LINAC	Linear Accelerator
LLETZ	Large Loop Excision of the Transformational Zone
MDT	Multidisciplinary
MRCP	Magnetic Resonance Cholangiopancreatograpy
MRI	Magnetic Resonance Imaging
NHS	National Health Service
OGD	Oesophago-gastroduodenoscopy
OMFS	Oral Maxillofacial Service
PET	Positron Emission Tomography
qFIT	Quantitive Faecal Immunochemical Test
QPI	Quality Performance Indicator
RCDS	Rapid Cancer Diagnosis Service (formerly known as Early Cancer Diagnosis Centre (ECDC)
RD&I	Research Development & Innovation
RFA	Radio Frequency Ablation

Acronym	Meaning
SACT	Systemic Anti Cancer Treatment
SCAN	South East Cancer Network
SCC	Squamous Cell Carcinoma
SPOCH	Single Point of Contact Hub
TRUS	Trans Rectal Ultrasound
TURBT	Trans Urethral Resection of Bladder Tumour
UK	United Kingdom
Upper GI	Upper Gastrointestinal
VATS	Video Assisted Thoracic Surgery

References

Strategic references and publications

Recovery and Redesign: An Action Plan for Cancer Services

Cancer Staging Data using 2018-2020 DCE Data – the impact of COVID-19

Beating Cancer: Ambition and Action

Effective Cancer Management Framework

Realising Realistic Medicine

'Reduce the Risk of Cancer'

Cancer In Scotland (ISD)\Cancer-in-Scotland-July-2020

Local references and documents

NHS Fife Population Health and Wellbeing Strategy [to follow]

Cancer Strategic Framework Communication Strategy v0.1

EQIA\Cancer Strategy Stage 1 Impact Assessment - signed 100821

High Level Summary of Engagement Sessions

Service Aims & Objectives

Service Priorities

SWOT All

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

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

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NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**3 November 2023**
Title:	**Clinical Governance Strategic Framework Delivery Plan 2023/24 – Mid-Year Report**
Responsible Executive:	**Dr Chris McKenna, Medical Director**
Report Author:	**Dr Shirley-Anne Savage, Associate Director for Quality and Clinical Governance**

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Annual Delivery Plan
- Government policy / directive
- Local policy
- National Health & Wellbeing Outcomes / Care & Wellbeing Portfolio
- NHS Board / IJB Strategy or Direction / Plan for Fife

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This paper and associated appendices provides an overview of the:

- Clinical Governance Strategic Framework Delivery Plan 2023/24

2.2 Background

The Clinical Governance Strategic Framework is fundamental to set out our aim of delivering safe, effective, patient-centred care as an organisation which listens, learns and improves. The Framework was designed to ensure alignment with our 4 strategic priorities. Each year we will develop a workplan to sit alongside the Framework.

2.3 Assessment

Annual Delivery Plan

Appendix 1 sets out the progress with the Annual Delivery Plan for 2023/2024. The Clinical Governance Oversight Group are asked to provide oversight of this delivery plan. The delivery plan will be refreshed for 2024/25.

2.3.1 Quality / Patient Care

Quality and patient care is at the heart of this framework

2.3.2 Workforce

The wellbeing and contribution of workforce is a key to this framework

2.3.3 Financial

N/A

2.3.4 Risk Assessment / Management

This framework aims to mitigate the Quality and Safety corporate risk.

2.3.5 Equality and Diversity, including health inequalities and Anchor Institution ambitions

N/A

2.3.6 Climate Emergency & Sustainability Impact

N/A

2.3.7 Communication, involvement, engagement and consultation

The Clinical Governance Strategic Framework workplan has been developed through:

- Discussion with Executive Leads
- Feedback from key stakeholders

2.3.8 Route to the Meeting

Clinical Governance Oversight Group, 24 October 2023

2.4 Recommendation

- Assurance

3 List of appendices

The following appendices are included with this report:

- Appendix 1, Clinical Governance Strategic Framework Delivery Plan 2023/24 Mid-Year Update

Report Contact
Shirley-Anne Savage
Associate Director for Quality and Clinical Governance
Email shirley-anne.savage@nhs.scot

Clinical Governance Strategic Framework Annual Delivery Plan 2023/2024

- The principles and intentions set out in the Clinical Governance Strategic Framework will only be fully realised through the support of an annual delivery plan.
- Assurance and oversight of the delivery plan will be provided through the Clinical Governance Oversight Group supported by a midyear and end of year report to the Clinical Governance Committee. Any matters that require escalation will be escalated to these groups as appropriate.
- Any emerging issues would come to the Committee by exception.
- The annual delivery plan for 2023/2024 is set out below:

		Workstream	Description/ Objectives	Lead(s)	Timescale	Update/Status
Our Values: Care and Compassion Dignity and Respect Quality and Teamwork Openness, Honesty and Responsibility	1.1	Organisational Learning	Continue to develop the Organisational Learning Group to establish a process for organisational learning and develop a means for sharing learning across the organisation	Associate Director for Quality and Clinical Governance (Q&CG) and Associate Director for Nursing (Corporate)	Mar 24	Currently chaired by the Assistant Medical Director and Director of Nursing (Corporate). The role of the Organisational Learning Group is currently under review.
	1.2	Safety and Just Culture	Work with Workforce Directorate to develop a programme of work to ensure that staff are supported to engage in safe, open and transparent way with clinical governance activities. Link with the Staff Health & Wellbeing Group with a focus on advert events to roll around the work on trauma informed workforce.	Lead for Adverse Events and Associate Director for Q&CG Head of Workforce Planning and Staff Wellbeing	Mar 24	Staff Support following an Adverse Event Pathway has been developed from a SLWG. The Pathway will be piloted in two directorates (Emergency Care and Woman & Children's) commencing in November 2023. There will be a full training package delivered face to face over two sessions at the end of October 2023.
	1.3	Patient Representation on the Clinical Governance Committee	Explore innovative ways of providing patient and public input to the Clinical Governance Committee.	Associate Director for Quality and Clinical Governance	Dec 23	After discussion with other Boards this remains a challenge and further work is required.

	1.4	A focus on quality and safety	Work with clinical teams to co-produce a refreshed approach to safety and quality visits	Director of Nursing Medical Director Associate Director for Q&CG	Mar 24	Care Assurance Walkarounds have been established. After being tested on paper in both ASD and HSCP, an electronic tool was developed on Microstrategy. This tool has recently been transferred to Formic Web. Further discussions are underway to re-establish Leadership Walkarounds. Infection Control Walkarounds. These walkarounds complement outputs from the Safe and Clean audits, and findings will be shared with clinical teams and discussed with CNMs at 1:1 conversations.
Clinical Governance Activities	2.1	Develop the Clinical Governance Strategic Framework Workplan 23/24	Update and implement the CGSF Workplan for 2023/24	Associate Director for Q&CG	Mar 24	The workplan has been updated and has been reviewed. Progress will be presented to NHS Fife Clinical Governance Oversight Group on the 24th October 2023 then to Clinical Governance Committee on the 3rd November 2023 as a Mid-year review.
	2.2	Risk Management Framework	Update the Risk Management Framework and Policy	Director of Finance and Strategic Planning, Risk Manager and Associate Director for CG and Q	Aug 23	On 31st August 2023 the Audit & Risk Committee endorsed the draft Framework for Board approval. The Board approved on the 26th September 2023. The policy update is currently underway.
	2.3	Review of Adverse Events Policy and Procedure	Develop the Adverse Events Operational Procedure to link with the New Adverse Events Policy	Lead for Adverse Events	Jun 23	Updated Adverse Events Policy published 19th May 2023. Adverse Events Management Resource Pack sections are being completed in individual sections by topic and published on Blink as they are completed.
		Organisational learning communication QI project	Scope programme of work in collaboration with realistic medicine to develop quality improvement actions to address the theme of	Associate Director of Nursing for Corporate and Associate Director for Q&CG	Oct 23	The Realistic medicine communications plan has been developed and is being implemented.

			patient communication identified in patient complaints and adverse events.			A realistic medicine workshop was held on 20th September 2023 with representation from quality improvement, adverse events, complaints and nursing to agree a work programme.
	2.4	Scottish Patient Safety Programme	Participation in SPSP Adult Acute Collaborative including the work on the deteriorating patient.	Clinical Effectiveness Manager	Ongoing	There has been good progress on the deteriorating patient work. The initial workshop was held on the 23rd August 2023 and a project brief will go to NHS Fife Clinical Governance Oversight Group on 24 October 2023. A programme of improvement is currently being developed. High level progress Reports will be submitted monthly to Executive Directors Group.
	2.5	Medicines Safety Programmes	Ensure NHS Fife has a programme of continued improvement with medications safety, including learning from incidents, education improvements, ensuring safe and effective prescribing.	Director of Pharmacy Deputy Director of Pharmacy Lead Pharmacist Medicines Governance	Mar 24	The Safe Use of Medicines Group is to evolve (from October 2024) into the Medicines Safety and Policy Group. The ToR is being reviewed and updated, with a revised membership. A Medicines Safety Programme is being developed, initial areas of priority are Diabetes, Valproate, Lithium, Anticoagulants and High Risk Pain Medicines. A weekly MDT Medicines Safety Drumbeat has been established (commenced January 2023) where all datixed medicine incidents are reviewed, themes identified and a weekly medicine safety bulletin (the medicine safety minute) is developed and issued. Copies are held on staffblink. The SSUMPP is being updated and new version will be launched Dec23/Jan24.

						Resources i.e. video, lanyard and stickers are being developed to support staff to improve prescribing and administration of oxycodone and morphine, which feature regularly as incidents. Ongoing programme of education to support improvement.
	2.6	Excellence in Care	Development of Care Assurance Framework for NHS Fife	Director of Nursing	Mar 24	A Short Life Working Group (SLWG) involving Lead Nurses, Excellence in Care Senior Nurse, Heads of Nursing from HSCP and Acute Services and Clinical Development Nurse has been established to scope out the variety of tools and templates being used, the frequency of use and by whom, with the aim of creating a consistent approach to providing care assurance from ward to board. This approach aligns with Excellence in Care (EiC), the national approach to assurance and will provide a strong foundation for further improvement to ensure safe, effective and person-centred care. The Excellence in Care CAIR Dashboard, which has been presented to the Clinical Governance Committee, demonstrates that from a measurement perspective, Fife is performing well. The use of the CAIR Dashboard will continue to be promoted and extended across services.
	2.7	Quality Network	Collaborate with the Planning and Performance (PMO) team to contribute to the shape of the quality network particularly in respect of the Organisational Learning Group	Associate Director of Q&CG	Mar 24	Associate Director of Q&CG works closely with the portfolio lead in the PMO to drive forward the quality network and the work of the OLG.

Enablers	3.1	Clinical Governance Oversight Group	Development and review of workplan for the group	Associate Director of Q&CG	Apr 24	Workplan reviewed. A CGOG Assurance Summary is now being produced to enhance the assurance given to the NHS Fife Clinical Governance Committee.
	3.2	Review of HSCP clinical governance structures	Continue to embed new clinical and care governance structures including services delegated to the IJB care governance framework linked to wider and ensure relevant legislation is considered (e.g. Scottish Governments NHS Public Protection Accountability and Assurance Framework)	Associate Director of Q&CG Director of Nursing HSCP	Mar 24	Work continues with the H&SCP to strengthen links.
	3.3	Upgrade Datix	Develop business case for Datix Cloud IQ providing improved functionality for clinical governance activities such as Morbidity and Mortality meetings	Associate Director of Q and CG	Mar 24	Discussion is currently underway with the Associate Director of Digital & Information to review RL Datix and whether at this stage we purchase an additional module rather than the new cloud system. Funding will have to be sourced.
	3.4	Continue to embed our systems and processes for the reviews of deaths of children and young people	Supporting training for staff including development of an extended role for the Children and Young People's Death Review Co-ordinator	Lead for Adverse Events	Dec 23	The extension of the Co-ordinator role to provide family support was explored and it was decided that it could be detrimental and conflicting to the coordinator remaining impartial so was not progressed. We are now exploring training options that could be provided to multi-agency staff on the front line of managing child deaths.
	3.5	NEWS2	Work in partnership with Digital and Information and the clinical teams to deliver NEWS2 to deliver benefits to the Deteriorating Patient work	Associate Director for Q and CG, Head of Programmes for D&I	Oct 24	NEWS2 rollout is being led by D&I supported by ITU Consultant and Deteriorating Patient Resuscitation Lead, to be implemented within the next 12 months.
	3.6	Development of a Quality Management	Develop business case in partnership with Digital and Information for a QMS for NHS Fife	Associate Director for Q and CG	Apr 24	Work continues looking at an appropriate QMS that would facilitate work across a

		System (QMS) for NHS Fife	which enables NHS Fife to achieve its quality objectives whilst enabling patient focussed quality monitoring and process improvements. The solution should enable a controlled and formalised record of relevant documentation including policies, processes, procedures and responsibilities. The solution should facilitate the key activities (Quality planning, assurance, control & improvement) required to meet quality objectives and regulatory requirements.			number of areas however funding will have to be sourced to support this.

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**3 November 2023**
Title:	**NHS Fife Incident Management Framework**
Responsible Executive:	**Joy Tomlinson – Director of Public Health**
Report Author:	**Susan Cameron – Head of Resilience**

1 Purpose

This report is presented for:

- Discussion

This report relates to:

- Legal requirement for Civil Contingencies Act 2004
- Local Policy

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

- Safe
- Legal Requirement

2 Report summary

2.1 Situation

The purpose of this paper is to present NHS Fife's Incident Management Framework (Escalation Levels 1,2,3,4, Major Incident Declared and Category 1 Response) to CGC for discussion.

NHS Fife requires to respond effectively to a wide range of events, including critical incidents and emergencies that could adversely affect health or patient care.

The Civil Contingencies Act 2004 (the Act) places a statutory duty on NHS Fife to have local planning for preparedness in place to facilitate emergency response & recovery management. Planning required additionally supports our multiagency responsibilities to save life in conjunction with other emergency service partners.

The resilience team have been working closely with key stakeholders to create a revised Incident Management Framework for NHS Fife (Appendix 1).

2.2 Background

NHS Fife is required under the Civil Contingencies Act 2004 and NHS standard contract to be able to respond to any emergency situation while maintaining some level of service delivery. NHS Fife and the Integration Joint Board are Category 1 responders under the Civil Contingencies Act, this places additional duties on our organisation where supporting the assessment of risks (of different types of emergency and their impacts).

The response section for the Major Incident plan for NHS Fife has been available in near final version since 2019. However, it has been recognised that a more comprehensive approach to Incident management was required.

The drivers for change include the development of the Operational Pressures Escalation Level approach and recognition that a range of incidents require whole system response, beyond the planning for short lived acute emergencies involving casualties.

2.3 Assessment

An extensive consultation process took place between 4 March to 4 August 2023 which was used to develop the approach set out in the framework. Feedback from individual stakeholders has been incorporated into the final version of the framework. The framework has also been formally tabled through internal governance structures, as set out in section 2.3.8.

The framework aims to establish good practice for escalation & management of incidents, which includes maintaining an operational ability during any disruptive event. As part of this, NHS Fife's Operational Pressures Escalation Level (OPEL) triggers have been incorporated into the incident escalation strategy.

The framework will be supported by additional guidance covering specific topic areas, which are listed on page 9 of Appendix 1. The Incident Management Framework will be stored electronically and backed up to a USB Drive which is held in the Major Incident equipment store. Incident management framework guidance will be provided in hard copy at incident in control room locations. All National guidance referred to & hyperlinked in the incident framework plan are available as hard copies folder in the Major Incident equipment store.

2.3.1 Quality, Patient and Value-Based Health & Care

The Incident Framework will increase situational awareness of incidents which may escalate to protect patients & the workforce during any unforeseen events.

2.3.2 Workforce

The Incident Management Framework will improve situational awareness for the workforce, and strengthen their ability to respond effectively.

2.3.3 Financial

Category 1 emergency response and business continuity incidents have the potential to rapidly cause financial impact. Thorough preparedness saves life and reduces financial impact of response and recovery.

2.3.4 Risk Assessment / Management

Risk mitigation management includes a need for information, instruction and education to be provided.

2.3.5 Equality and Diversity, including health inequalities and Anchor Institution ambitions

Equality and diversity assessment is integrated into emergency planning and in-house resilience training.

2.3.6 Climate Emergency & Sustainability Impact

Climate and sustainability are considered in recovery measures.

2.3.7 Communication, involvement, engagement and consultation

A quarterly resilience workforce briefing newsletter is published for management teams to local meetings for workforce situational awareness. This resilience newsletter will be used as a platform for sharing ratified framework documents to the wider workforce.

2.3.8 Route to the Meeting

The following groups have been consulted and contributed to the development of the new framework:

- EDG Major Incident Workshop, 23 February 23
- NHS Fife Resilience Forum, 8 June 2023
- Acute SLT group 25 July 2023
- H&SCP SLT group 18 September 2023
- EDG 10 August 2023

2.4 Recommendation

CGC are asked to acknowledge the Incident Management Framework as the new management strategy for oversight and escalation of incidents within NHS Fife.

3 List of appendices

Supporting Documents:

- Appendix 1 – NHS Fife: Incident Management Framework

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Author's Job Title: **Head of Resilience**
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Incident Management

Escalation Levels 1,2,3,4, Major Incident Declared and Category 1 Response

Framework Document

nhsfife.org

Version 1 - August 2023

Contents

Abbreviations used:

AHP	Allied Health Professional
ALO	Ambulance Liaison Officer
ANP	Advanced Nurse Practitioner
BCP	Business Continuity Plan
CBRNe/HAZMAT	Chemical, Biological, Radiological or Nuclear (explosive) or Hazardous Material
CMHT	Community Mental Health Team (H&SCP)
C3	Command, Control & Communication
DVI	Disaster Victim Identification
ED	Emergency Department
EOSRRP	East of Scotland Regional Resilience Partnership
EPRR	Emergency Preparedness Resilience Response
GP	General Practitioner
H&SCP	Health & Social Care Partnership
HIC	Health Information Cell
HOTO	Handover – Takeover
IBIS	Interagency Bronze Interoperable Solution (Airwave Radios)
ICT	Incident Control Team
IMT	Incident management Team
LRP	Local Resilience Partners
MACA	Military Aid to the Civil Authorities
MACC	Multi Agency Control Centre
MI	Major Incident
MIF	Major Incident Framework document
MI-MC	Major Incident with Mass Casualties
MIO	Medical Incident Officer
NHS	National Health Service
OoH	Out of Hours
OPEL	Operational Pressures Escalation levels
SAS	Scottish Ambulance Service
SHG	Strategic Health Group
SHPIR	Scottish Health Protection Information Resource
SOP	Safe Operating Procedure
SPOC	Single Point of Contact
STAC	Scientific & Technical Advice Cell
VHK	Victoria Hospital Kirkcaldy
VIP	Very Important Person’s
WRVS	Women’s Royal Voluntary Service

IMPORTANT NOTICE

NHS Fife's Incident Co-ordination Action Cards (Level 4) are hyperlinked forefront to this document for immediate use where required:

Major Incident Action Card – Chief Executive
Major Incident Action Card – Executive (Gold) On-call
Major Incident Action Card – Duty Manager/Silver On-Call
Incident Level 3 (Critical) Action Card – Manager/Silver On-Call
Incident Level 4 (Major Incident) Mortuary Services Action Card
Public Health Incident Consultant in Public Health Medicine/On-call Consultant.
Loggist Action Card

For H&SCP-specific actions, refer to the following Action Cards (authored and maintained by H&SCP):

Director HSCP Action Card
HSCP Senior Leadership Team Action Card
HSCP Extended Leadership Team Action Card

All associated National Guidance, Service area Business Continuity Plans & Official Sensitive restricted guidance will be available electronically to GOLD Command in the Resilience folder in the "T:/ Drive" . Documents will be available from within the Executive Virtual Incident Room folders & are fully backed up on a USB drive held in the Major Incident Store. In the event that IT access is unavailable, physical copies are maintained within the Major Incident Store in the Education Centre at VHK.

1 Introduction

NHS Fife requires an ability to respond effectively to a wide range of events, including critical incidents and emergencies that could adversely affect health or patient care. The Civil Contingencies Act 2004 (the Act) places a duty on NHS Fife to have local planning for preparedness in place to facilitate emergency response & recovery management. Under the Civil Contingencies Act 2004 NHS Fife, as a public organisation, is regarded as a Category 1 multiagency responder with key multiagency responsibilities being to save lives in conjunction with other emergency services. See: Civil Contingencies Act 2004 (legislation.gov.uk) and Civil Contingencies Act 2004 (Contingency Planning) (Scotland) Regulations 2005

NHS Fife's resilience framework aims to establish good practice/s within the escalation & management of incidents, this includes maintaining an operational ability during any disruptive event to ensure continued NHS services for patients. To enact this NHS Fife must ensure;

- Planning for preparedness within response & recovery is in place locally and is aligned to national guidance/s Preparing-Scotland-Responding-to-Emergencies (ready.scot) & Major Incidents with Mass Casualties
- That the workforce has received adequate information, instruction, training & education within incident escalation, management, response & recovery.
- Effective communications can be maintained with partner Health Boards, partner agencies and local/national resilience partnerships within any incidents arising.

The resilience framework escalation Levels 1, 2, 3 & 4 reflect the reporting structure of NHS Fife. Framework incident Levels 1, 2, 3 & 4 provide a common approach for internal incident escalation with any disruptive events that can evolve into critical or major incident situations.

During day-to-day operations NHS Fife deals with a wide range of issues that are typically resolved by enacting local business continuity plans. Certain incidents, however, in response might require a different approach where it is necessary to establish a dedicated command & control incident management team. Operationally NHS Fife adopts Gold (strategic)/ Silver (tactical) & Bronze (operational) command & control.

The command-and-control hierarchy, when required, provides strategic level authority with the deployment of available NHS resources and equipment. The principles of command and control are operationally scalable where it may also be required as part of a much wider multiagency Category 1 major incident response.

NHS Fife's Major Incident Framework planning is broken down into three sections Prepare, Respond & Recover following the Emergency Management Cycle.

Prepare	Sets out the structure and organisation of NHS Fife's Acute Services Division during a Major Incident. It also outlines the roles and responsibilities of partner agencies in the event of a Major Incident.
Respond	The response focus is on saving lives and protecting public assets such as our NHS hospital buildings & infrastructure. It sets out the management communication links, the patient journey through the system and the key actions when responding to any Major Incident declared.
Recover	Supports a coordinated process of recovery following emergency-affected areas & how NHS Fife will return to normal after a Major Incident.

2 Associated Framework Guidance/s may be required during incident response (dependant on incident situation & support required) these include:

Business Continuity Management Systems	The ability of Category 1 organisations to continue to be able to perform their functions in the event of emergencies.
Bomb Threat /Suspicious Packages	Threats concerning bombs or explosive items, whether genuine or false, are regrettable hazards of modern day living. Hospitals, due to their open nature, are particularly at risk.
Fire Procedures/Building Evacuation	Fire Strategy - including buildings evacuation. Managed via NHS Fife Estates & Security.
Buildings Lockdown Framework	The planning and execution of a lockdown of a healthcare site or building within NHS Fife.
Severe Weather Framework	Procedure for mitigating and limiting the effects of the climate emergency impact to NHS Fife.
Scientific Technical Advice Cell (STAC)	Dependant on the scale and impact of an incident, Health Boards need to be prepared to: • Convene and chair a STAC, providing advice to the local LRP/RRP on human health, risk management strategies, countermeasures, and longer-term health monitoring. • Advise SAS and other first responders, other public bodies, the public and the media about effects of a Hazmat incident on human health, and of countermeasures to those effects.
CBRN/HAZMAT	All Category 1 designated Health Boards have a duty to provide care for people who may be contaminated with chemical, biological, radiological, or nuclear (CBRN) material or hazardous material (Hazmat) and a role in managing the consequences of such incidents.

PREPARE

3 Incident Levels Defined:

NHS Fife manages incident escalation through a series of incident level triggers. The levels are defined as follows:

Incident Level 1 - Locally managed incidents

Incident level 1 describes any incident event that can be responded to and managed within the department (within business-as-usual capabilities) using safe operating procedures (SOPs).

Incident Level 2 - Business Continuity Incident

A Business Continuity Incident (Incident Level 2) is any internal board event that disrupts normal service delivery where special arrangements/mitigating actions are required to be implemented until services can return to an acceptable level.

Within NHS Fife a central repository of service area Business Continuity plans is held in the Board's "T:/ Drive" and access is shared with executive directors on call. "T:/ Drive" data is backed up locally on an encrypted USB memory stick held securely within the Resilience department. Each individual service area should also maintain an electronic and hard copy of their Business Continuity Plan.

In any event where a Business Continuity incident escalates across to two or more service areas or is deemed as may have significant impact on Board-wide services then it must be escalated from Incident Level 2 (Business Continuity Incident) to Critical Incident (Incident Level 3) verbally or in writing using the SBAR format.

Incident Level 3 - Critical Incident

Critical Incident (Incident Level 3) is defined as a localised event where the level of disruption results in NHS Fife as an organisation temporarily or permanently losing its ability to deliver critical services, patients may have been harmed, or the environment is not safe requiring special measures and support from other departments, Health boards & partner agencies support is required to restore normal operating functions.

Examples:

- Bomb Alert
- Explosion
- Failure of electrical/mechanical systems in buildings infrastructure
- Fire
- Flood

- Infant abduction
- Infestation
- Significant IT failure/Cyber Attack
- Telecommunications system failure
- Water Contamination/Loss
- Infectious Diseases
- Operational Pressures Escalation Level (OPEL): Purple (L5) Acute & H&SCP (trigger 90>+)
  ***Note**: Capacity & Flow metric is not directly related to incidents, instead focuses on hospital capacity, however, in instances where both Acute & H&SCP services have escalated to OPEL Purple (L5) with an OPEL scoring of 90>+: Incident Level 3 critical incident framework management must be adopted.*

Critical incidents are managed though control measures identified locally in Business Continuity departmental plans & action cards. In situations where Critical (Incident Level 3) incident is escalating to Level 4 it must be escalated to Gold Command verbally or in writing using the SBAR format. Any SBAR detail shared during incident management handover must be recorded into the decision logs (with the time also being noted) for the incident record.

Public Health Incident

Any of the above examples could lead to a Public Health Incident, which would require an Incident Management Team (IMT) to be enabled or a Scientific Technical Advice Cell (STAC) to support incident management via NHS Fife Public Health Department. An Incident Management Team (IMT) is defined as a multi-disciplinary, multi-agency group with responsibility for investigating and managing the incident. Following a Public Health Incident, 'lessons learned' must be captured in the form of a 'hot debrief'. The storage and dissemination of the completed debrief is covered in Management of Public Health Incidents: Guidance on the Roles and Responsibilities of NHS Led Incident Management Teams (publichealthscotland.scot) and STAC | Ready Scotland and the debrief template is at Annex 2. The Scottish Health Protection Information Resource, listing Public Health alerts and information can be found online at SHPIR - Home (scot.nhs.uk) using the NHS Fife password (held by the on-call Public Health Consultant).

CHEMET information can be found on the SHPIR website at the following link: A Guide to Environmental Incident Response for NHS Boards (scot.nhs.uk). This information resource is also duplicated in the Virtual Incident Room and is backed up

in Major Incident Folders in all agreed locations.

Health & Social Care Partnership (H&SCP) Incident

Although The Health & Social Care Partnership (H&SCP) forms part of a response to incidents collectively, alongside NHS Fife and the EoSRRP for example, there may be times when an incident is defined as internal, affecting only the H&SCP. Fife H&SCP maintains a **Resilience Framework** document which sets out the response to such incidents, as well as the collective response to regional or national Major Incidents.

Incident Level 4 - Major Incident Declared:

This is defined as any occurrence that presents a serious high-risk threat to the health of the community or causes such numbers or types of casualties as to require specialist arrangements to be implemented. This includes any incident defined as an "emergency" as in Section 1 of the Civil Contingencies Act 2004 and is coordinated by GOLD command.

NHS Fife may determine to follow an Incident Level 4 incident response in any situation where a Major Incident has been declared in a neighbouring Health Board where mutual aid for patient welfare is required.

Examples of incidents which could lead to a major incident occurring are, but not limited to:

Type	Key Characteristics	Example
Big Bang	Happens unexpectedly	A serious transport accident or explosion
Rising Tide	Builds over a period of time and allows some time to prepare.	COVID-19
Cloud on the Horizon	Significant chemical or nuclear release developing elsewhere and needing preparatory action.	Volcanic Ash
Headline News	Public or media alarm about an impending situation, which may be an over-reaction.	Zika Virus
Chemical, Biological, Radiological, Nuclear and explosives (CBRNE)	Actual or threatened dispersal of CBRNE material, with deliberate criminal, malicious or murderous intent.	Salisbury Novichok nerve agent release
Hazardous Materials (HAZMAT)	Accident involving hazardous materials.	Self-presenters at A&E Secondary exposure
Cyber Attacks	Attacks on systems to cause disruption.	'Wannacry' malware attack

4 Incident Escalation

Diagram 1: Internal/External Incident Escalation (Levels 1, 2, 3 & 4 Major Incident/Category 1 response)

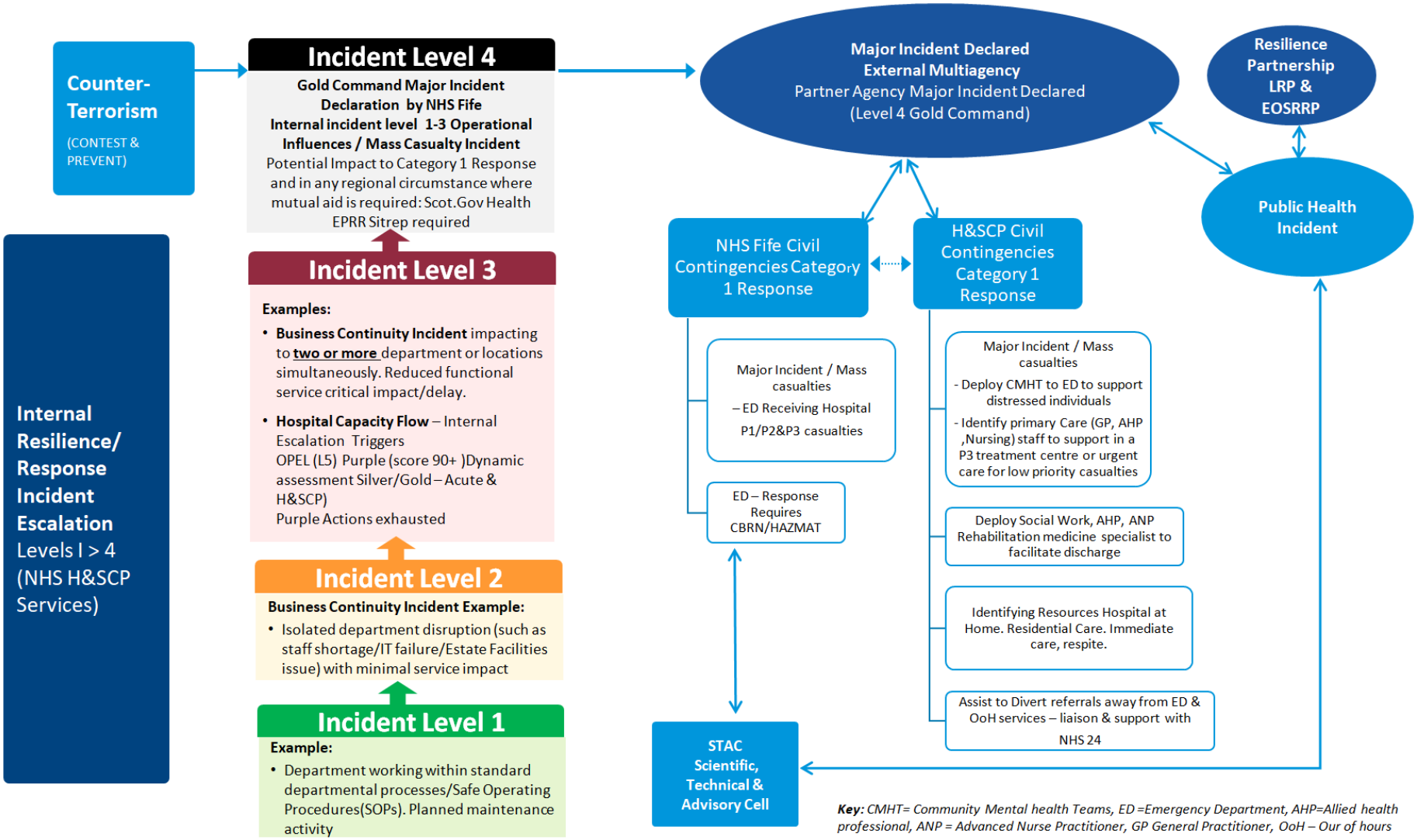


Diagram 2: Internal incident escalation Levels

Situation Background Assessment Report (SBAR) format should be used when escalating incident level

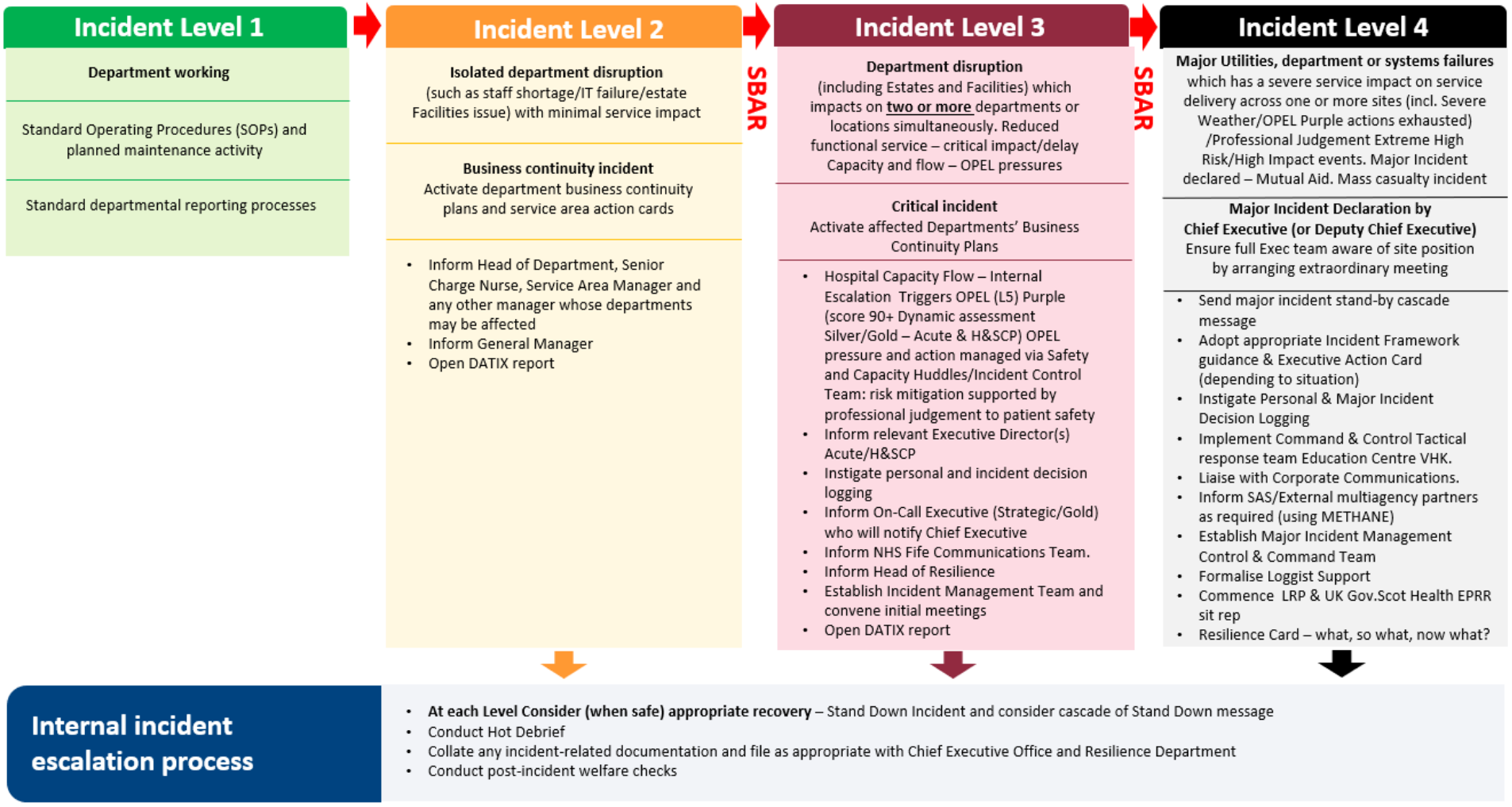


Diagram 3: S BAR

SBAR Format: verbally or written using Appendix 1 template.

Incident Level 2 (Business Continuity Incident) – Level 3 (Critical Incident) – Level 4

SBAR Report	
Situation	Describe situation/incident that has occurred i.e. Exceptional risks arising from weekend or overnight, surges in activity, increases in ED presentations, workforce.
Background	Explain history and impact of incident on services/patient safety – risk/s
Assessment	Confirm your understanding of the issues involved. What measures are in place. What has already been exhausted other than business as usual. Have all organisations confirmed that hey have implemented all relevant actions from their own internal escalation plans. Has any provider declared or is about to declare an internal critical.
Recommendation	Explain what you need, clarify expectations and what support is needed. What benefit / outcome do we need to achieve de-escalation.
Ask receiver to repeat information to ensure understanding	

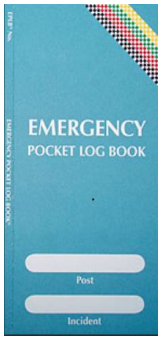
For SBAR template go to Appendix 1 **Note** – SBAR detail shared during incident management & handover must be recorded into the decision logs (with the time being noted) for the incident records. In instances where a written SBAR has been provided it must be uploaded to the DATIX incident record.

4.1 Decision Logging/Meeting Minutes

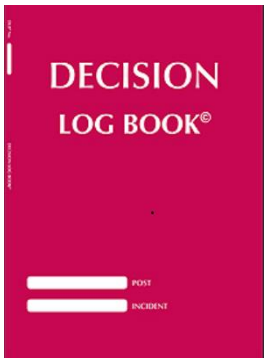
Logging incident information and decisions is an essential part of incident management and is required at all levels within Response and Recovery. Decision logging is a means of providing an auditable trail of defensible decision making. Strategic decisions need to withstand 'hindsight scrutiny' should negative outcomes occur. Decision logs must be used to keep a comprehensive record of all events, information received, decisions, reasoning behind those decisions and actions taken. Personal logs must also be enabled as part of the incident record. NHS Fife has a register of trained Loggists who would be made available to Gold Command (listed in T: / Drive Resilience Folder). Any meetings in relation to the Major Incident must produce a full set of minutes and action points and be separately retained. Decision Logs and Personal Logs have individual identification codes which must be annotated in the DATIX incident report.

Emergency Log Books are available via the Public Health Resilience Team and these **physical logs must be used by default** as this provides resilience in the event of power outage or loss of infrastructure. Log Books fall under 'records retention' legalities and must be forwarded to the Resilience Team to be retained centrally following any Major Incidents.

Picture 1:
Emergency Pocket Log Book



Picture 2:
Loggist Decision Log Book



4.2 Reporting Major Incidents (Gov.Scot Health EPRR)

On declaration of a Major Incident with Mass Casualties (MI-MC), a Strategic Health Group (SHG) will be established by the Chief Executive of the territorial NHS Board in whose area the MI-MC incident first takes place or where the greatest impacts occur, if it is a multi-site incident. There is an option for this Chief Executive to formally pass on the role of SHG Chair to another Chief Executive at the outset, according to their judgement in the circumstances of an actual incident. Their decision for doing so must be recorded at the first meeting of the SHG.

NHS Scotland reporting arrangements require a sitrep proforma to be completed (within 2-3 hours) to Health EPRR in Scottish Government following an Incident Level 3-4 incident including:

- Internal incidents within NHS Fife Health Board
- Incidents declared by a Regional Resilience Partner (RRP) that requires the deployment of healthcare resources; and
- An incident that creates significant service pressures for the Health Board and is likely to impact on business as usual or NHS Fifes agility to undertake category 1 response.

See: NHSScotland Resilience Preparing for Emergencies - Guidance for Health Boards in Scotland (www.gov.scot) (Section 5.17)

- Scottish Government Health EPRR Situation Report:
  The proforma Health EPRR - SITREP Template must be completed and submitted to Health EPRR health.eprr@gov.scot no later than 2 or 3 hours following the occurrence of an incident

UK.Gov.Scot Health EPRR Contact Numbers:	
Weekday 08:30-17:00	0131 244 2429
Out of hours emergency pager 17:00-08:30 weekdays/weekends & Public Holidays	07623 909981
*In any event that the out-of-hours SG Health EPRR contact has not responded **within 1 hour**, follow up with another call to the duty pager and a follow-up email.*	

Scottish Government Health EPRR Situation Report

NHS Boards – Incident Reporting Levels

Level	Scale	Impact	Response	Reporting action and timeframe for notifying SG Health EPRR
1	Minor – local	Low. Business continuity issues - impact is localised.	Can be managed by the Department/Hospital within BAU capabilities and BCP's	No reporting required
2	Medium	Moderate. Larger business continuity issues such as local IT outages, major infrastructure damage, larger Road Traffic Collisions, and other issues impacting on a larger part of the hospital; has led to or likely to lead to suspension or delay to healthcare services; contained to one hospital site.		Submit SitRep to SG Health EPRR within 3 hours.
3	Significant	Impact on the whole Board and service provision / performance, as well as neighbouring NHS Boards. Loss of critical services and functionality. Normal functions interrupted /suspended. No workaround exists.	MI team / C3 set up at Hospital or Board Level. Possible regional and national co-ordination established.	Immediate by phone followed by SitRep within 2 hours
4	Major	The specific functionality is mission critical to the business and the situation is considered an emergency. Severe weather affecting the whole or part of Scotland, terrorist incidents, any incidents/accidents which cause mass casualties, major business continuity issues such as pan-Scotland IT outages.	Requires Board C3 group to be set up. Potentially an SHG would be established. Regional and national co-ordination in place.	Immediate by phone, followed by SitRep within 2 hours

4.3 Incident Health and Safety

For all personnel involved in the response to an incident (including 3rd sector volunteers working under NHS Fife direction) Gold Commanders must ensure that suitably qualified and experienced personnel are brought into the response to ensure the health, safety and welfare of all personnel involved is observed. The focus should be around the availability of appropriate equipment, monitoring of environmental conditions, wearing of appropriate PPE and the recording of actions taken in relation to these. Advice, where appropriate, should be sought from the Health and Safety Manager.

4.4 (M)ETHANE Report

A notification of a Major Incident (either internally via Gold command or externally via any partner Category 1 agency) will be in the form of a (M)ETHANE report. The Joint Emergency Services Interoperability Principles (The Joint Decision Model (JDM) - JESIP Website) identifies (M)ETHANE as the preferred model for sharing information to promote a shared situational awareness for all responders.

Diagram 4: (M)ETHANE

4.5 Major Incident Standby (Emergency Department)

This is used when there has been a report that a Major Incident has occurred but is not confirmed, or where the capabilities/capacities of other hospitals already alerted are filled. The Scottish Ambulance Service (SAS) will issue a Major Incident Standby message. If a Major Incident Standby message is received from another source, it must be confirmed by the SAS before any actions are taken.

4.6 Major Incident Declared (MID)

This is when the call-out procedures and actions are needed to mobilise additional staff & resources to cope. MID can be activated either internally via Chief Executive (or their deputy) or externally via a partner agency such as Scottish Ambulance Service / Police Scotland.

The Major Incidents with Mass Casualties National Plan for NHS Boards and H&SCP 2019 will be enacted where appropriate.

4.7 Stand-Down (Recovery):

This is determined and actioned by the designated incident lead when pressure on services is reduced after a declared incident, or when standby is no longer deemed necessary.

4.8 Incident Exercise:

This is when NHS Fife initiates an exercise which can be tabletop or live play exercise. Exercises are used to identify any planning gaps & to validate planning.

5 The Role of NHS Fife Acute Hospital/s

NHS Fife operates 2 acute sites:

Victoria Hospital Kirkcaldy (VHK): VHK is the designated hospital to receive casualties in the event of an external Major Incident being declared.
Queen Margaret Hospital (QMH) Dunfermline: The QMH will provide support to VHK to enable resources to be used flexibly across both sites in order to respond to any increased activity.

5.1 Incident Control Room Location/s:

PRIMARY VENUE (virtual meeting room) **- Fife Executive Virtual Control room via M/S Teams** by Chair invitation.

In any event where a virtual control room cannot be facilitated physical control rooms will be located at:

Victoria Hospital Kirkcaldy

Physical location PRIMARY	**Physical location SECONDARY**
Lecture Theatre, Education Centre Incident Control Teams locate into Seminar Room 2	Meeting Room 1, Hayfield House
Executive Response Group Chief Executive's Office, Hayfield House	**Executive Response Group** Staff Club

National Teleconference Facilities:

- Lothian/Fife/Borders/D&G sites: bring up **1MCU10** from the **system phonebook** and press Connect.
- NHSS sites who are set up to dial over IP nationally, dial **520469237**
- Joining details for the **Scottish Strategic Health Group - Major Incident Bridge** can be found in the Fife Executive Virtual Control room on Teams.

5.1.1 Multi Agency Control Centre (MACC)

Physical MACC	**Fife Police Headquarters**, Detroit Road, Glenrothes, Fife KY6 2RJ
Virtual MACC	Membership by Teams invitation from MACC Commander/Police Incident Officer

5.2 NHS Fife Incident Control Team (ICT)

In order to ensure a co-ordinated and appropriate response, an Incident Control Team (ICT) will be formed under Executive (GOLD) direction dependant on the nature of incident & management required. (Consider requirement from the following: Director of Acute Services, Director of Public Health, Director of H&SCP, Estates Lead, Finance Lead, Incident-specific Specialists, Resilience Team, Comms Lead, Loggist support.

5.2.1 Control Room

If the virtual (Teams) meeting platform is unavailable, each member of the designated Incident Control Team should report in person to Seminar room 2, Education Centre, VHK where a physical major incident box is located in the major incident store cupboard.

5.2.2 Major Incident Equipment

Major Incident Equipment is held in the following locations:

Location	Site
Seminar Room 4, Education Centre	VHK
Maternity Unit - Main Reception Area	VHK
Major Incident Equipment Store, Emergency Department	VHK
Public Health Department	Cameron Hospital
Minor Injuries Unit(CBRN-specific)	St Andrews Hospital
Minor Injuries Unit(CBRN-specific)	Adamson's Hospital

Major Incident Equipment areas are highlighted with the following signposting:

There are physical folders of all required framework documents in each of the above locations, alongside physical Decision Logs & stationery supplies (pens, paper etc). Emergency Department, VHK hold physical copies of all ED Action Cards in the Major Incident Store.

5.2.3 Communication Equipment (telecommunications failure)

In any local event of telecommunication systems failure 2-way radios are available in the Control Room, VHK for in-house communications use. If these are adopted for internal communication, the person to whom the handset is issued must be noted into the decision log book.

In the event of a regional communication network failure the Interagency Bronze Interoperable Solution (**IBIS)** airwave radio handsets are available from Police Scotland partners for communication between Emergency Services, multiagency partners (GOLD command) and, in the event of mutual incident response, between NHS & Scottish Government Health EPRR. **IBIS** radios are available on request

from the Senior Police Incident commander. In any event that **IBIS** messaging is taking place the person using the handset and its unique radio identifier should be noted into decision logbook detail.

When adopting use of radio handsets the phonetic alphabet is used; see Radio handset guide Annex 1.

5.2.4 Physical Messaging

In any event where digital systems & telecommunications networks are locally unavailable it may be necessary to delegate a physical team of staff to act as messaging runners between various departments. In the event that this is required, numbered tabards are available for use in the major incident equipment store in the Education Centre VHK. The number and name of the person passing on information as part of this role must be noted in the decision logbook detail.

5.3 Command, Control and Coordination (C3)

Command, control & coordination communication strategy is adopted during incident management by Gold/Silver in Incident Level 3/4 management. Gold command will establish Silver/Bronze groups as required by the nature of the incident, for receiving hospital Category 1 incident hosptial control structure (see diagram 5B: Receiving Hospital Category 1 Response)

Gold	Strategic
Silver	Tactical
Bronze	Operational

During incident management, key roles should be rotated (with a full handover) every 6 - 8 hours. An SBAR format handover record (utilising the ongoing decision log) must be annotated each time a role handover takes place; all documents must be retained as part of incident management record.

Diagram 5A: C3 Strategy

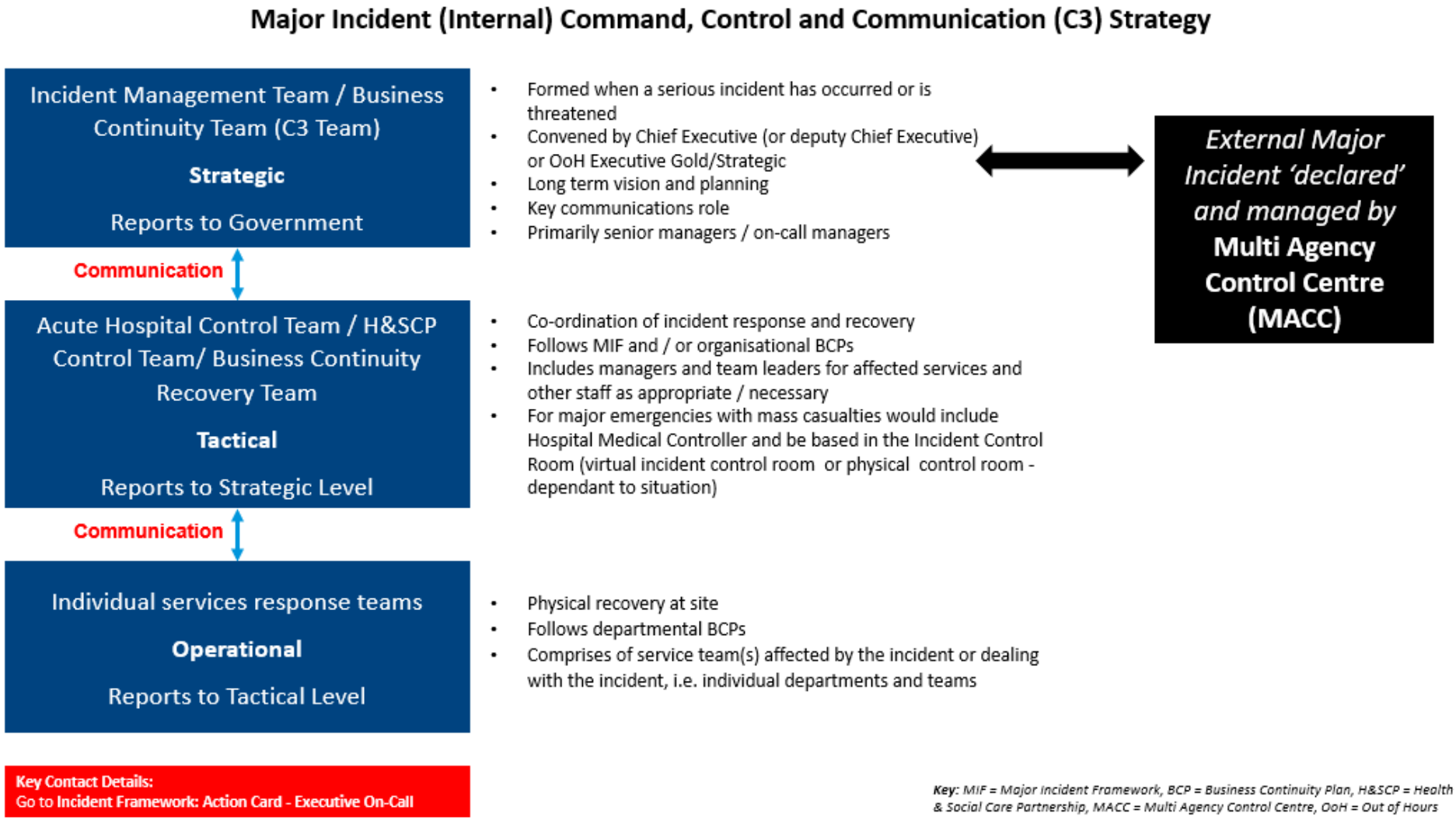
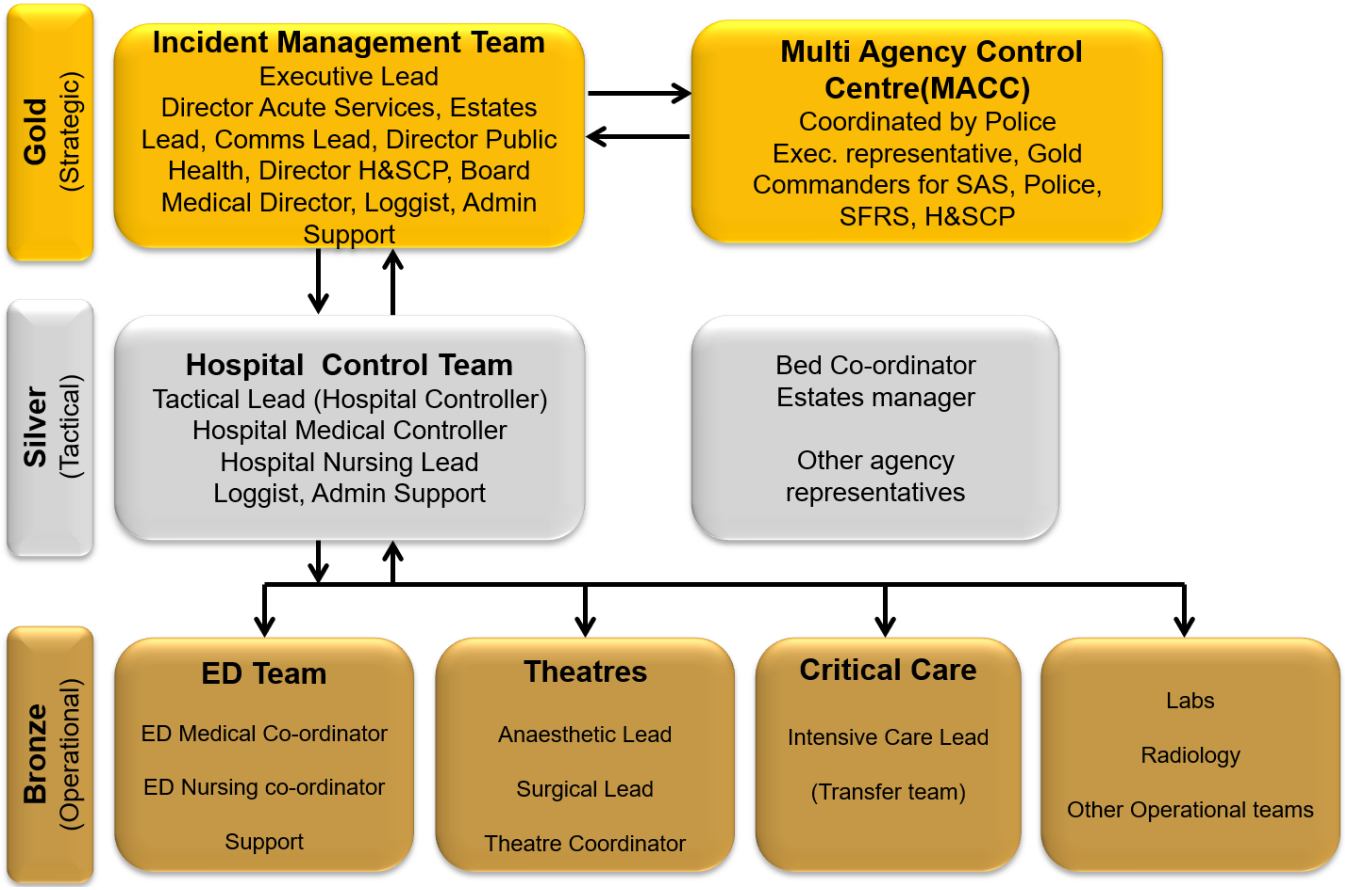


Diagram 5B: Receiving Hospital Category 1 Response



6 Corporate Communications (Incident Management)

The Corporate Communications team at NHS Fife will lead on and coordinate all internal and external communications on behalf of the organisation, in response to a major incident. What and when we can communicate will be agreed in liaison with the agency leading the initial incident response e.g., Police Scotland. This will also include liaison with partner organisation communications leads such as Fife Local Resilience Partnership (LRP), Police Scotland, and Fife Council, as well as local and national press, media outlets and local elected members including Councillors, MSPs and MPs.

NHS Fife's Corporate Communications team will also coordinate all posts and monitor the organisations social media channels as well as issuing regular updates via NHS Fife's internal communications channels including the StaffLink App and all-staff email updates and briefings.

Corporate Communications will also have representation on Gold Command as well as appropriate Silver Commands and the Fife LRP or its communications subgroup to ensure a consistent and timely flow of information to inform and instruct colleagues, service users, partners and the general public as the incident evolves and as the impact on service provision is fully evaluated and any mitigating actions to be taken.

Corporate Communications activity as part of a major incident will fall into four main phases:

1. Alert users that an incident has occurred.
2. Provide users with regular updates throughout the duration of an incident.
3. Notify users once an incident has been resolved.
4. Contribute to post incident review and follow-up.

Corporate Communications will also keep a live log of all communications activity throughout the period of the incident for future incident review and follow-up.

6.1 Minimal Information required by Corporate Communications team to aid communications during an incident.

To aid business continuity communications, particularly when a major incident may be declared, the minimum information the Corporate Communications team will require in the form of a briefing can be best summarised using the acronym -

"METHANE" this information will be used as the basis to coordinate and create consistent communications from NHS Fife.

- Major Incident Declared.
- Exact Location.
- Type of Incident.
- Hazards – present and potential.
- Access – routes safe to use.
- Number, type, severity of causalities.
- Emergency services present / required.

6.2 Press and Media Management

NHS Fife staff are reminded that they must direct any press or media calls, requests, or enquiries to NHS Fife Communications – Ext: 27971 Tel: 01592 647971 (Monday – Friday 9am-5pm), Email: fife.communications@nhs.scot

Out with these hours please call switchboard on Tel: 01592 643 355 and they will forward your message to the on-call service. Staff should not address any media enquiries or requests directly or agree to interviews without discussing first with a member of the NHS Fife Corporate Communications team.

6.3 Social Media

NHS Fife Corporate Accounts:

Social media accounts are NHS Fife's main social media channels and messages and content issued on them represent the official view or comment from NHS Fife. There is only one official-corporate account for each social media platform and these accounts are managed by Corporate Communications on behalf of the Chief Executive and NHS Fife as a corporate entity. These accounts are where the public, stakeholders and the news media can expect to hear the latest news, comment, and campaign messages from NHS Fife. During an incident, these channels are where people will often look to first for real-time updates. Posts, messages, and comments will be coordinated and monitored by Corporate Communications during an incident.

Individual-personal accounts:

Personal social media accounts are private profiles and unregulated by NHS Fife and the responsibilities of the account holder. However, members of NHS Fife staff identifying as such should consider their security settings in the event of a major incident and be mindful that their views or content could be presented as being those of the organisation. This is especially important during an incident as press and media will use social media to solicitate interviews, opinions, or other content. Staff are asked not to post images or film footage of NHS Fife premises during an incident as this could breach confidentiality and negatively impact on any potential police investigation.

6.4 Internal Communications:

NHS Fife Internal Communications during an incident will use a combination of channels. The primary channel for incident communications will be via the Staff Link App (powered by Blink software) – with staff asked to ensure they have downloaded the App to their phone or have access to the desk-top version. StaffLink communications will also be complemented with All Staff Emails as well as Managers' briefings for dissemination via staff huddles, safety briefings and meetings.

6.5 Elected Members Updates and Briefings:

All enquiries from elected members should be directed to the NHS Fife Chief Executive Office for response and co-ordination at: fife.chiefexecutive@nhs.scot. Staff members should also direct any enquires from elected members to this mailbox.

6.6 Corporate Communications Mobile Phones:

The Associate Director of Communications and the three Communications Managers all have work mobile phones. Switchboard, EDG Gold Command and the resilience team also have access to the Corporate Communications on-call rota and mobile numbers for the Corporate Communications team for weekend and out of hour's calls.

6.7 Major Incident Media Centre:

In case of a major incident on the VHK site – any media that arrive on site should be directed to the Staff Club, where the Corporate Communications Team will operate a media hub.

6.8 Casualty Bureau:

Following a Major Incident Police Scotland will establish a Casualty Bureau Team to collate information on those who may or may not be involved in the incident. Once the Casualty Bureau Team have been established; the Police will issue a telephone number to the public via the media. In advance of the Casualty Bureau Telephone number being established, the public will be asked to monitor the news section of the NHS Fife Website and NHS Fife Social Media Channels for latest news and guidance associated with the incident, with the Casualty Bureau number actively promoted via these channels once the numbers have been released by Police Scotland.

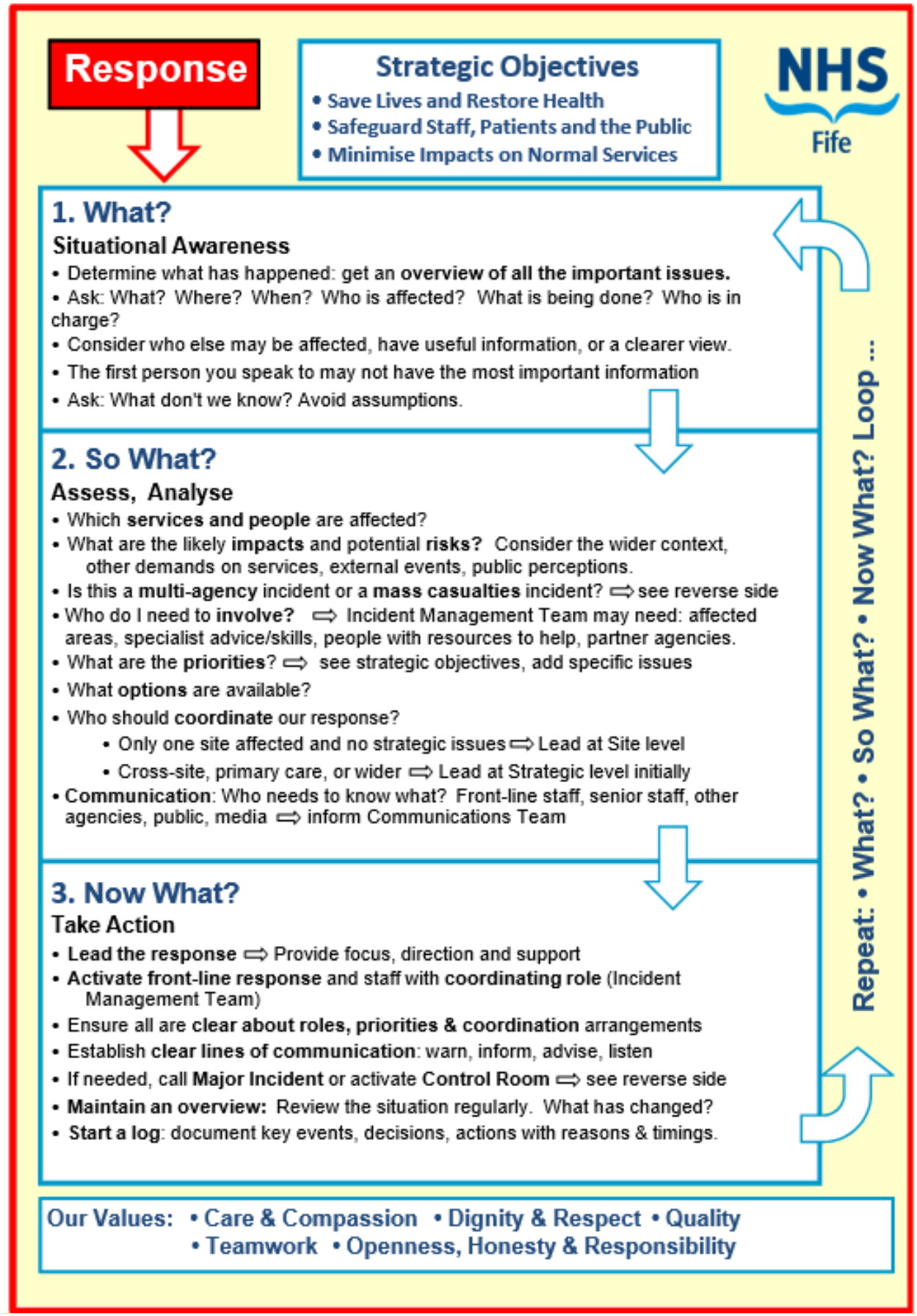
6.9 IT or phone outage:

In the case of an IT or phone outage, media should be directed to submit any initial media enquiries via the NHS Fife Press and Media Enquiry Form on the NHS Fife website: https://www.nhsfife.org/news-updates/press-and-media/press-and-media-enquiry-form/

As the NHS Fife website is hosted separately from any national NHS systems this form should still be accessible in the case of an IT or phone outage.

Alternatively, in the interim any press, media, or general public enquiries should be directed to follow NHS Fife's social media channels for the latest updates and comments from the organisation.

7 Resilience Card (What? - So What? - Now What?)



OFFICIAL

Resilience Card

Information

NHS Fife

See also: Action Cards in designated Incident Control Rooms
NHS Fife Resilience intranet site: Staff Link: NHS Fife EPRR Pages
Scottish Government: www.readyscotland.org/ready-government/

Strategic Incident Management Team

AGENDA

1. **Introduction**
   - Purpose, membership
   - Urgent actions
2. **Situation Update – What?**
   - Actions from previous meeting
   - Reports from internal departments, specialists & external agencies
3. **Assessment and Significance – So What?**
   - Set/Review Strategic Objectives
   - Assess current/future impacts/risks
     - Consider: Strategic Objectives, Service provision, legal, financial, political and reputational aspects
   - Agree Priorities
   - Identify Options available – strengths & weaknesses
   - Review Communications Strategy – Internal & external
4. **Agree Actions – Now What?**
   - To manage incident
   - To manage normal services
   - To manage communications
   - To direct and support staff
5. **AOB**
   - Time of next meeting

Note: To ensure priorities are addressed first, get *concise updates* from all *before* discussing how issues will be managed

Mass Casualty Incidents

Key tactical (site level) tasks:

- Find out how many casualties are expected, how many may need immediate surgery; whether they pose any hazards to staff, any other security risks.
- Ensure theatre lists are halted, space is created in ICU & HDU, both Recovery and Emergency Dept. are cleared and Blood Transfusion Service is aware.
- Ensure the following have met and are clear about their roles (on their Action Cards): Hospital Medical Coordinator, Surgical Lead (coordinating role), Surgical triage, ED Lead consultant

The **National Mass Casualties Plan**

- SAS will assume that Territorial Boards will make available their default trauma capacity levels (28 Adult P1/P2 casualties for NHS Fife)
- The Board where the incident occurs should activate and chair a cross-board **Strategic Health Group** within 2 hours.

Police & Scottish Government

- To contact **Police** in an emergency call **999**.
- To activate the multi-agency **Resilience Partnership** response (MACC) call Police Control Room **0131 203 7904,** request RRP response and say who you need: Council, Police, RRP Coordinator, etc.
- **Who to speak to in a multi-agency incident**: ask for the Police Incident Officer (PIO); identify yourself as NHSL **Tactical** (Site Dir.) or **Strategic Lead** (Exec. Dir.).
- **Scottish Government** should be told about incidents that may seriously affect services or attract media interest. A Director or member of the Resilience Team should do this: call **0131 244 2429** (Out of hours call **07623 909 981** leave a 'call me back' message that includes your contact number)

Coordination & Control Rooms

- The Executive Team provides NHS Fife's **GOLD** (Strategic level) **coordination** of incidents, based at Education Centre Victoria Hospital Kirkcaldy
- VHK is the **Control Hospital**; it provides **SILVER** (Tactical) coordination of the clinical responses for acute hospital, from the VHK Control Room via the management teams on each site.
- **Local Resilience Partnership** is a regional multi-agency group including Police (often including Police (often chair), Fire, Police, Local Authority, SAS & NHS Board.

What?

So What?

Now What?

8 Roles & Responsibilities

8.1 Chief Executive

NHS Fife's Chief Executive (or designated deputy) has overall responsibility for the strategic & operational leadership within crisis & incident management for the board (Operational functions in emergency planning & incident response will be delegated). In MI-MC responsibility to set up Strategic Health Group (for cross-board response) and Health Information Cell.

8.2 Director of Public Health

The Board has delegated the supervision of emergency planning to the Director of Public Health. The Director of Public Health is also one of the Co-Chairs of the Fife Local Resilience Partnership (Fife LRP).

8.2.1 On-call Public Health Consultant would chair the STAC and Public Health Incident Management Team. Also forms part of the East Region Health Protection Team.

8.3 Director of Acute Services

- To establish a tactical-level incident control group to mobilise and coordinate Acute resources in response to incidents.
- Engage and steer resources across multi-disciplinary services involved in the Medical, Nursing, Pharmacy, Allied Health Practitioners, and other Acute & H&SCP rehabilitation services.

8.4 Director of Health & Social Care Partnership / Chief Officer Fife IJB

- To establish a tactical-level incident control group to mobilise and coordinate the primary and community resources under their control.
- Identify, support, and protect vulnerable adults and children; the latter will be achieved by working with the local authority's Chief Social Work Officer / Head of Children's Services.
- Work in partnership with Acute Sector sites to create capacity by supporting rapid discharges from hospital and commissioning additional social care support if necessary.
- Engage and steer resources from multi-disciplinary partners involved in the HSCP, especially Primary Care Services – GPs, Nursing, Pharmacy and Allied Health Practitioners, and other rehabilitation services.

- Arrange for HSCP staff to signpost people to local services or to NHS 24/NHS Inform and/or assisting those who are displaced to access medication or other everyday items.
- Commissioning services from the third sector and independent sector and/or arrange for supervision of volunteers at Rest Centres/Family and Survivor Centres.

If the incident occurs in a HSCP setting the Director will undertake the following:

- Responsible for the implementation of the Fife HSCP Resilience Framework (this document) across the partnership and on behalf of the IJB
- Responsible (in conjunction with Fife Council Chief Social Worker) for managing Care for People response, including the activation of the Fife Care for People Response Arrangements
- Approve / lead an appropriate level of incident management response to any incident.
- Represent Fife HSCP / IJB at the Fife LRP
- Ensure that the Fife HSCP has appropriate resilience related plans in place and can effectively respond to any incident both during and out-with office hours.
- Appoint a Resilience Lead for the Fife HSCP / IJB who will chair the Fife HSCP Resilience Assurance Group and ensure all actions are implemented.
- Ensure appropriate attendance at the NHS Fife Resilience Forum.

8.5 Executive Directors & Directorate Managers

- Ensure that all of their staff are aware of their departmental responsibilities.
- Ensure that all action cards are developed, maintained, and updated for their department.
- Ensure that call-out systems for off duty staff are in place.
- Ensure that their departmental response arrangements are included in local induction programmes for all staff.
- Ensure amendments to the plan are notified to the NHS Fife Resilience Team
- Ensure changes to the Switchboard Major Incident Call-Out List are notified to the switchboard.
- Ensure staff attend on-going training and awareness sessions.

8.6 NHS Fife Communications

- The Corporate Communications team at NHS Fife will lead on and coordinate all internal and external communications on behalf of the organisation, in response to a Major Incident.

8.7 Estates: including Security & Facilities (overseen by the Director of Property & Asset Management)

- Provide annual assurance to NHS Fife board to the resilience of the Estate & Security.
- Take an active role in the development and maintenance of emergency and business continuity plans.
- Take an active role in the annual exercise programme and maintain a separate testing programme of response capabilities (i.e.: generator testing/medical gas supplies maintenance/security).
- Take a lead role in the preparation of Board Estates for winter.
- Take a lead role in maintenance of essential supplies such as Food/Water/ Fuel /Laundry.
- Buildings Security, Lockdown procedures & CCTV.

8.8 Director of Workforce

The Director of Workforce will be responsible for the development and review of plans designed to provide support for staff during the response to an incident and for ensuring arrangements are in place to allow for an appropriate level of de-briefing and the on-going support for staff.

8.9 Pharmacy and Medicines

The Pharmacy & Medicines Directorate is responsible for ensuring access to all medicines during a major incident including medicines for pandemic influenza and counter measures for a chemical, biological, radiological or nuclear (CBRN) incident. This includes ensuring medicines are redistributed from across NHS Fife holding areas, enacting reciprocal medicine supply arrangements with other Boards, arranging access to the centrally held national stockpiles (pandemic influenza/CBRN) and engagement with Community Pharmacy as required. Non-Pharmacy personnel should not move, request or purchase medicines without Pharmacy advice.

During working hours (Monday to Friday), contact the Director of Pharmacy & Medicines (01383 674169) or the Deputy Director of Pharmacy & Medicines

(01592 648037). Out with Pharmacy working hours, contact the on-call Pharmacist via Switchboard.

8.10 The Resilience Team

The Resilience Team supports the Executive in the discharge of its duties for emergency preparedness. NHS Fife Resilience Team provides support in Emergency Preparedness, Resilience and Response (EPRR) to Major Incidents by:

- Providing a single point of contact (Head of Resilience) for advice concerning all aspects of EPRR.
- Ensuring that all plans and action cards are available, in all formats, for use in Major Incidents.
- Ensuring all plans and framework documents reflect National guidance and remain current should legislation be updated or changed.
- Testing and exercising plans and action cards on a regular basis in order to ensure they are fit for purpose.

8.11 Scottish Ambulance Service (SAS)

The role of the SAS is to:

- Alert NHS Fife of a Major Incident Standby or Major Incident Declared
- The Ambulance Control Centre (ACC) Duty Manager is the tactical level manager responsible for running the ACC response to the Major Incident.
- Deploy a Medical Incident Officer (MIO) to the scene of the incident.
- Deployment of Hospital Ambulance Liaison Officer (HALO)

8.12 NHS 24

NHS 24 play a central role during Major Incident – Mass Casualties (MI-MC) incidents providing tele-health and care information for the public. In any event of MI-MC being declared by SAS, NHS 24 are notified at the same time as Territorial Boards, and will:

- Be ready to support the responding Territorial Boards and partner agencies by preparing to activate relevant web pages with pre-agreed content onto their website;
- Fulfil a public messaging function in support of Territorial Boards to keep patients informed of which service to access if they have been injured in the incident, need medical attention for other reasons, or attending for routine appointments.

- Refer to NHS 24 sections at the following link: Major Incidents with Mass Casualties.

8.13 External Agencies

Dependant on the nature, location, and scale of any the incident, NHS Fife will liaise with partner agencies (i.e. the Emergency Services, including Scottish Fire and Rescue (SFRS) and the Maritime and Coastguard Agency, as per inter-operability principles, ensuring shared situational awareness and understanding of tasks) and Fife Council through the Fife LRP to ensure that it is delivering an effective response which is co-ordinated with multi-agency partners.

8.13.1 Police Scotland

Police Scotland has overall responsibility for co-ordinating the strategic response to a Major Incident of all emergency services and any other organisation involved. Moreover, they will co-ordinate the provision of information to the public and the media. Police Scotland will instigate a Multi-Agency Control Cell (MACC) either virtually through Teams or physically within a defined location. All Emergency Services and associated agencies (incident-specific) will be represented in order to form a working strategy for the Incident Leads. NHS Fife may be required to nominate a Medical Incident Officer for the MACC in order to provide updates and liaison between the MACC and NHS.

Police Scotland will, when deemed necessary due to mass fatalities, send a Casualty Bureau Team to the VHK. The role of the Casualty Bureau Team is to collate demographic information of the arrivals at the Emergency Department (ED) for the purposes of identifying the deceased and injured. Upon arrival, the Team will liaise with the ED Senior Charge Nurse and Senior Health Records Manager. The Team will establish an operating centre within the Children's Outpatient Department alongside Medical Records staff.

8.13.2 Fife Council Emergency Resilience Team

The role of Fife Council is to:

- Co-ordinate the Council response to an emergency.

- Arrange Rest Centres/Survivor Centres and any emergency. accommodation to be provided for those involved in the incident, including those who have to be evacuated.
- Facilitate the provision of Council and other resources to assist the emergency services.
- In the event of a mass fatality incident, consult with Police Scotland to select the most suitable designated emergency mortuary option.
- Co-ordinate the recovery from the emergency in conjunction with Fife Local Resilience Partnership (LRP) with health-specific input from Director of Public Health.

8.13.3 Military Assistance to Civil Authorities (MACA)

MOD's role is concentrated on 2 main areas:

- Providing niche capabilities which MOD needs for its own purposes and which would not be efficient for the rest of government to generate independently, for example Explosive Ordnance Disposal (EOD).
- Standing ready to support the civil authorities when their capacity is overwhelmed.

Scottish Government Ministers are solely responsible for authorising and making a request to the Ministry of Defence (MOD) for military assistance under the MACA18 agreement. It is expected that the need for such assistance will have been fully discussed at the SHG and taken forward by the SG HSCD Incident Director. No direct request or approach should be made by NHS Boards to local Reservist Divisions. SG Health Resilience Unit will lead and coordinate the arrangements with MOD on behalf the SG HSCD. The situation must satisfy 4 criteria:

1. There is a definite need to act and the tasks the Armed Forces are being asked to perform are clear.
2. Other options, including mutual aid and commercial alternatives, have been discounted; and either:
3. The Civil Authority lacks the necessary capability to fulfil the task and it is unreasonable or prohibitively expensive to expect it to develop one; or
4. The Civil Authority has all or some capability, but it may not be available immediately, or to the required scale, and the urgency of the task requires rapid external support from MOD.

8.13.4 Military Support for Blast and High Velocity Injuries

In the event of a MI-MC resulting in blast and high velocity injuries, SG HSCD, can if necessary, via the UK Government, request the MOD to make available suitably experienced personnel from within the Defence Medical Service (DMS) to provide expert advice and guidance on treatment of these types of injuries. However there are a number of clinicians working in the NHS in Scotland who as active military reservists, have the relevant operational experience and may be able to act as a source of advice and guidance to colleagues within the Responding Territorial Boards.

9 VIPs

VIPs could present as casualties, relatives of casualties or on arranged visits following a Major Incident. Reference should be made to the NHS Fife VIP Operation Consort Plan which is a 'restricted' document only available to Executive Directors.

10 Fatalities

NHS Fife has a responsibility to sensitively deal with incident casualties who die within the hospital as a result of injuries sustained in a Major Incident. NHS Fife is responsible to maintain dignity and care of the deceased whilst preserving forensic evidence. Police Scotland will provide Family Liaison Officers (FLO) at the time of notification and identification of the deceased. NHS Fife has a responsibility to assist in this process by providing staff to support care for the deceased & bereaved at this time.

11 Welfare support for staff during and after a Major Incident

11.1 TRiM/CISM

Support and qualified trauma management such as Trauma Risk Management (TRiM) or Critical Incident Stress Management (CISM) can reduce the severity of distress in staff and patients alike following their involvement in a Major Incident. Early intervention, along with continued monitoring and support, is vital in order to reduce the risk of people developing emotional disorders such as Post Traumatic Stress Disorder (PTSD) later.

11.2 Peer Support Network

Peer Supporters are trained colleagues available to listen and talk to NHS Fife staff. Peer Support is a voluntary, supportive and confidential conversation aiming

to help the staff member regardless of the source of stress. Group support can also be offered. Peer Supporters aim to respond within 2 working days. Further details are available on Staff Link.

Staff can access peer support by emailing/phoning one of the following and leaving a message simply asking for peer support, leaving contact details (no other information is required initially):

- fife.staffpeersupport@nhs.scot
- fife.medicalpeersupport@nhs.scot
- fife.criticalcareps@nhs.scot
- 01592 729673

11.3 H&SCP Community Mental Health Services

As part of the immediate response to a Major Incident with Mass Casualties (MI-MC), the H&SCP will mobilise Community Mental Health Teams (CMHT) to:

- Arrange for the provision of information, advice and support for distressed individuals at the acute receiving hospital.
- Ensure adequate mental health assessment, care and support is offered with attention being given to follow up arrangements.
- Work collaboratively with ED staff to ensure professional advice on where to seek treatment and support and the issuing of the post incident leaflet (Coping with Stress After a Major Incident - nhs_trauma_leaflet.pdf)
- Ensure that arrangements for psychosocial care and mental health support are in place, coordinated and signposting to other agencies, such as NHS 24 .
- Ensure adequate mental health liaison resources are made available to those care providers who have responded to the incident.

(Annex 7 & 13 to Major Incidents with Mass Casualties National Plan for NHS Boards and H&SCP 2019)

Advice available: NHS Fife Chaplaincy Team are the initial point of contact for Trauma Risk Management Support (TRiM) and Critical Incident Stress Management (CISM): NHS Fife-Department of Spiritual Care, Victoria Hospital, Kirkcaldy. Tel: 01592 648158 (Internal Ext: 28158)

12 Procurement

Where it is deemed essential to maintain short/long term stockpiles of equipment or products a range of measures will be established by Head of Procurement and

Senior Procurement Team to mitigate any supply chain issues arising in any incident situation. In any incident level 4 (Major Incident) event contact should be made via the central Procurement phone line (01592 657320 or Internal ext. 61320). On contact please indicate to the call handler that the issue needs to be escalate immediately to the Head of Procurement/Senior Procurement Team**.**

13 Debrief

The debrief process is an important part of the learning cycle as it provides an opportunity to demonstrate continuous improvement within the resilience of the organisation whilst simultaneously providing an audit trail of all actions and procedures carried out during the incident. Each debrief should have an individual who assumes the lead and ownership for any outputs from the debrief. This person is referred to as the “sponsor” and would normally be a Senior Manager from the department or the directorate where the incident happened. Individual departmental or ward debriefs will be completed at a time deemed appropriate by the departmental or ward lead.

A **Hot** Debrief must be carried out as soon as possible once the Major Incident has been stood down. A further formal (**Cold**) Debrief should be completed within 6 weeks of the incident and may involve external agencies (this may be initiated by the Fife Local Resilience Forum).

A Debriefing Template can be found at Appendix 2

14 Training and Awareness

NHS Fife will provide mandatory training for all staff in Major Incident awareness. The level of training will be dependent on the level of responsibility of staff who undertakes key roles key roles in the event of a major incident will be given role specific training.

RESPOND

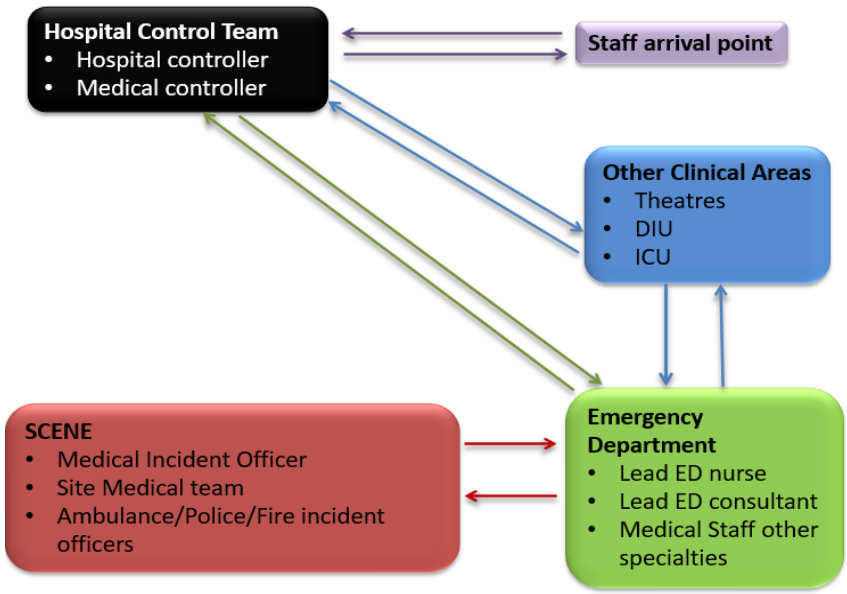
(Incident Level 4 - Category 1 Major Incident Declared / Receiving Hospital)

15 Respond: Major Incident Declared to Emergency Department (VHK)

This section covers the Category 1 response, commencing via Emergency Department VHK on notification of a Major Incident standby or declaration of a Major Incident via Scottish Ambulance Services (SAS). Internal incidents should be escalated through the *Internal/External Incident Escalation (Levels 1, 2, 3 & 4 Major Incident/Category 1 response).*

15.1 Lines of Acute Hospital Communication in Category 1 Response

The diagram below outlines the basic C3 structure with lines of communication between all areas of the Acute Hospital, the Control Team, and the scene of the declared incident:



15.2 Acute Guidance for Staff Call-Out

Not all staff will be required to attend during a major incident. This decision will be made by the Incident (C3) Controller in conjunction with the Medical and Nurse Controller.

The following should be considered when calling staff out:

- The nature of the incident.
- The number of casualties expected.
- The capacity within the hospital at the time of the incident.
- Staffing levels within the hospital at the time of the incident.
- How long the incident is likely to have an impact on the hospital.

15.3 Acute Staff Reporting Point – Maternity Out-Patients Department, Phase 3, VHK

15.4 Major Incident (Level 4) – Acute Call-out Procedure

- All wards and departments will keep an up-to-date call-out list. This must be checked on a regular basis.
- Staff will only be called in when the wards and departments are instructed to activate their call-out procedures by the Incident Controller; Staff will be asked to report to the Staff Reporting Point and not their usual place of work.
- All staff on duty at the time of the incident should stay in their ward or department and should attempt to stay on duty until stood down by the Incident Controller.
- When instructed by the Incident Controller, all off duty staff will be called out by a delegated individual allocated by the most Senior Manager on duty (Acute and H&SCP staff).
- See below for Call-Out Procedure scripting (can be printed and kept available in hard copy).

The following statement will be made:

Call-Out Procedure - Notification Script Major Incident (Incident Level 4):

“This is NHS Fife calling. This is not an exercise.

A Major Incident has been declared.

You are requested to attend work.

The staff reporting point is located at Maternity Outpatients VHK.

Bring your identification badge and uniform (if worn).

Confirm your ability to attend and expected time of arrival.

For Emergency Department - Go to Appendix 3 and 15.5 (below)

15.5 Accident & Emergency Department (ED) Notifications:

The ED Floor Co-ordinator will notify the following :
Switchboard
The senior doctor and nurse in the Emergency Department
The Emergency Medicine consultant on call (if not present in the department)
The Hospital co-ordinator 27902
The Hospital co-ordinator who will attend the Emergency Department for briefing and will also contact:
Day intervention co-ordinator Ext 29907
Theatre co-ordinator (phase 2) Ext 28293 Theatre co-ordinator (phase 3) Ext 29900
Hospital Switchboard will notify:
Executive On-Call & Chief Executive (or Deputy Chief Executive)
The Duty Manager who will contact the: Control Team (Acute and H&SCP)
Head of Resilience
Resident on-call doctors for all specialties (via page)
On-Call Healthcare Chaplain
Security
Porters
Medical records
Mortuary

The below senior staff, when notified of a Major Incident Standby, should attend the Emergency Department for briefing and to collect their action cards:

Role	**Ext No.**
Emergency Department Senior Doctor	29791
Emergency department Senior Nurse	29792
ED Floor Co-ordinator	29792
Co-ordinator	27902

Other staff notified of a Major Incident Declared **must** attend Maternity Outpatients and may be directed immediately to a clinical area or asked to remain in Maternity Outpatients until staffing need is identified.

All other responding staff **must** remain in Maternity Outpatients until directed to attend another area.

15.6 Declaring Major Incident with Mass Casualties (MI-MC)

A Mass Casualty Incident (MCI) for the NHS is defined as an incident (or series of incidents) causing casualties on a scale that is beyond the normal resources of the emergency and healthcare services' ability to manage where this would be navigated & coordinated via the National Major Incident Mass Casualties National Plan.

See: The National Plan for NHS Boards and Health and Social Care Partnerships 2019 (guidance link and QR code below):

Major Incidents with Mass Casualties - National Plan for NHS Boards and Health and Social Care Partnerships 2019

A Mass Casualties Incident should be declared by the Chief Executive or named Deputy based on a combination of factors. These include;

- The likely number of casualties
- The ability of local health services to cope with demand and the potential of the incident to overwhelm the combined resources of Health Boards in a local Regional Resilience Partnership (RRP) area.

The ability of local services to cope with demand may itself be affected if an incident has a direct impact on NHS sites or staff (e.g. through evacuation).

Several smaller scale major incidents may combine or occur in quick succession to become larger & geographically diverse; this may require a mass casualty incident response (including Regional Mass Fatalities Group) to be triggered due to the large volume of simultaneous casualties and the potential impact on one or more Territorial NHS Board areas.

15.6.1 Health Information Cell

The Health Information Cell (HIC) will be established at the request of the Strategic Health Group (SHG) in response to a Major Incident Mass Casualty event. The purpose of the HIC is to provide the Strategic Health Group with details on the location of casualties in NHS Fife and other supporting Boards. This information will be shared with other territorial and special Boards (SAS, NHS 24 etc,) the Scottish Government and the Police Scotland Casualty Bureau.

The SHG Chair will appoint a HIC Lead (appropriate Director who will also be a member of the SHG).

The HIC will:

- Coordinate information in relation to patients and patient transfers between healthcare facilities, and other key information;
- Act as the Single point of contact for the Casualty Bureau in relation to the patients in the care of NHS Scotland

Refer to: Major Incidents with Mass Casualties - National Plan for NHS Boards and Health and Social Care Partnerships 2019

15.6.2 Communication Between Scottish Health Boards During Major Incidents and Major Incidents with Mass Casualties

Predominantly, communication will be from the Scottish Ambulance Service to Territorial Health Boards in order to notify them of the incident and to share early thoughts on casualty numbers and distribution. However, critical in a Mass Casualty event will be to also communicate with the Scottish National Blood Transfusion Service (SNBTS) in order to facilitate the effective distribution of the finite supply of blood components to receiving hospitals. It will also be essential to inform NHS24 and the Golden Jubilee National Hospital so that they can support a national response as required.

Communication Between Scottish Health Boards During Major Incidents and Major Incidents with Mass Casualties (official sensitive) guidance plan can be found electronically in the Resilience folders in the "T:/ Drive" and also from within the Executive Virtual Incident Room folders. In any event that a hard copy is needed this is held with the Physical

Major Incident Framework folder in the education centre at VHK.

Once a board has been notified of an MI or MI-MC there will be a need for further strategic conversations to take place as the incident progresses. The strategic contact number should be for an individual within a board that is sufficiently senior and sighted on overall board capacity to be able to discuss board stress points, skills imbalance, etc. in order to inform further casualty distribution decisions.

15.6.3 Mortuary

In the event of a Major Incident with Mass Casualties (MI-MC), the national arrangements for Disaster Victim Identification (DVI) will be activated by the Procurator Fiscal and the Police DVI lead. Fatalities at the scene will be transported to one of the designated mortuaries which have been assessed as suitable for accommodating mass fatalities. Details of these Mortuaries can be found in the Major Incidents with Mass Casualties – National Plan for NHS Boards and Health and Social care Partnerships 2019 (See section 15.6 above).

The NHS Fife Mortuary facilities will be used to receive casualties who are certified ‘dead on arrival’ or following arrival at the Hospital. Deceased will be transferred to the hospital mortuary following normal hospital procedures.

NHS Fife Mortuary facilities are split across VHK and QMH. The VHK Mortuary has capacity for 76 deceased; this includes 4 freezer spaces and 8 bariatric spaces. QMH has capacity for 26 deceased. Two of these can accommodate bariatric patients. NHS Fife has contingency refrigerated units (Nutwells) for surge periods which have the capacity to store 60 deceased. The combined capacity across all sites is 158 spaces. This allows for space for BAU and deceased in the event of a major incident. If further storage space is required then the Mortuary and Fife Mass Fatalities Logistics Plan will be implemented.

The Procurator Fiscal is responsible for all deceased casualties that have been involved in the incident, although this responsibility may be delegated to the Police Scotland.

When a Mass fatalities incident occurs, Switchboard will contact the

Mortuary on Ext. 28122 (during working hours; Monday to Friday 8am – 4pm) or the Senior Anatomical Pathology Technician/Cellular Pathology Department Service Manager (out of hours). The Major Incident Action card will then be implemented.

15.7 Trauma Centres

NHS Scotland currently has four established regional Pre-Hospital Trauma Teams available:

- Medic 1, based in Edinburgh.
- Tayside Trauma Team, based in Ninewells Hospital, Dundee.
- Emergency Medical Retrieval Service, based in Glasgow.
- North Trauma Team, based in Aberdeen.

These are consultant-led and delivered services working closely with the Scottish Ambulance Service. They are deployed via Scottish Ambulance Service Trauma Desk. In addition to being a regional resource, they can be deployed by helicopter or road to the scene of any major or serious incident in Scotland through mutual aid.

Specialist highly qualified Medical Officers provide appropriate medical support, senior clinical decision making and critical care to casualties as Site Medical Teams. The teams can also provide the Medical Incident Officer capability.

15.8 Major Incident Patient Triage

Casualties are triaged via SAS into three categories.

NHS Fife, on receipt of an external Major Incident Standby message, or on a Major Incident being declared, puts into action preparations in order to receive incoming casualties classified as follows:

Medical Teams in ED follow National Clinical Guidelines for Major Incident Patient Care:

I. B0128- Clinical Guidelines Major Incident 2020
II. NHS Scotland Emergencies

Priority Group	Order of Treatment	Description of casualties needs
P1	1	**IMMEDIATE** Life-saving procedures required
P2	2	**URGENT** Intervention required within 4-6 hours
P3	3	**DELAYED** Less serious cases who do not require treatment within the times given above
		EXPECTANT Casualties whose injuries are so severe that they either cannot survive or would require so much input from the limited resources available that their treatment would seriously compromise the treatment of large numbers of less seriously ill casualties.
DEAD	DEAD	**DEAD** No medical attention required

15.9 Emergency Department associated local triage guidance:

(Appendices are hyperlinked below for ease)

Appendix 4: Executive Response Team. NHS Fife Major Incident (Incident Level 4) Command and Control Structure

Appendix 5: Major Incident (Incident Level 4) – Patient Outcomes from Emergency Department Triage

Appendix 6: Major Incident (Incident Level 4) – Patient Journey from ED

Appendix 7: P1, P2, P3 Patient Management & Triage

Appendix 8: Patient Discharge Records

Appendix 2: Hot/Cold Debrief Template

NHS Fife CBRN Framework (dependant on dynamic risk assessment and hazard management)

Category 1 Hospital Response Major Incident Action Cards 1 – 28 (physical copies located in ED Major Incident Store)

RECOVER

16 Incident Recovery

Recovery is the coordinated process of supporting progression to normal working conditions and support for the emotional, social, and physical wellbeing of those affected, it may also include the reconstruction of the physical infrastructure. Recovery should commence as soon as safely possible but also make allowances for a period of disruption whilst the response is ongoing. NHS Fife Chief Executive (or acting deputy) at an appropriate stage will establish a Recovery Coordination Group.

Key Recovery Objectives:

- Returning to normal business.
- Implications of, and solutions to, any lack of resources.
- An assessment of the Incident on NHS Fife (covering impacts on services and staff e.g. social, health, environment, economic, etc.) is carried out as soon as possible and is regularly updated.
- Determine opportunities for longer term regeneration and economic development as part of the recovery process.
- If affected, utilities (e.g. power & water) are brought back into use as soon as practicable.
- All affected areas are restored to an agreed standard so that they are 'suitable for use' for their defined future purposes.
- Environmental protection and recovery issues are co-ordinated.
- Information and media management of the recovery process is co-ordinated.

16.1 Recovery Co-ordination Group (RCG)

The Recovery Co-ordination Group (RCG) is responsible for the overall recovery from the incident and should be accountable to the Chief Executive and Director of Acute Services.

Group Membership:

- Director of Acute Services (Chair)
- Director of Public Health
- Director of Health and Social Care Partnership

- Representatives of affected directorates/teams
- Estates & Facilities Representatives
- Finance Representative
- HR Representative
- Emergency Planning Officer/Resilience Team
- Communications Team Representative
- Loggist

16.2 Recovery Resources

Directors setting the strategy in the Executive Directors Group (EDG) need to consider the conflicting demands of the immediate emergency response, the longer recovery period, and the maintenance of critical services. Resources should be prioritised accordingly to ensure a successful recovery as well as the continued delivery of critical services in order that normal business is resumed as quickly as possible. The RCG should liaise closely with the EDG to ensure co-ordination of resources.

16.3 Communications

Internally: It will be important for the RCG to keep staff informed as to the progress of recovery via regular updates. Additionally, NHS Board members will require regular briefing as the situation develops. Where an Incident Control Team remains in operation, liaison between it and the RCG is essential.

Externally: NHS Scotland and the Scottish Government may require regular situation reports. During recovery the RCG should ensure that all communications with outside agencies are coordinated via the NHS Fife Communication Team.

16.4 Finance

The role of the Finance team is vital to response and recovery, and there should be a finance representative in the RCG. Financial aspects of major incidents may be complex and open to interpretation. Two main processes need to be considered: expenditure whilst delivering services and reimbursement of costs afterwards.

Key areas:

- Future costs and long-term expenditure.
- Overall cost of the emergency cost of damage, loss of income, access to emergency funding.
- Agree who is responsible for authorising spend.
- Establishing systems for emergency expenditure
- Ensuring financial records have records of “non routine” spend so costs of incident and recovery can be easily identified.

16.5 Building Damage

If the usual place of work is damaged in the event of a major incident, the building should be assessed by the relevant Estates representative immediately to determine if it is safe, and to start repairs. If the building is deemed unsafe staff/patients may have to be deployed to other locations and services. Should a service need to be relocated NHS Fife Estates and Facilities teams may have to arrange to provide support services at alternative locations.

17 Reference Documents

- Management of Public Health Incidents: Guidance on the Roles and Responsibilities of NHS Led Incident Management Teams
- STAC | Ready Scotland
- A Guide to Environmental Incident Response for NHS Boards (scot.nhs.uk) (CHEMET information hosted on SHPIR website)
- Civil Contingencies Act 2004 (legislation.gov.uk)
- Civil Contingencies Act 2004 (Contingency Planning)(Scotland) Regulations 2005
- nhs_trauma_leaflet.pdf
- NHSScotland Resilience Preparing for Emergencies - Guidance for Health Boards in Scotland (www.gov.scot)
- Major Incidents with Mass Casualties - National Plan for NHS Boards and Health and Social Care Partnerships 2019
- Joint Doctrine Archive - JESIP Website

Appendix 1: SBAR:

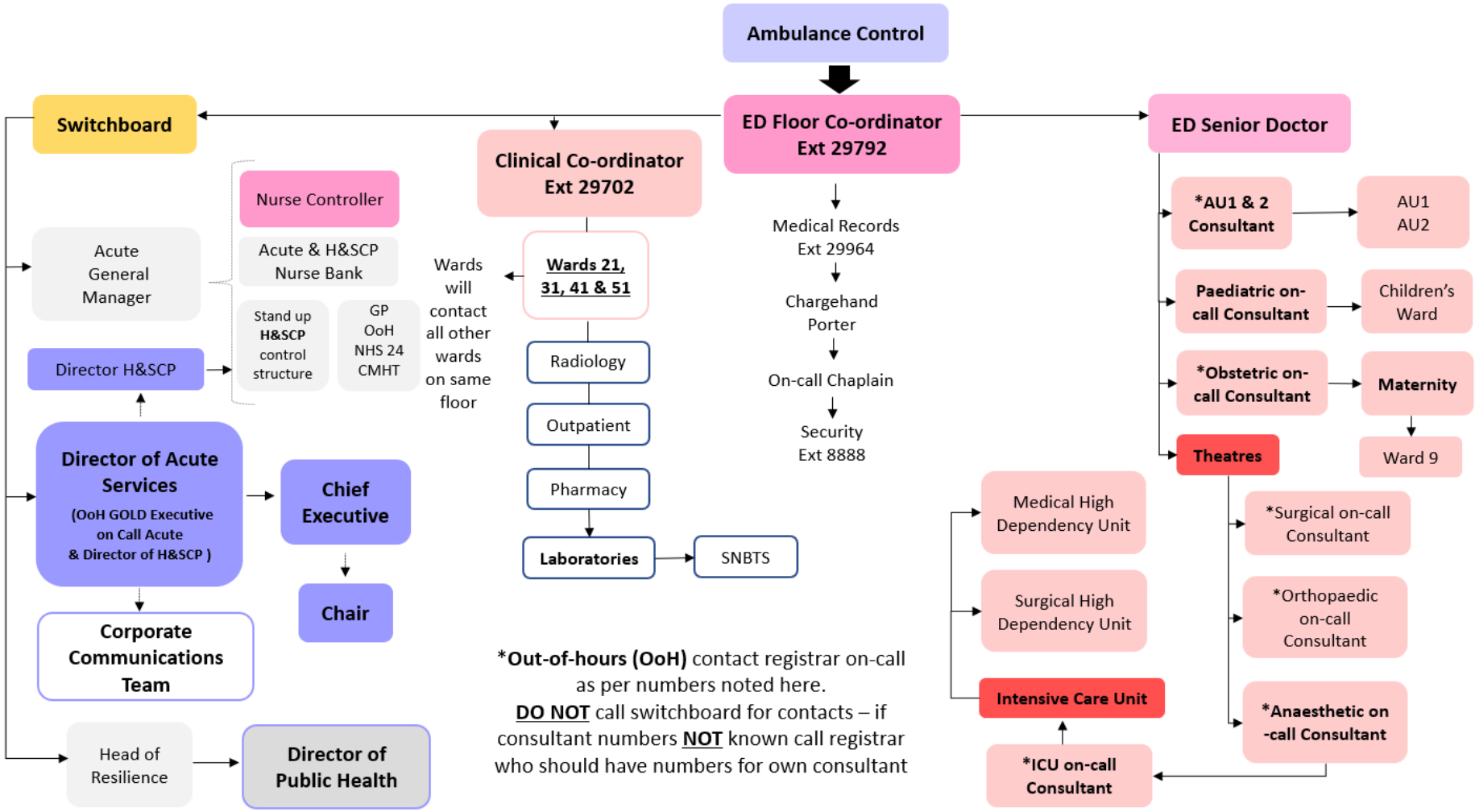
SBAR Report	
Situation	Describe situation/incident that has occurred i.e. Exceptional risks arising from weekend or overnight, surges in activity, increases in ED presentations, workforce.
Background	Explain history and impact of incident on services/patient safety – risk/s
Assessment	Confirm your understanding of the issues involved. What measures are in place. What has already been exhausted other than business as usual. Have all organisations confirmed that hey have implemented all relevant actions from their own internal escalation plans. Has any provider declared or is about to declare an internal critical.
Recommendation	Explain what you need, clarify expectations and what support is needed. What benefit / outcome do we need to achieve de-escalation.
Ask receiver to repeat information to ensure understanding	

SBAR Template	
Situation	
Background	
Assessment	
Recommendations	

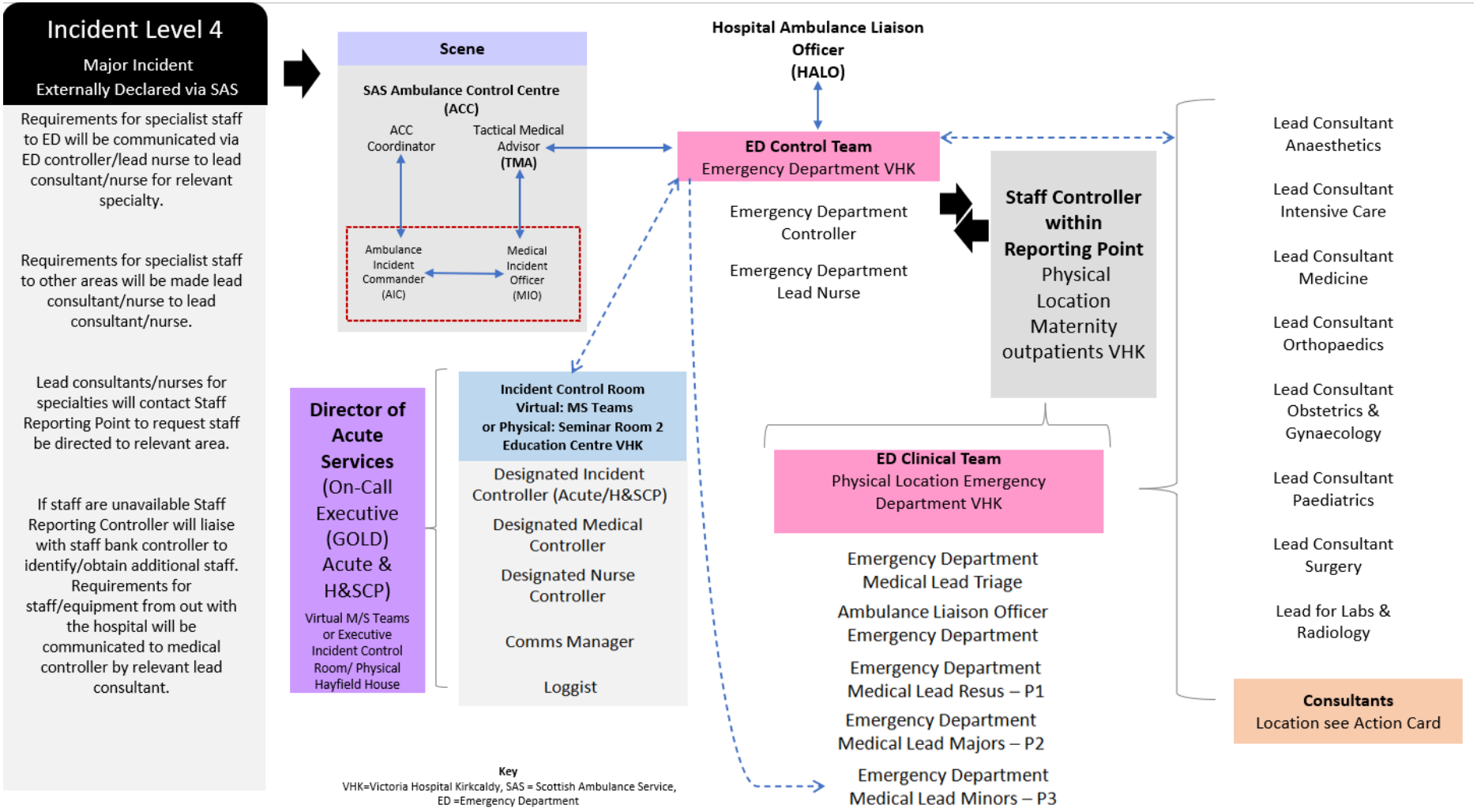
Appendix 2: Hot/Cold Debrief Template

1. Incident Reference	
Provide a reference / title for this incident.	
2. Details of Incident	
Provide a brief summary of incident*:* *include details of the following where relevant: dates when incident started/ended; case definition; description, number, and features of cases; care areas/locations affected; source and modes of cross-transmission/exposure; diagnosis and treatment, any enhanced surveillance of interventions, any hypotheses.*	
3. What went well?	
Please list aspects of the incident considered to have been managed well:	
4. What did not go well?	
Please list aspects of the incident considered not to have been managed well:	
5. Lessons Learned	
Please provide details of any learning points or recommendations:	
6. IMT lead details	
Name:	Email:
Job Title:	Address:
Contact number:	Contact number (mobile):
Date:	Signed:

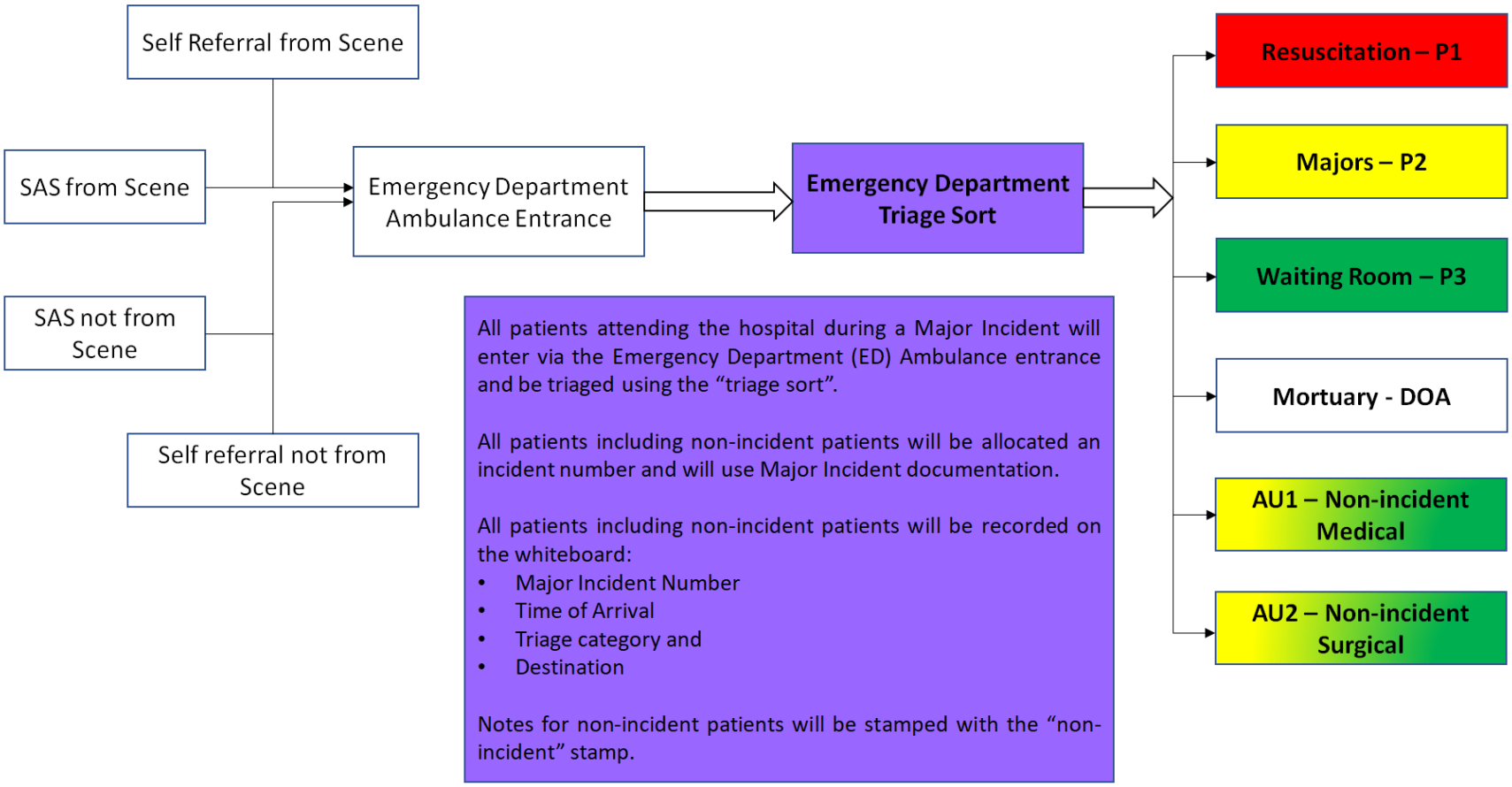
Appendix 3: NHS Fife Emergency Department Major Incident (Incident Level 4) Notification Plan:



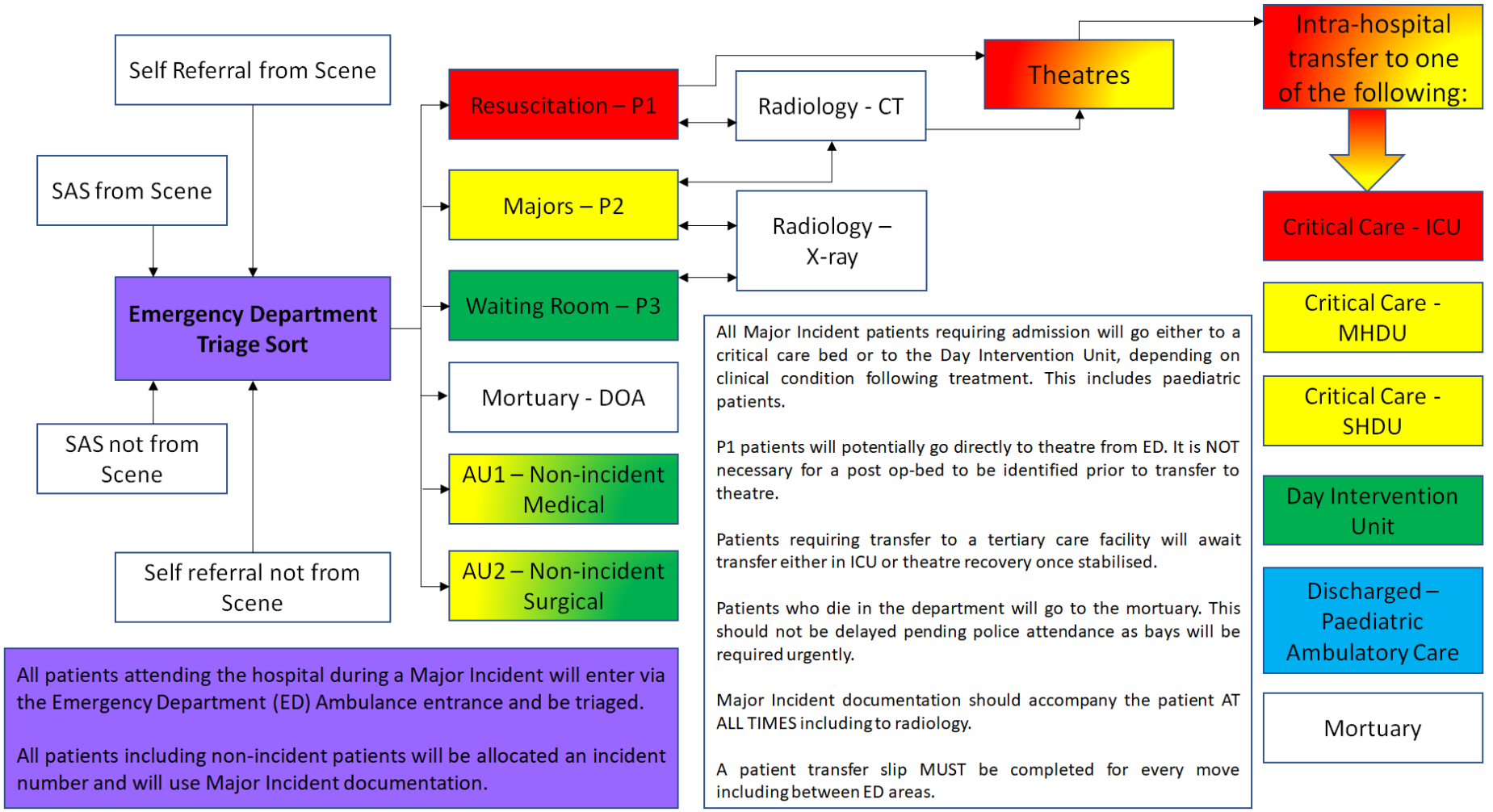
Appendix 4: Executive Response Team. NHS Fife Major Incident (Incident Level 4) Command and Control Structure:



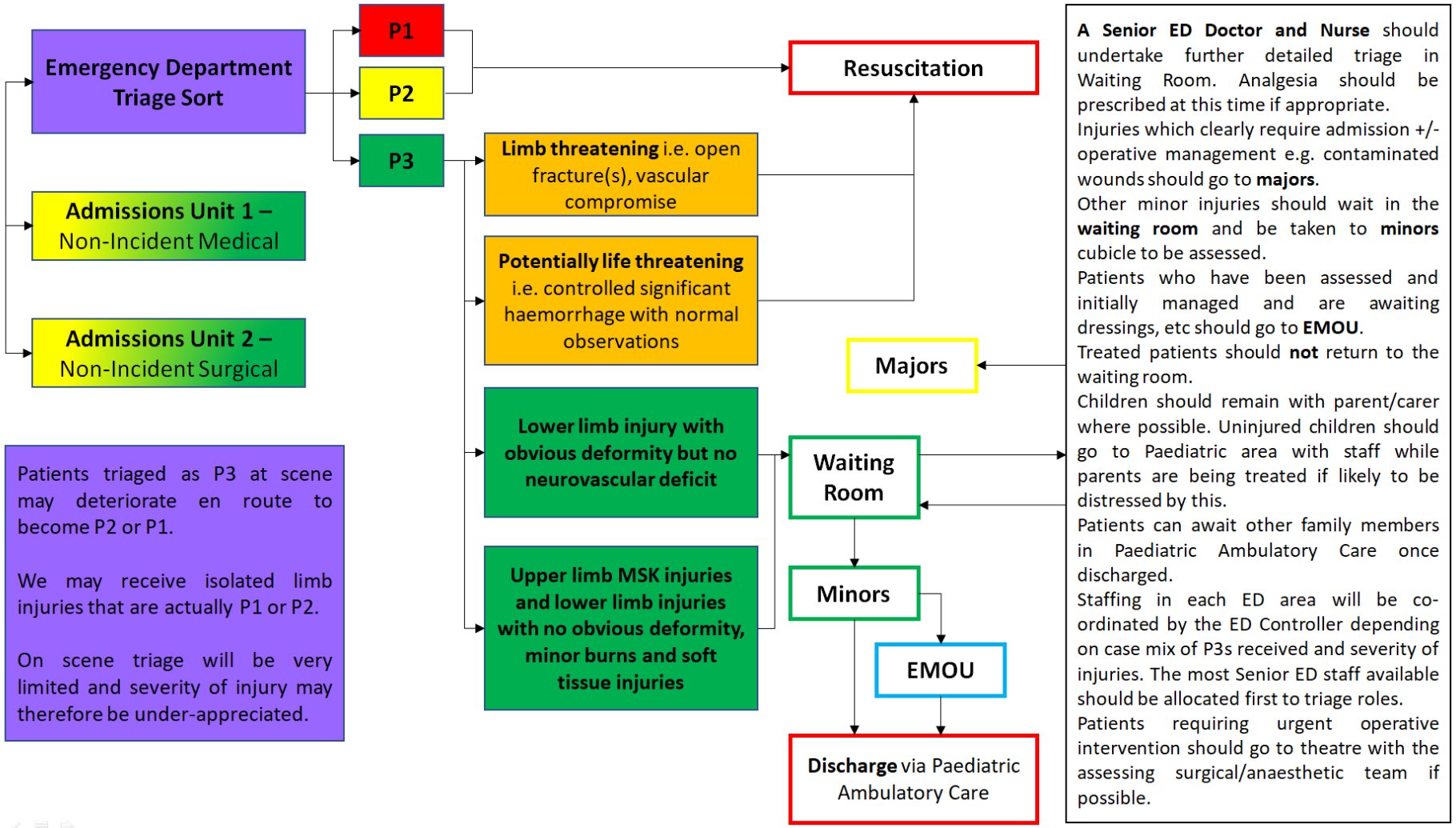
Appendix 5: Major Incident (Incident Level 4) – Patient Outcomes from Emergency Department Triage:



Appendix 6: Major Incident (Incident Level 4) – Patient Journey from ED:



Appendix 7: P1, P2, P3 Patient Management & Triage:



Appendix 8: Patient Discharge Records

Major Incident Declared

Patient Discharge Record - current non-incident patients

This refers to patients discharged rapidly in the event of a major incident for bed availabilty

Ward/Unit:

Date:

Time:

Patient Details/Label	Time of Discharge	Discharge Destination	Contact needed within 48hrs?	Follow-up Required?	Follow up Arranged
		Home Y/N Hospital: Ward:	Contacted needed Y/N Made by; Date: Time:	☐ Date for procedure ☐ Review appt ☐ GP review ☐ Other:	Follow up: Arranged by: Date: Time:
		Home Y/N Hospital: Ward:	Contacted needed Y/N Made by; Date: Time:	☐ Date for procedure ☐ Review appt ☐ GP review ☐ Other:	Follow up: Arranged by: Date: Time:
		Home Y/N Hospital: Ward:	Contacted needed Y/N Made by; Date: Time:	☐ Date for procedure ☐ Review appt ☐ GP review ☐ Other:	Follow up: Arranged by: Date: Time:

Major Incident Patient Discharge Record

Date of Incident:
Date of discharge:

Patient details/Label	Time of discharge	Discharge destination	Follow-up required?	Follow up information given?
		Home Y/N Other:	☐ General ☐ Plastics ☐ Ortho ☐ Surgery ☐ Other: Imaging required Yes/No/not known	Yes/No By: If no, please document reason:
		Home Y/N Other:	☐ General ☐ Plastics ☐ Ortho ☐ Surgery ☐ Other: Imaging required Yes/No/not known	Yes/No By: If no, please document reason:
		Home Y/N Other:	☐ General ☐ Plastics ☐ Ortho ☐ Surgery ☐ Other: Imaging required Yes/No/not known	Yes/No By: If no please document reason:

Discharge Letter

Victoria Hospital
Hayfield Road
Kirkcaldy
KY2 5AH
Tel 01592 643355

Major Incident Label

Date of incident:

Date of discharge:

Time of discharge:

Discharge destination: home / other

If other please specify: _____

Patient Name: Address:

Date of Birth (dd/mm/yyyy):

CHI (if known): Contact telephone number:

GP (if known):

Treating Clinician (name, grade):

Diagnosis:

Procedures/treatments:

Discharge medications given:

Hospital follow up date: time:

☐ General ☐ Ortho ☐ Surgery ☐ Other

Primary Care Follow up:

☐ Suture removal ____ days ☐ Wound dressing _____days ☐ Other

Other – please specify.

MAJOR INCIDENT DECLARED

Patient Information Leaflet

NHS Fife is currently responding to a declared Major Incident and is therefore only managing the highest priority patients.

Your presenting problem has been assessed as not being immediately life-threatening and you have therefore been advised to leave the Emergency Department and seek advice elsewhere.

Options for advice and support include:

NHS 24 will have up-to-date information about the situation at the Victoria Hospital, Minor Injuries units in Fife and Emergency Departments in other areas.
They can advise on self-care if appropriate.
They can assist with review at GP surgeries or out-of-hours services.
Freephone 111 www.nhs24.scot

NHS inform is Scotland's health information service. It offers quality assured health and care information via a website and phone service.
Helpline: **0800 22 44 88**
www.nhsinform.scot

Community Pharmacists can offer advice on minor ailments and injuries and suggest/supply over the counter medications.

Contact your own GP to arrange an appointment.
Attend a Minor Injuries Unit in Fife – if you wish to check that they can deal with your concern before travelling you can either contact NHS 24 or the MIU directly.

St Andrews Hospital	01334 465683
Adamson Hospital Cupar	01334 651200
Queen Margaret Hospital	01383 623623

Attend an ED out with Fife – please be aware that adjacent Health Boards may also be receiving casualties from the incident, and even if not will probably have a higher number of attendances than normal, so your wait may be longer than usual.

There will be regular updates posted on NHS Fife social media sites.

ACTION CARDS

Appendix 9: Incident Level 4 Executive Action Card – Chief Executive

Incident Level 4 Action Card – Chief Executive				
Board	**Version**	**Ratified Date**	**Review Date**	**Date Published**
NHS Fife				
Location	Incident Management Team: **PRIMARY** Meeting Space: MS Teams - NHS Fife Executive Virtual Control Room **SECONDARY** Location: Chief Exec Office, Hayfield House **ALTERNATIVE** Location: Education Centre, VHK (IMT) All locations will have Major Incident boxes with copies of all relevant plans, procedures, and action cards.			
Role Description	To consider the wider impact of the incident on NHS Fife services for the immediate & long-term future to enable a recovery plan to be developed.			
Key Contacts:				
Switchboard	**01592 643 355**			
NHS Fife Communications Email:	Ext: 27971 Tel: 01592 647971 (Monday – Friday 9am-5pm) fife.communications@nhs.scot Out-of-hours contact Switchboard			
Scot Gov Health EPRR Contact Numbers:	**0131 244 2429** – Weekday working hours (08:30 to 17:00) **07623 909981** (Out of hours Emergency pager)			

GATHER INFORMATION AND INTELLIGENCE

- **Emails**: If during working hours and of significant scale, instruct PA to monitor emails and inform you immediately of any significant ones relating to the incident.
- **Base yourself in the Chief Executive's Office** (where practicable); this is to ensure you maintain a strategic Board-wide perspective & don't get involved with Silver or Bronze level actions/issues.
- **Establish** and maintain close liaison with the Gold On-call Executive, Director of Acute Services and Silver On-Call Manager. If comms systems are down, consider nominating a runner to relay messages.
- Following a MI-MC declaration, **Establish** a Strategic Health Group (SHG). **Consider** passing on the role of SHG Chair to another Chief Executive at the outset, according to assessment of circumstances/incident. The decision for doing so must be logged.
- The SHG may consider the requirement for a Health Information Cell (HIC). **Refer to MI-MC National Guidance** for HIC templates.

ASSESS RISKS AND DEVELOP A WORKING STRATEGY

- **Receive** regular updates from the Incident Control Team of the situation.
  - **What? – So What? – Now What?**
  - Details will be communicated and logged using the (M)ETHANE Acronym.
    - **M**: Has a major incident been declared, by whom & what type?
    - **E**: Exact location of incident
    - **T**: Type & details of the incident
    - **H**: Hazards present or suspected

- **A**: Access routes that are safe to use
- **N**: Number & Types of casualties
- **E**: Emergency service present or requested

- ☐ **Consider** standing up a Scientific & Technical Advisory Cell (STAC), depending on type of incident.
- ☐ **Consider** the requirement to escalate to the Fife Local Resilience Partnership and the East of Scotland Regional Resilience Partnership.
- ☐ **Escalate** to Scottish Government Health EPRR through the **EPRR Sitrep.**
- ☐ **Other CEs**: When appropriate, establish contact with CEs of local partners and stakeholders. Provide information on the Board's response when necessary.
- ☐ **Comms/Media**: Maintain close links with the Comms Team; ensure that you are available (when required) to give media statements that you and the Corporate Comms Team have prepared, with input from Police Scotland where necessary.

CONSIDER POWERS, POLICIES AND PROCEDURES

- ☐ **Ensure** incident-specific plans are being implemented.
- ☐ **Two Hourly Major Incident briefing**: Maintain awareness of 2-hourly Major Incident briefing within the Incident Control Team and prepare to be briefed by exception by Exec On-call.

IDENTIFY OPTIONS AND CONTINGENCIES

- ☐ **Relief**: If it is a prolonged incident assess need to call in the Deputy Chief Executive to take over from you after 6-8 hours or when necessary. Conduct a full Handover/Takeover (HOTO).

STAND DOWN, RECOVER AND REVIEW

- ☐ **Recovery**: Begin to consider the wider impact of the incident on the Board's services for the immediate & longer-term future. Oversee the Board's recovery and return to 'normal' service.
- ☐ **Stand down**: The decision to stand down must be made in liaison with the Incident Management Team (Strategic/Gold) having performed a full assessment of the continuing impact of the incident on the Board. Ensure Incident declaration update is communicated ("**Major Incident – STAND DOWN**) to all Staff and any external agencies initially informed.
- ☐ **Post incident**: Consider the post incident requirements, such as business continuity issues, finance, VIP visit, media etc.
- ☐ **Debrief**: Arrange a 'hot' debrief with workforce involved immediately after the incident.
- ☐ **Sitrep**: Ensure details of the incident are included as required in Sitrep reports.

Appendix 10: Incident Level 4 Executive (Gold) Action Card

Incident Level 4 Action Card - Executive (Gold) / OoH Gold On-Call				
Board	**Version**	**Ratified Date**	**Review Date**	**Date Published**
NHS Fife				
Location	Incident Management Team: **PRIMARY** Meeting Space: MS Teams - NHS Fife Executive Virtual Control Room **SECONDARY** Location: Chief Exec Office, Hayfield House **ALTERNATIVE** Location: Education Centre, VHK (IMT) All locations will have Major Incident boxes with copies of all relevant plans, procedures, and action cards.			
Role Description	To lead NHS Fife's strategic response to a Level 4 Major Incident, set the aim and support decision making. Responsible for analysing the overall impact of the incident on staff, patients & services & planning the return to regular service delivery.			
Key Contacts:				
Switchboard	**01592 643 355**			
NHS Fife Communications	Tel: 01592 647971 (Monday – Friday 9am-5pm) or Ext: 27971 Email: fife.communications@nhs.scot			
Scot Gov Health EPRR	**0131 244 2429** – Weekday working hours (08:30 to 17:00) **07623 909981** (Out of hours Emergency pager) - Follow up within 1 hour if no response.			

GATHER INFORMATION AND INTELLIGENCE

- **Assume the role of Gold Commander**. Commence **Incident Decision Log** to ensure you document decisions made and/or actions taken. Utilise (physical) personal Decision Logbook (until a loggist has been identified)
- **For incidents where physical presence is required, base yourself in the Chief Executive's Office** (where practicable); this is to ensure you maintain a strategic Board-wide perspective & don't get involved with silver or bronze level actions/issues. Keep in regular contact with the On-Call Manager. If comms systems are down, consider a team of runners to relay messages.
- **Check details** of current situation with Incident Manager (manager of affected area who instigated escalation/or multiagency MACC, Mass Casualties: Mortuary capacity)
- **Notify**: The Chief Executive and Executive Directors Group
- **Establish Incident situation**: Obtain a (M)ETHANE report from Emergency Department (ED) if available. If unavailable, known details should be logged using the (M)ETHANE Acronym. Log this in **Incident Decision Log** and display this in the central Control Room
- **For incident-specific guidance**, refer to associated Framework Documents and Action Cards within the Incident Management Framework (example – Lockdown, CBRN)
- **Ensure** all above actions have been taken and are logged (Level 4 standby & response)

ASSESS RISKS AND DEVELOP A WORKING STRATEGY

- **Formulate the Strategy**: Formulate a written strategy & identify the Board's aims and objectives to drive the resolution of the incident. Share this with the Duty/Service Manager or On-Call Manager / Designated NHS Fife MACC Lead
- **Establish Incident Management Teams required** and convene initial meeting (refer to Major Incident Framework) – Director of Acute Services, Director of Public Health, Director of H&SCP, Estates Lead, Finance Lead, Incident-specific Specialists, Resilience Team, Comms Lead, Loggist support.

- **Locate Airwave Radios** as contingency against loss of normal comms. IBIS (Airwave) radios, provided to NHS Fife by Police Scotland for Major Incidents, should then be used to contact all multi-agency partners.
- **Contact other agencies:** Ensure that contact has been made with H&SCP, Police Scotland, Scottish Fire & Rescue, Scottish Ambulance Service control rooms, neighbouring Boards and Local Authorities if necessary and mutual aid requested through LRP if needed.
- **Consider** requirement to contact NHS24 to redirect patients/reduce site footfall.
- **Consider** standing up a Scientific & Technical Advisory Cell (STAC) or Mass Fatalities Group, depending on type of incident.
- **Consider** the requirement to escalate to the East of Scotland Regional Resilience Partnership (EOSRRP)
- **Escalate** to Scottish Government Health EPRR through the **EPRR Sitrep**
- **Comms**: Ensure that the Comms Team and Directorate Leads inform all staff of the incident & nature of the Board's response. Comms Team will work with Police Scotland on messages out to the public.
- **Support** the Duty/Service Manager/Silver's decision making as necessary during the incident.
- **Estates and Security**: Consider Site lock down with Facilities & Security

CONSIDER POWERS, POLICIES AND PROCEDURES

- **Invoke** incident-specific plans and ensure actions within those plans are implemented.
- **Consider** the need to have staff allocated to relieve those allocated earlier.
- **Consider the psychological impact** of the incident on staff within these areas.
- **Two Hourly Major Incident briefing**: Establish & Chair 1 to 2-hourly Major Incident briefing within the Incident Control Team (Silver), documenting updates & actions for completion. Brief by exception the Chief Executive.

IDENTIFY OPTIONS AND CONTINGENCIES

- **Relief**: If it is a prolonged incident assess need to call in another Executive & Manager to take over from you & within the Incident Control Team after 6-8 hours or when necessary. Conduct a full Handover/Takeover (HOTO).
- **Identify a Recovery Lead** and ensure they are developing plans for incident recovery (in liaison with Director of Acute Services)

STAND DOWN, RECOVER AND REVIEW

- **Recovery**: Start to consider the longer-term recovery issues & the need to enact part/all of the Business Continuity Plans. If it is a prolonged incident or a large impact on Board operations is expected, a Recovery Team will need to begin this process early.
- **Stand down**: The decision to stand down must be made by the Incident Management Team (Strategic/Gold) having performed a full assessment of the continuing impact of the incident on the Board. Ensure Incident declaration update is communicated ("**Major Incident – STAND DOWN** to all Staff and any external agencies initially informed.
- **Check** arrangements staff support post-incident in place.
- **Post-incident**: Consider the post-incident requirements, such as Business Continuity issues, finance, VIP visit, media etc.
- **Debrief**: Attend the 'hot' debrief immediately after the incident.
- **Recovery**: Oversee the Board's recovery and return to 'normal' service. Following a long incident, it may be necessary for you to handover to the nominated Recovery Team.
- **Sitrep**: Ensure details of the incident are included as required in Sitrep reports.
- **Documentation**: Complete any documentation created during the incident, and file in agreement with Chief Executive, Director of Acute Services, (and Director H&SCP, and Director Public Health if those services are involved/affected).

Appendix 11: Incident Level 4 Action Card – Manager/Silver On-Call

Incident Level 4 Action Card – Manager/Silver On-Call				
Board	**Version**	**Ratified Date**	**Review Date**	**Date Published**
NHS Fife				
Location	Incident Management Team: **PRIMARY** Meeting Space: MS Teams - NHS Fife Executive Virtual Control Room **SECONDARY** Location: Education Centre, VHK (IMT) **ALTERNATIVE** Location: Meeting Room 1, Hayfield House. All locations will have Major Incident boxes with copies of all relevant plans, procedures, and action cards.			
Role Description	**Major Incident Declared:** lead the Board's operational activity & formulate the Silver/tactical plan to achieve the strategic aim set by the Strategic (Gold) Command. Determine priorities in obtaining & allocating resources as required, planning & coordinating tasks			
Key Contacts:				
Switchboard	**01592 643 355**			
NHS Fife Communications Email:	Ext: 27971 Tel: 01592 647971 (Monday – Friday 9am-5pm) fife.communications@nhs.scot Out-of-hours contact Switchboard			
Scot Gov Health EPRR Contact Numbers:	**0131 244 2429** – Weekday working hours (08:30 to 17:00) **07623 909981** (Out of hours Emergency pager)			

GATHER INFORMATION AND INTELLIGENCE

- ☐ Proceed to the Education Centre, VHK (ICT) **Ensure it is set up** & control access to those with specific roles. (If H&SCP, then establish virtual meeting room or central meeting room as per direction by H&SCP Incident Controller)
- ☐ Commence **Incident Decision Log** to ensure you document decisions made and/or actions taken. Utilise personal Decision Logbook (until a loggist has been identified)
- ☐ **Establish Incident situation**: Obtain a (M)ETHANE report from Emergency Department (ED) if available. If unavailable, known details should be logged using the (M)ETHANE Acronym. Log this in the **Incident Decision Log** and display this in the Incident Control Room (ICT)
  - **M**: Has a major incident been declared, by whom & what type?
  - **E**: Exact location of incident
  - **T**: Type & details of the incident
  - **H**: Hazards present or suspected
  - **A**: Access routes that are safe to use
  - **N**: Number & Types of casualties
  - **E**: Emergency service present or requested
- ☐ **Establish Board situation**: Establish current situation within the Board relating to capacity, staffing, ED, theatre & outpatient activity & anything else that may affect the Board's ability to receive patients upon escalation & display in the ICT.

- **Brief Exec (Gold) On-Call:** With the Lead ED Consultant brief the Exec (Gold) On-Call of incident details & current Board situation.
- **Consider** the need to call in specific staff now prior to a declaration of a major incident. If Staff don't need to come in yet create a list of the staff you might need to call in at Declared Status & ensure you have their contact details to hand.

ASSESS RISKS AND DEVELOP A WORKING STRATEGY

- **Liaise** with Scottish Ambulance Service, ensure divert of Non-Critical, Non-major incident patients is requested. An Ambulance Liaison Officer (ALO) may join the ICT.
- **Awareness of the Strategy**: Obtain the written strategy from Gold (Exec) On Call
- **Consider** the level of response required by departments in light of information received from the incident scene e.g. do you need to open Out-Patients as a relatives' reception area or another area as extra capacity for Minor Injuries etc.
- **Capacity**: Liaise with the Clinical Co-ordinators re regular bed states and the possible requirement for extra bed spaces aligned to OPEL Framework guidance
- **Liaise** with Mortuary Manager/Department in Mass Casualty incidents.
- **Board-wide activity**: Decisions will need to be taken concerning cancellation of electives & outpatient clinics to free up resources (liaise with the Director of Acute Services or Gold Exec On-Call). This info must be relayed to all appropriate service managers.
- **Staffing**: In conjunction with the Service Managers/Heads of Department and Clinical Nurse Managers deploy nursing & support staff to the following areas if necessary (ensure they are given their action cards to follow):
  - Discharge Lounge Ambulatory Care Outpatients – for the reception of rapid discharges created by the discharge ward round. Ensure Pharmacy aware of extra capacity areas that may need their input Deploy coordinator.
  - Staff Reporting Point (Maternity Outpatients) – Nominate a staff coordinator to ensure staff are deployed where required. If available, use Nurse Bank Manager
  - Relative Reception (Main Outpatients) – include a senior member of nursing staff to act as liaison between the ED & further support staff. Utilise chaplaincy, H&SCP, volunteers & WRVS to support this.
- **Media**: Contact Comms & decide with the Comms Lead on the need for a Media Reception Area. If needed ensure it has been opened, that signage (from Education Centre) is in place & that staff are available to log in and chaperone the media.

CONSIDER POWERS, POLICIES AND PROCEDURES

- **Security**: Consider Site lock down with Facilities & Security
- **Consider** the need to identify staff to relieve those allocated earlier.
- **Consider the psychological impact** of the incident on staff within these areas. (Liaise with H&SCP partners who will be deploying support via Community Mental Health Teams (CMHT) to ED)
- **Two-Hourly Major Incident briefing**: Attend 2-hourly Major Incident briefings within the Incident Control Team chaired by Gold (Strategic) Controller. Ensure an update is sent out to all relevant staff/departments.

IDENTIFY OPTIONS AND CONTINGENCIES

- **Relief**: If this is likely to be a prolonged incident assess the need to call in another Manager to take over from you after 6-8 hours or when necessary. Conduct a full Handover/Takeover (HOTO).

STAND DOWN, RECOVER AND REVIEW

- **Stand down**: Switchboard will inform you that Scottish Ambulance Service have notified the Board of 'Casualty evacuation complete'. This is not an instruction for the Board to stand down.
  - The decision to stand down must be made by the Chief Executive, Director of Acute Services or Gold (Exec) On-Call (or Director H&SCP and Director of Public Health where those services are involved/affected), having performed a full assessment of the continuing impact of the incident on the Board.
  - Inform Switchboard, the Comms Team & the Directorate Leads when the decision to Stand down has been made to allow them to communicate this to all areas. This will be achieved through the Comms Team (all staff emails/Intranet/NHS Fife Website etc) & via Operational (Bronze)Teams and senior nurses.
  - Notify all external agencies previously notified of the stand down declaration.
- **Recovery**: Together with the Chief Executive, Director of Acute Services or Gold (Exec) On-Call, consider the business continuity implications caused by the incident & work with the Recovery Team who will prepare a plan to address them.
- **Post-incident**: Consider, with Gold Command, the post-incident requirements, such as business continuity issues, finance, VIP visit, media etc.
- **Establish** a '**hot' debrief** for staff that responded to the incident. Ensure ALL staff involved are aware.
- **Maintain ICT**: Ensure that the Incident Control Team remains established – with phones connected & staff present, for 1-2 hours after stand-down.
- **Documentation**: Complete and secure any documentation created during the incident, and file in agreement with Chief Executive and Director of Acute Services.

Appendix 12: Mortuary Action Card

Incident Level 4 Action Card – Mortuary Services				
Board	**Version**	**Ratified Date**	**Review Date**	**Date Published**
NHS Fife				
Location	Mortuary, VHK.			
Role Description	Consider the need to increase capacity or utilise alternative body storing facilities. Assess the need to contact further mortuary staff.			
Key Contacts:				
Switchboard	**01592 643 355**			
Porters	VHK: QMH:			
Procurator Fiscal	Tel: 08445614110 david.degnan@copfs.gov.uk; _sfiueast@copfs.gov.uk			
Fife Council	**Team 24/7 Tel: 01592 583544** Mobile: 07985718243 duty.officerppt@fife.gov.uk ; Tel: 03451 555550			
Police appointed Funeral Director	07714598892 Co-op Funeralcare ross.drummond@coop.co.uk			
Head of Laboratory Services	robyn.gunn@nhs.scot Ext. 28055			

GATHER INFORMATION AND INTELLIGENCE

- ☐ Base yourself in the APT office, VHK Mortuary.
- ☐ Check details of incident & current situation and Establish Incident situation.
- ☐ For incident-specific guidance, refer to Major Incident Plan, Action Card and Contingency SOPs within QPulse or Business Continuity Folder in the Service managers Office.
- ☐ Identify the number storage spaces available for use including BAU requirements.
- ☐ Identify number of body bags in stock and make available to services as required.
- ☐ Liaise with (Gold) Incident Control Team, ED Controller and (Silver) Incident Management Team in order to clarify current storage situation and receive update on number of deceased expected following the incident.
- ☐ Consider the need to call in staff. If Staff don't need to come in yet create a list of the staff you might need to call in & ensure you have their contact details to hand.
- ☐ Ensure all above actions have been taken and are logged.

ASSESS RISKS AND DEVELOP A WORKING STRATEGY

- ☐ Consider the level of response required by the department in light of information received above.
- ☐ During working hours inform the Departments Clinical Lead or Deputy.
- ☐ During working hours inform the head of Laboratory Services.
- ☐ Contact charge hand porter to confirm transport arrangements for deceased to the Mortuary.
- ☐ Contact the Procurator Fiscal, to inform them that a Major Incident has been declared and Post-mortems will be deferred, and any urgent PM will have to be transferred to alternate mortuary.

CONSIDER POWERS, POLICIES AND PROCEDURES

- ☐ Implement BAU procedures for receipt and release of deceased (See QPulse ALML 013).

- When the number of critically or fatally injured casualties is high, consider the need to increase capacity or utilise alternative body storing facilities. See QPulse or folder in Service Managers office for AMAA 027 Business Continuity Plan for Cellular Pathology Services.
- Consider the requirement to escalate to the Fife Mass Fatalities Group.

IDENTIFY OPTIONS AND CONTINGENCIES

- BAU processes will continue to be carried out until permanent storage capacity at Victoria Hospital and Queen Margaret Hospital Mortuaries reaches 80%. At that point, all partners in the Mass Fatalities Group will be informed. The coordination team will meet to explore options to increase capacity e.g. mutual aid, lease of alternative storage etc.
- Implement contingency plans (See QPulse or Business Continuity Folder in Service Manager's office: AMAA 027, ALML 022, ALML 017).
- Contact Funeral Directors to arrange the collection of deceased that are cleared for collection.
- Put all four contingency Nutwell storage units into use.
- Contact facilities to inform them that the Nutwell units are in use.
- Identify any deceased that can be transferred to the QMH Body store and arrange for transfer by Police appointed Funeral Directors.
- Call in additional staff to assist with implementation of contingencies if needed.
- Update (Gold) Incident Control Team at regular intervals, or immediately if there is a sudden surge in numbers, on capacity and projected challenges.

STAND DOWN, RECOVER AND REVIEW

- Prepare a list of all deceased patients from the major incident and their current locations.
- Keep the next of kin informed of the location of deceased casualties.
- Liaise with the Police and the Procurator Fiscal regarding the undertaking of post mortems.
- Ensure staff are available to help in the mortuary until recovery to BAU and then Stand down.
- Record the details of all staff involved in the incident and contact Chaplaincy/OH regarding counselling/wellbeing support.
- Facilitate Department 'hot' debrief and attend NHS Fife 'hot' debrief if required.
- Complete any documentation created during the incident.
- Liaise with Mass Fatalities Group regarding the recovery phase.
- Release deceased to appointed Funeral Directors when instructed 'clear' by the Procurator Fiscal.

Appendix 13: Public Health Incident Consultant in Public Health Medicine/On-call Consultant.

Public Health Incident Action Card				
Board	**Version**	**Ratified Date**	**Review Date**	**Date Published**
NHS Fife				
Location	Incident Management Team: **PRIMARY** Meeting Space: MS Teams - NHS Fife Executive Virtual Control Room **SECONDARY** Location: Education Centre, VHK (IMT) **ALTERNATIVE** Location: Meeting Room 1, Hayfield House. All locations will have Major Incident boxes with copies of all relevant plans, procedures, and action cards.			
Role Description	Provide expert advice about issues and incidents likely to affect the public.			
Key Contacts:				
Switchboard	**01592 643 355**			
Director of Public Health	Office Hours - 01592 226514 Out of Hours - 01592 643355			
Duty Microbiologist	EXT 28176 or Switchboard, then Option 1 After hours dial Switchboard			
ED Duty Consultant	Ext 20622 (between 0600hrs - 1800hrs) After 1800hrs contact Switchboard and ask for On-call Consultant (mobile)			
Infection Prevention and Control	01592 643355 or EXT 28833 Infection Control Nurse (Out of Hours) - 01383 623623			

GATHER INFORMATION AND INTELLIGENCE

- **Establish Incident situation**: Obtain a (M)ETHANE report from Emergency Department (ED)/multiagency partners if available. If unavailable, known details should be logged using the (M)ETHANE Acronym. Log this in the **Incident Decision Log** and display this in the Incident Control Room (ICR)
  - **M**: Has a major incident been declared, by whom & what type?
  - **E**: Exact location of incident
  - **T**: Type & details of the incident
  - **H**: Hazards present or suspected
  - **A**: Access routes that are safe to use
  - **N**: Number & Types of casualties
  - **E**: Emergency service present or requested

- **Establish current situation** within the Board relating to capacity, staffing, activity and resources that may affect the ability to receive and manage patients. Consider contacting NHS24 to redirect patients.
- **Refer** to NHS Fife Incident Management Framework
- **Refer** to Health Protection Manual
- **Facilitate the coordination of IMT**; (Chair and lead). Include detail of membership and rotas to ensure staff can be relieved.
- **Commence Incident Decision Log** to ensure you document decisions made and actions taken. Utilise a physical personal Decision Logbook until a loggist is available.

- **Formulate the Strategy**: Formulate a written strategy & identify the Board's IMT aims and objectives to drive the resolution of the incident. Share this with the Duty/Service Manager or On-Call Manager / Designated NHS Fife MACC Lead
- For incident-specific guidance, refer to associated Framework Documents and Action Cards within the Incident Management Framework (example – Lockdown, CBRN)
- Utilise issued **Airwave Radios** as contingency against loss of normal comms. IBIS (Airwave) radios will be provided by Police Scotland for such incidents and should be used to contact all multi-agency partners.
- Be prepared to provide information to the **MACC** on request of the MACC chair (virtually or in person)

ASSESS RISKS AND DEVELOP A WORKING STRATEGY

- **Brief Executive On-Call** (or Gold Commander): brief the Exec (Gold) On-Call of incident details & current Board situation. Where appropriate include the Lead ED Consultant. Inform the Director of Public Health and the Board's Communications Manager when an incident is declared.
- **Obtain CHEMET** from SFRS
- **Liaise** with other agencies and multiagency partners as required e.g. Met office, Scottish Water, DEFRA.
- **Contact Microbiologist** & Infection Control & Labs – initiate planning swabbing/testing where required.
- **Consider** the need to call in specific staff now prior to a declaration of a major incident. If staff don't need to come in yet create a list of the staff you might need to call in & ensure you have their contact details to hand.
- **Liaise with Mortuary** Manager/Department in Mass Casualty incidents.
- **Media**: Contact Comms about public messaging.
- **Two Hourly Major Incident briefing**: Establish & Chair 1 to 2-hourly Major Incident briefing within the Incident Control Team (Gold/Silver), documenting updates & actions for completion. Brief by exception the Chief Executive.
- **Estates and Security**: Consider site lock down with Facilities & Security with any exposure risks.
- **Ensure exposure controls are put in place** (risk management) Hazmat/CBRN – PPE etc.
- **Ensure information is made available** to the incident lead or external agencies.
- **Liaise with East Region Health Protection Team.**

CONSIDER POWERS, POLICIES AND PROCEDURES

- **STAC**: Consider standing up a Scientific & Technical Advisory Cell (STAC) or Mass Fatalities Group, depending on type of incident.
- Issue a preliminary report within 48 Hours and subsequent reports as necessary.
- **Advise** nearby sites and adjoining NHS boards about the incident and subsequent investigation and control measures as appropriate.

IDENTIFY OPTIONS AND CONTINGENCIES

- **Relief**: If this is likely to be a prolonged incident assess the need to call in another consultant to take over from you after 6-8 hours or when necessary. Conduct a full Handover/Takeover (HOTO).
- Be responsible for communicating with (including issuing the final report) the NHS Board, PHS and others, as appropriate.
- Liaise with the Board Chief Executive who may set up a Strategic Health Group and Health Information Cell where required.
- Liaise with Police Scotland about any forensic issues.

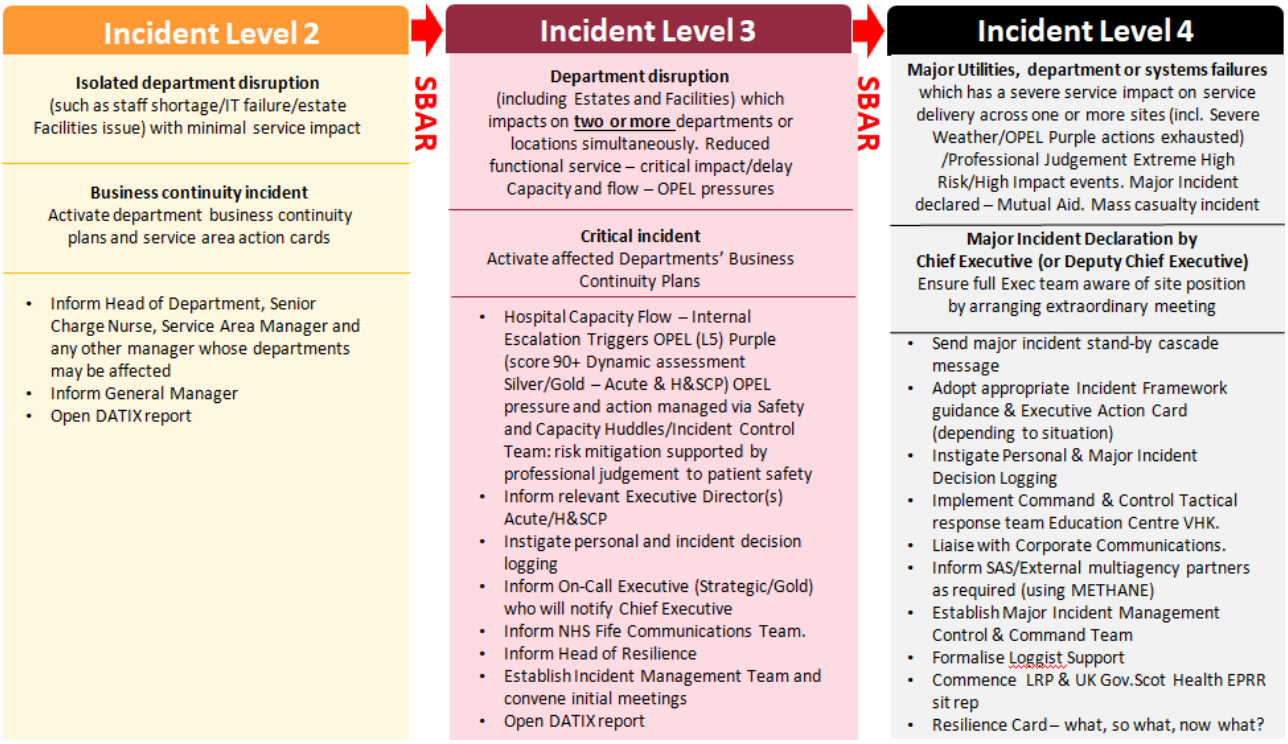
STAND DOWN, RECOVER AND REVIEW

- IMT Undertake a **Hot Debrief** using Public Health Scotland Template
- **Stand down**: The decision to stand down must be made by the Incident Management Team (Strategic/Gold) having performed a full assessment of the continuing impact of the incident on the Board. Ensure Incident declaration update is communicated (“Major Incident – STAND DOWN") to all Staff and any external agencies initially informed.
- Check support and care arrangements for staff are in place.
- **Post-incident**: Consider the post-incident requirements, such as Business Continuity issues, finance, VIP visit, media etc.
- **Recovery**: Support the Board’s recovery and return to ‘normal’ service. Following a long incident, it may be necessary for you to handover to the nominated Recovery Team.
- **Sitrep**: Ensure details of the incident are included as required in Sitrep reports.
- **Documentation**: Complete any documentation created during the incident, and file in agreement with Chief Executive, Director of Public Health, Director of Acute Services, and Director H&SCP

Appendix 14: Incident Level 3 (Critical) Action Card – Manager/Silver On-Call

Critical Incident (Level 3) Action Card – Manager/Silver On-Call				
Board	**Version**	**Ratified Date**	**Review Date**	**Date Published**
NHS Fife				
Location	Incident Management Team: **Control Room VHK**			
Role Description	**Critical Incident:** lead the Board's operational activity & formulate the Silver/tactical plan (as per action cards) to achieve the strategic aim set by the Strategic (Gold) Command and return services to BAU as soon as possible following an incident. Determine priorities in obtaining & allocating resources as required, planning & coordinating tasks			
Key Contacts:				
Switchboard	**01592 643 355**			
NHS Fife Communications Email:	Ext: 27971 Tel: 01592 647971 (Monday – Friday 9am-5pm) Out-of-hours contact Switchboard. fife.communications@nhs.scot			
Scot Gov Health EPRR Contact Numbers:	**0131 244 2429** – Weekday working hours (08:30 to 17:00) **07623 909981** (Out of hours Emergency pager)			

Assess Situation to Incident Level:



Refer to OPEL Escalation Triggers to aid situation assessment.
(Chart on final page of this action card) – Extra-ordinary OPEL meetings may be required.

GATHER INFORMATION AND INTELLIGENCE

- ☐ **Consider all information** as soon as possible and match to the relevant incident level: Business Continuity Plan enacted but exhausted (where relevant OPEL escalation pathway been followed). Escalate (via SBAR format) to Gold Command for Major Incident declaration (BC plans for all service areas will be accessible T Drive resilience folder master ledger)
- ☐ **Enable** the (virtual/physical) Incident Control Room. Designate tasks and lead Incident management Loggist/Incident Manager Communications/Operational Support Staff
- ☐ **Call Switchboard** on **01592 643355**, confirm incident and ask for additional workforce (who may be required immediately called in or to be put on standby), to be informed of the incident, together with any support staff and Loggist. Delegate switchboard to cascade information to relevant teams where appropriate.
- ☐ Make sure you retain names and contact details for all staff directly involved.
- ☐ Commence **Incident Decision Log** to ensure you document decisions made and/or actions taken (include timing and rationales). Utilise personal Decision Logbook (until a loggist has been identified)
- ☐ **Establish Board situation**: Establish current situation and, using information gathered, decide whether the board can respond on its own through its Business Continuity Plans, or if it may require assistance from partner boards.
- ☐ **Consider Escalation** to higher level incident (**utilise SBAR Report format to escalate to Gold for ultimate decision on Major Incident declaration**)

SBAR Report	
Situation	Describe situation that has occurred
Background	Explain background/history of incident and impact on services/patient safety – risk/s
Assessment	Confirm your understanding of issues involved. What measures are in place? What has already been exhausted other than business as usual? Have all areas confirmed that they have implemented all relevant actions from their own Business Continuity Plan?
Recommendation	Explain needs, clarify expectations and what support is needed. What benefit/outcome is needed to achieve de-escalation? Information included in the SBAR should be as specific as possible.

- ☐ **Assist** with the establishment of Gold Command to Incident controls (if required)
- ☐ **Brief Exec (Gold) On-Call:** Brief the Exec (Gold) On-Call of incident details & current Board situation.
- ☐ **Contact** Comms team and pass on all relevant information which will feed into the internal and external NHS Fife comms message via StaffLink/intranet.

ASSESS RISKS AND DEVELOP A WORKING STRATEGY

- ☐ **Liaise** with Scottish Ambulance Service, ensure divert of Non-Critical, Non-major incident patients is requested. Mutual aid should be discussed as part of any required divert of patients. (e.g. for diagnostics issues, diverting patients for best clinical outcome). Liaise with ED regarding diversion criteria.
- ☐ **Consider** the actions required by departments in light of known information. Unanticipated situations may require additional provider action beyond the limits of agreed Surge & Escalation OPEL frameworks and require wider resources (e.g. committing additional expenditure or enacting other contracts).
- ☐ **Capacity**: Liaise with the Clinical Co-ordinators re regular bed status and the possible requirement for extra bed spaces aligned to OPEL Framework guidance.
- ☐ **Board-wide activity**: Decisions will need to be taken concerning cancellation of planned

procedures/appointments to free up resources (liaise with the Director of Acute Services or Gold Exec On-Call). This info must be relayed to all appropriate service managers.

- Discharge Lounge Ambulatory Care Outpatients – for the reception of rapid discharges created by the discharge ward round. Ensure Pharmacy aware of extra capacity areas that may need their input Deploy coordinator.

CONSIDER POWERS, POLICIES AND PROCEDURES

- ☐ **Assist** Gold Commander with regular updates.
- ☐ **Security**: Consider area/service lock down with Facilities & Security
- ☐ **Consider** the need to identify staff to relieve those allocated earlier.

IDENTIFY OPTIONS AND CONTINGENCIES

- ☐ **Relief**: If this is likely to be a prolonged event assess the need to call in another Manager or Deputy to take over from you after 6-8 hours or when necessary. Conduct Critical Level Handover.
- ☐ Liaise with Estates (where required)

STAND DOWN, RECOVER AND REVIEW

- ☐ Inform Switchboard, the Comms Team & the Directorate Leads when the decision to Stand down has been made to allow them to communicate this to all areas. This will be achieved through the Comms Team (all staff emails/Intranet/NHS Fife Website etc) & via Operational (Bronze)Teams and senior nurses.
- ☐ Notify all external agencies previously notified of the stand down declaration.
- ☐ **Recovery**: Together with the Gold Commander / (Exec) On-Call, consider the business continuity implications caused by the incident & work with the Recovery Team who will prepare a plan to address them.
- ☐ **Post-incident**: Consider, with Gold Command, the post-incident requirements, such as business continuity issues, finance, staff welfare.
- ☐ **Establish** a '**Hot' Debrief** for staff that responded to the incident. Ensure ALL staff involved are aware.
- ☐ Maintain Incident Control Team **(ICT)**: Ensure that the Incident Control Team remains established – with phones connected & staff present, for 1-2 hours after stand-down.
- ☐ **Documentation**: Complete and secure any documentation created during the incident, and file with Resilience Team/Public Health (and in agreement with Chief Executive and Director of Acute Services).

	IMMEDIATE ACTIONS - checklist	DONE
1	Safety of Patients	
2	Safety of Staff	
3	Check vicinity to assess scale of problem	
4	Maintain communication channels to ensure prompt resolution with other concerned departments e.g. Estates/Medical Physics, Digital, Facilities etc.	
5	Communication with team on nature/scale of problem.	
6	Notify switchboard.	
7	Assessment of time to resolve	
8	Communication of alternate contact arrangements, if required	
9	Relocate as appropriate.	

1

2

Incident Level 3

OPEL (L5) Purple (score 90+)
In Acute and H&SCP
Escalation in OPEL communications
Active management via Silver & Gold Safety & Capacity Huddles / Control Team

I. Critical Incident determined via Silver/Gold due to Escalating/Extended OPEL Pressure/Other Issues arising
II. Silver / Gold have instigated personal and incident decision logging as per Level 3 incident framework
III. Additional capacity management meetings arranged
IV. Patient Prioritisation - Ethical & Service Determinations to be determined by Executive /Deputy professional leads
V. Determination Taken By Gold to Trigger All OPEL L5 (Purple) Actions Exhausted

Level 4 Internal Incident Management Triggered
Escalation Framework
(Control & Command Team Implemented)

Strategic/Gold - Director/s (or acting deputy) of Acute and H&SCP services making decisions across the whole systems covering all urgent care pathways

OPEL Purple (L5) Acute

Silver > On-Call Executive (Strategic/Gold) Informed actions at OPEL L5(Purple) failed to deliver capacity
There is no capacity across all urgent care points
Health Board unable to admit GP referrals
There are severe handover delays
The whole systems is unable to management flow/discharge capacity
All emergency care pathways are significantly compromised
Ambulances are unable to off load their patients
The whole system is experiencing reduced staffing levels (e.g. due to sickness, weather conditions) where this causes increased pressure on patient flow/safety

OPEL Purple (L5) H&SCP

Discharge Hub have exhausted L5 (Purple) action options
Social Services unable to facilitate care packages, discharges
There is no capacity across all urgent care points
There are severe handover delays
Community Capacity Full
Care at Home – significant number of unmet critical need
Primary Care : Health Board unable to admit GP referrals. Out of Hours (OoHs) Primary Care OoHS 3 site model implemented - inability to see all OoHs/GP referrals
Flow and navigation Hub not alleviating ED pressures due to clinical presentation of patients
Inability to see all NHS 24 urgent referrals
Significant unexpected reduced staffing numbers (e.g. due to sickness, weather conditions) in areas where this causes increased pressure on patient flow/patient safety

Other Intelligence

Rising NHS 24 Activity Information indicates significant increase in demand

Infection Control Issues resulting in significant pressures on services

999 Call volume significantly raised with normal or increased acuity of referrals

Weather Conditions resulting in significant pressure on services

Incident Level 4

All OPEL L5 (Purple) Actions Exhausted / Extreme High Risk Situation

Chief Executive
(or acting deputy)
MAJOR INCIDENT DECLARATION

Major Incident Declared
External Multiagency
Partner Agency Major Incident Declared
(Level 4 Gold Command)

Internal Incident Escalation
OPEL Escalation Status
Triggers
Level 3 > 4 Activation

Appendix 15: Loggist Action Card

Action Card	
Job Title	**LOGGIST**
Role Undertaken By	Role must be assigned to a certificated loggist
Responsible for	Decision logging – the decision logging role is required only once the decision has been taken to implement the level 4 Major Incident Plan
Accountable to	Incident Manager

DECISION LOGGIST	
1	Report to the relevant Control room.
2	Liaise with incident manager to find out who you are logging for and attend a pre-brief with that manager before you begin. Use decision logbooks provided.
3	Ensure accurate and timely records are kept and that decision logs are signed as 'approved by' the incident meeting chair (e.g. GOLD command). You will most likely be logging during Gold Command meetings and annotating decisions taken in response to a major incident: Logbooks are stored in the Major Incident Equipment Store, seminar room 4 in the Education Centre VHK – keys accessible via key safe.
4	Ensure that these records are stored safely and confidentially with resilience department post-incident. Pass decision logbook unique identifying code to the manager for recording to the DATIX incident record.
5	Liaise with incident manager to facilitate a de brief of the situation with the relevant staff once command stand down has been given.
6	If passing incident log to another person in handover, rule 2 black lines and put in an entry noting who you are handing over to with the date and time and your signature and have the new loggist enter their details. The entries must follow on sequentially to ensure that there is no gap in the recording.
7	You are not a minute taker; you should only be taking notes of decisions made or actions. Someone else will be assigned to take the minutes in meetings.

Ideally the Loggist should not perform the role for more than 2 hours at a time without a break.

Appendix 16: Director HSCP Action Card

Incident Level 4 Action Card - Director of FHSCP (Gold Command)				
Board	**Version**	**Ratified Date**	**Review Date**	**Date Published**
Fife Health & Social Care Partnership	**V01.0**	**29/08/2023**	**31/01/2024**	
Location	Incident Management Team: **PRIMARY** Meeting Space: Virtual Control Room / HSCP Headquarters, Fife House, Glenrothes **SECONDARY** Location: Control Room, Lynebank Hospital **ALTERNATIVE** Location: Bankhead Depot, Glenrothes or Cameron Hospital Training Centre, Windygates			
Role Description	To consider the wider impact of the incident on Fife Health & Social Care Partnership services for the immediate & long-term future to enable a recovery plan to be developed			
Key Contacts:				
HSCP Communications	Tel: TBC Email: fifehscpcommssupport@fife.gov.uk Out-of-hours contact Switchboard of partner bodies: • NHS Fife: 01592 643355 • Fife Council Contact Centre: 0345 1 55 00 99 • Fife Council Resilience Team: 01592 583544 In the event of a major incident, Police Scotland, as lead agency, will initiate communication through agreed channels.			
Scot Gov Health EPRR	**0131 244 2429** – Weekday working hours (08:30 to 17:00) **07623 909981** (Out of hours Emergency pager) - Follow up within 1 hour if no response.			

GATHER INFORMATION AND INTELLIGENCE

- **Assume** the role of **Gold Commander** for partnership related **major incidents.** Commence **Incident Decision Log** to ensure decisions made and / or actions taken are documented.
- **Emails:** If during working hours and of significant scale, instruct PA to monitor emails and inform you immediately of any significant ones relating to the incident.
- **Base yourself in the Fife HSCP Headquarters** (where practicable); this is to ensure you maintain a strategic Partnership-wide perspective. If a major incident occurs within NHS Fife or Fife Council then initiate Silver Control within Fife HSCP
- **Establish** the Fife HSCP IMT and maintain close liaison with SLT Members and Silver / Bronze Controllers (if applicable) for Partnership related major incidents. For multi-agency / partner major incidents, maintain close liaison with partner IMTs. If comms systems are down, consider nominating a runner to relay messages.

ASSESS RISKS AND DEVELOP A WORKING STRATEGY

- **Receive** regular updates from the Incident Control Team of the situation.
  - **What? – So What? – Now What?**
  - Details will be communicated and logged using the (M)ETHANE Acronym.

- **M:** Has a major incident been declared, by whom & what type?
- **E:** Exact location of incident
- **T:** Type & details of the incident
- **H:** Hazards present or suspected
- **A:** Access routes that are safe to use
- **N:** Number & Types of casualties
- **E:** Emergency service present or requested

- **Discuss** with Public Health Executive regarding a Scientific & Technical Advisory Cell (STAC)
- **Consider**, alongside Fife Council and partners, standing up a Care for People Group
- **Consider** the requirement to inform NHS Fife Board Chief Executive / NHS Fife Acute / NHS Fife Resilience Team / Fife Council Chief Executive / Fife Council Resilience Team
- **Consider** the requirement to escalate to the Fife Local Resilience Partnership (LRP) and the East of Scotland Regional Resilience Partnership (EOSRRP)
- **Consider** the requirement to escalate to Scottish Government Health EPRR through the **EPRR Sitrep.**
- **Other CEs:** When appropriate, establish contact with CEs of local partners and stakeholders. Provide information on the Partnership's response when necessary.
- **Comms/Media:** Maintain close links with the Comms Team; ensure that you are available (when required) to give media statements that you and the Partnership Comms Team have prepared, with input from NHS Fife & Fife Council Comms Teams and Police Scotland where necessary.

CONSIDER POWERS, POLICIES AND PROCEDURES

- **Ensure** incident-specific plans are being implemented.
- **Two Hourly Major Incident briefing:** Maintain awareness of 2-hourly Major Incident briefing within the Incident Control Team and prepare to be briefed by exception by Gold / Silver / Bronze command.

IDENTIFY OPTIONS AND CONTINGENCIES

- **Relief**: If it is a prolonged incident assess need to call in a Deputy Director to take over from you after 6-8 hours or when necessary. Conduct a full Handover/Takeover (HOTO).

STAND DOWN, RECOVER AND REVIEW

- **Recovery**: Begin to consider the wider impact of the incident on the Partnership services for the immediate & longer-term future. Oversee the Partnership recovery and return to 'normal' service.
- **Stand down**: The decision to stand down must be made in liaison with the Incident Management Team (Strategic/Gold) having performed a full assessment of the continuing impact of the incident on the Partnership. Ensure Incident declaration update is communicated ("Major Incident – STAND DOWN, or Major Incident – CANCELLED") to all staff and any external agencies initially informed.
- **Post-incident**: Consider the post-incident requirements, such as Business Continuity issues, finance, VIP visit, media etc.
- **Debrief**: Attend the 'hot' debrief immediately after the incident.
- **Sitrep**: Ensure details of the incident are included as required in Sitrep reports.

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

Appendix 17: HSCP Senior Leadership Team Action Card

Incident Level 4 Action Card - Senior Leadership Team (Silver Command)				
Board	**Version**	**Ratified Date**	**Review Date**	**Date Published**
Fife Health & Social Care Partnership	**V01.0**	**29/08/2023**	**31/01/2024**	
Location	Incident Management Team: **PRIMARY** Meeting Space: Virtual Control Room (MS Teams) **SECONDARY** Location: Fife HSCP Headquarters, Fife House, Glenrothes **ALTERNATIVE** Location: Location: Bankhead Depot, Glenrothes or Cameron Hospital Training Centre, Windygates. All locations will have Major Incident boxes with copies of all relevant plans, procedures, and action cards.			
Role Description	To **lead** Fife HSCP's strategic response to a Level 4 Major Incident, **set** the aim and **support** decision making. **Lead** the Partnership's activity and formulate the Silver / tactical plan to achieve the strategic aim set by the Strategic (Gold) Command **Responsible** for analysing the overall impact of the incident on staff, patients & services, and planning the return to regular service delivery.			
Key Contacts:				
HSCP Communications	Tel: TBC (Monday-Friday 9am-5pm) Email: fifehscpcommssupport@fife.gov.uk Out-of-hours contact Switchboard of partner bodies: • NHS Fife: 01592 643355 • Fife Council Contact Centre: 0345 1 55 00 99 • Fife Council Resilience Team: 01592 583544 In the event of a major incident, Police Scotland, as lead agency, will initiate communication through agreed channels.			
Scot Gov Health EPRR	**0131 244 2429** – Weekday working hours (08:30 to 17:00) **07623 909981** (Out of hours Emergency pager) - Follow up within 1 hour if no response.			

GATHER INFORMATION AND INTELLIGENCE

- ☐ **Assume the role of Silver Commander.** Commence Incident Decision Log to ensure you document decisions made and/or actions taken.
- ☐ **For incidents where physical presence is required, base yourself in the HSCP Director's Office** (where practicable); this is to ensure you maintain a strategic Partnership-wide perspective. Keep in regular contact with the On-Call Manager. If comms systems are down, consider a team of runners to relay messages.
- ☐ **Check details** of incident & current situation with Incident Manager (manager of affected area who instigated escalation / or multi-agency MACC)

- **Notify**: The HSCP Director and Senior Leadership Team
- **Establish Incident situation**: Obtain a Rereport from affected service if available. If unavailable, known details should be logged using the (M)ETHANE Acronym:

    - **M:** Has a major incident been declared, by whom & what type?
    - **E:** Exact location of incident
    - **T:** Type & details of the incident
    - **H:** Hazards present or suspected
    - **A:** Access routes that are safe to use
    - **N:** Number & Types of casualties
    - **E:** Emergency service present or requested

  Log this in the **Incident Decision Log** and display this in the central Control Room
- **For incident-specific guidance** refer to HSCP Resilience Framework
- **Ensure** all above standby actions have been taken and are logged (templates within major incident folder / HSCP Resilience Framework)

ASSESS RISKS AND DEVELOP A WORKING STRATEGY

- **Formulate the Strategy:** Formulate a written strategy & identify the Partnership's aims and objectives to drive the resolution of the incident.
- **Establish Incident Management Teams** as required and convene initial meeting (refer to HSCP Resilience Framework).
- **Ensure Airwave Radios** as contingency against loss of normal comms. IBIS (Airwave) radios, provided by Police Scotland for Major Incidents, should then be used to contact all multi-agency partners.
- **Contact other agencies**: Ensure that contact has been made with NHS Fife, Fife Council, Police Scotland, Scottish Fire & Rescue, Scottish Ambulance Service control rooms, neighbouring Boards and Local Authorities if necessary and mutual aid requested through LRP if needed.
- **Consider** requirement to contact NHS24 to redirect patients/reduce site footfall.
- **Consider** the requirement to escalate to the East of Scotland Regional Resilience Partnership (EOSRRP); and advise / request escalation via HSCP Director / HSCP IMT
- **Consider** the requirement to escalate to Scottish Government Health EPRR through the EPRR Sitrep via HSCP Director / HSCP IMT
- **Comms**: Ensure that the Comms Team and Senior Leadership Team inform all staff of the incident & nature of the Partnership's response. HSCP Comms Team will work with NHS Fife, Fife Council and Police Scotland on messages out to the public for multi-agency major incidents.
- **Support** the Duty/Service Manager/Silver's decision making as necessary during the incident.
- **Estates and Security**: Consider Site lock down with Facilities & Security.

CONSIDER POWERS, POLICIES AND PROCEDURES

- Invoke incident-specific plans and ensure actions within those plans are implemented.
- Consider the need to allocate staff to relieve those allocated earlier.
- Consider the psychological impact of the incident on staff within these areas
- Two Hourly Major Incident briefing: Establish & Chair 1 to 2-hourly Major Incident briefings within the Incident Control Team (Silver), documenting updates & actions for completion. Brief by exception the HSCP Director

IDENTIFY OPTIONS AND CONTINGENCIES

- **Relief**: If it is a prolonged incident assess need to call in another Senior Leader to take over from you & within the Incident Control Team after 6-8 hours or when necessary. Conduct a full Handover/Takeover (HOTO).
- **Identify a Recovery Lead** and ensure they are developing plans for incident recovery (in liaison with wider Senior Leadership Team / HSCP Resilience Lead)

STAND DOWN, RECOVER AND REVIEW

- **Recovery:** Start to consider the longer-term recovery issues & the need to enact part/all of the Business Continuity Plans. If it is a prolonged incident or a large impact on Partnership operations is expected, a Recovery Team will need to begin this process early.
- **Recovery:** Oversee the Partnership's recovery and return to 'normal' service. Following a sustained incident, there may be a requirement to set up a Recovery Team.
- **Stand down:** The decision to stand down must be made by the Incident Management Team (Strategic/Gold) having performed a full assessment of the continuing impact of the incident on the Partnership. Ensure Incident declaration update is communicated ("**Major Incident – STAND DOWN, or Major Incident – CANCELLED**") to all staff and any external agencies initially informed.
- **Post-incident:** Consider the post-incident requirements, such as Business Continuity issues, finance, VIP visit, media etc.
- **Debrief:** Attend the 'hot' debrief immediately after the incident.
- **Sitrep:** Ensure details of the incident are included as required in Sitrep reports.
- **Documentation:** Complete any documentation created during the incident, and file in agreement with HSCP Director

Appendix 18: HSCP Extended Leadership Team Action Card

Incident Level 4 Action Card - Extended Leadership Team (Bronze Command)				
Board	**Version**	**Ratified Date**	**Review Date**	**Date Published**
Fife Health & Social Care Partnership	**V01.0**	**29/08/2023**	**31/01/2024**	
Location	Incident Management Team: **PRIMARY** Meeting Space: Virtual Control Room (MS Teams) **SECONDARY** Location: Control Room, Lynebank Hospital **ALTERNATIVE** Location: Depending on location of incident All locations will have Major Incident folders with copies of all relevant plans, procedures and actions cards.			
Role Description	**Major Incident Declared:** **Lead** the Partnership's activity and formulate the Bronze plan to achieve the strategic aim set by the Silver & Gold Command. **Determine** priorities in obtaining and allocating resources as required, planning & coordinating tasks.			
Key Contacts:				
HSCP Communications	Tel: TBC (Monday-Friday 9am-5pm) Email: fifehscpcommssupport@fife.gov.uk Out-of-hours contact Switchboard of partner bodies: • NHS Fife: 01592 643355 • Fife Council Contact Centre: 0345 1 55 00 99 • Fife Council Resilience Team: 01592 583544 In the event of a major incident, Police Scotland, as lead agency, will initiate communication through agreed channels.			
Scot Gov Health EPRR	**0131 244 2429** – Weekday working hours (08:30 to 17:00) **07623 909981** (Out of hours Emergency pager) - Follow up within 1 hour if no response.			

GATHER INFORMATION AND INTELLIGENCE

- ☐ Proceed to the Secondary location (Control Room, Lynebank). **Ensure it is set up** & control access to those with specific roles.
- ☐ Commence **Incident Decision Log** to ensure you document decisions made and/or actions taken.
- ☐ **Establish Incident situation**: Obtain a (M)ETHANE report from affected service if available. If unavailable, known details should be logged using the (M)ETHANE Acronym.
  - M: Has a major incident been declared, by whom & what type?
  - E: Exact location of incident

- T: Type & details of the incident
- H: Hazards present or suspected
- A: Access routes that are safe to use
- N: Number & Types of casualties
- E: Emergency service present or requested

Log this in the Incident Decision Log and display this in the central Control Room

- **Establish Partnership situation**: Establish current situation within the Partnership relating to capacity, staffing & anything else that may affect the Partnership's ability to deliver critical services and display in the Incident Control Room.
- **Brief Heads of Service**: brief on current situation and actions
- **Consider** the need to call in specific staff now prior to a declaration of a major incident. If Staff don't need to come in yet create a list of the staff you might need to call in at Declared Status & ensure you have their contact details to hand

ASSESS RISKS AND DEVELOP A WORKING STRATEGY

- **Awareness of the Strategy:** Obtain the written strategy from SLT (Silver Command) / HSCP Resilience Lead.
- **Capacity:** Liaise with the Clinical / Service Managers for current service positions aligned to OPEL Framework guidance.
- **Liaise** with Mortuary Manager/Department in Mass Casualty incidents (where applicable).
- **Partnership-wide activity**: Decisions may have to be taken concerning ceasing of non-critical activities (liaise with SLT (Silver Command) and refer to the HSCP Remobilisation Plan). This info must be relayed to all appropriate clinical / service managers.
- **Staffing**: In conjunction with the Heads of Services / Service Managers / Heads of Nursing deploy nursing & support staff to relevant areas (if required).
- **Ensure** wellbeing of all staff groups during what may be very distressing times and ensure Pastoral Care / peer support is available.
- **Ensure** all media enquiries are directed to relevant Comms department via agreed channels.

CONSIDER POWERS, POLICIES AND PROCEDURES

- **Security**: Consider Site lock down with Facilities & Security.
- **Consider** the need to allocate staff to relieve those allocated earlier.
- **Consider the psychological impact** of the incident on staff within affected areas.
- **Two-Hourly Major Incident briefing**: Attend 2-hourly Major Incident briefings within the Incident Control Team chaired by Gold (Strategic) Controller. Ensure an update is sent out to all relevant staff / services.

IDENTIFY OPTIONS AND CONTINGENCIES

- **Relief**: If it is likely to be a prolonged incident assess need to call in another Manager to take over from you after 6-8 hours or when necessary. Conduct a full Handover/Takeover (HOTO).

STAND DOWN, RECOVER AND REVIEW

- Stand down:
  - The decision to stand down must be made by the HSCP Director (Gold Command) having performed a full assessment of the continuing impact of the incident on the Partnership.
  - Inform the Comms Team & the Heads of Service when the decision to Stand down has been made to allow them to communicate this to all areas. This will be achieved through the Comms Team (all staff emails/Blink/NHS Fife Website etc) & via Heads of Service and Heads of Nursing.
  - Notify all external agencies previously notified of the stand down declaration.
- **Recovery**: Together with the HSCP Director or Senior Leadership Team consider the

business continuity implications caused by the incident & work with the Recovery Team (which HSCP IMT will set up) & prepare a plan to address them.

- **Post-incident**: Consider, with Gold Command, the post-incident requirements, such as business continuity issues, finance, VIP visit, media etc.
- **Establish a 'hot' debrief** for staff that responded to the incident. Ensure ALL staff involved are aware.
- **Maintain IMT**: Ensure that the Incident Management Team remains established – with phones connected & staff present, for 1-2 hours after stand-down.
- **Documentation**: Complete any documentation created during the incident, and file in agreement with HSCP Director.

Annex 1 : Radio Handset Guide

- When using IBIS Radios to pass on information, always remember A,B,C,D: **A**ccuracy, **B**revity, **C**larity, **D**iscipline.
- All dates must be in dd/mm/yyyy format and timings in 24-hour clock.
- All numbers must be read out in full, for example 12th Feb 2023 would be said as *"one two, zero two, two zero two three".*
- All letters when spelling out information should be given using the NATO Phonetic Alphabet (see table below).

A Alpha	**B** Bravo	**C** Charlie	**D** Delta	**E** Echo
F Foxtrot	**G** Golf	**H** Hotel	**I** India	**J** Juliet
K Kilo	**L** Lima	**M** Mike	**N** November	**O** Oscar
P Papa	**Q** Quebec	**R** Romeo	**S** Sierra	**T** Tango
U Uniform	**V** Victor	**W** Whiskey	**X** X-ray	**Y** Yankee
Z Zulu				

Some basic tips for radio etiquette:

- Use the callsign of the person you are calling twice at the beginning of your message, followed by "from" and your callsign once.
    - If your callsign is NHS 1 and you wish to speak to PC1 you should state: *"Papa Charlie one, Papa Charlie one from November Hotel Sierra 1, over".*
- Acknowledge you have understood any message to you by stating *"received"*, and if you wish the caller to repeat the message state *"Say Again, over".*
- If your message is long and detailed, pause every so often and state *"so far?".* This will allow the person on the other end of the call to clarify they have noted all of the information so far and will avoid the need to repeat the whole message from the start.

Annex 2: PHS Debrief Template

Public Health Scotland

Hot debriefing template

The Scottish Government **Guidance on the Roles and Responsibilities of NHS Led Incident Management Teams for the Management of Public Health Incidents**, highlights the need to learn from experience.

The IMT Chair should complete this document as soon as possible following the end of an incident. This is to capture initial lessons learnt immediately (a “hot debrief)”, recognising that some IMT reports take months/years to be published.

Incident reference.

Please provide a descriptive reference/title for this incident (e.g. incident/place/date)

IM&T Lead details

Name:

Email:

Job Title:

Contact number:

Contact number (mobile):

Address:

Date:

Signed:

Details of incident.

Please provide a brief summary of incident:

What went well?

Please list aspects of the incident that were managed well:

What did not go well?

Please list aspects of the incident that were not managed well.

Lessons learned.

Please provide details of any learning or recommendations for national consideration:

Return completed form to: phs.shpn-pmt-submissions@nhs.net

Annex 3: NHS 24 Info Card

SPECIAL HELPLINE ACTION CARD

BOARD SINGLE POINT OF CONTACT (SPOC)

NHS 24

1. **Key contact details**
   Request a special helpline by contacting either number below:
   Health Information Services Management: 0141 435 3889 (in hours)
   NHS 24 Team Leader: 0141 435 3889 (in hours)
   In exceptional circumstances, and only if the numbers above are unavailable please alert via 111 or email alert@nhs24.scot.nhs.uk
   Normal operating hours will be from 08.00 – 22.00, unless agreed otherwise.
2. **Provide the appropriate information** for the Q&A's Pro-forma.
3. **Provide a Single Point of Contact** for the duration of the response that can answer any queries on Q&A's.
4. **NHS 24 will provide a 0800 number** and staff the number appropriately within 4 hours.
5. **Maintain a battle rhythm to update the Q&A** information to ensure it is accurate and up to date as possible.
6. **Call stats will be reported on a timely basis**. They will be monitored to understand the uptake of the service and when to stand it down.

NHS 24 ROLE ACTION CARD

NHS 24

1. **Notify 111 service delivery on-call** of major incident with mass casualties.
2. **Inform NHS 24** communications on-call to engage with host board communications cell.
3. **Notify staff** to support potential additional demand.
4. **Initiate special helpline standby process**.
5. **Establish GP Out-of-hours hub** as per internal contingency and escalation plan.
6. **Initiate NHS Inform webpage** and populate with appropriate information.
7. **Signpost staff** to mental health managing distress.
8. **Support long term recovery arrangements** through Breathing Space and Living Life.

Annex 3: Special NHS 24 Helpline Information Request

Contact: alert@nhs24.scot.nhs.uk
Please submit as much information as possible to NHS 24 on the template below. It will help to prepare Call Handlers working on the national incident public Helpline. Acknowledging that all information will not be available in the first hour of an incident, submissions should be version controlled so that Call Handlers impart up to date information.

Submit answers to questions 1-11 immediately to enable the line to be operational. As the impact on the Board/services becomes clearer, your **NHS Board Single Point of Contact (SPOC)** should submit answers to Q 11-19. An update schedule will be agreed with the Board.

1	Please describe the disruption to services and identify location
2	How long has the incident being going on? (Date/time – hours/days/weeks)
3	What are the approximate numbers of casualties being dealt with at the site(s)?
4	Where are most of the casualties being treated?
5	Are there any public health consequences? e.g. smoke, contamination etc.
6	I was involved in the incident, and I have a minor ailment, where should I go? (In-hours, out-of-hours)
7	I need help but can't get through to the ambulance service, what should I do?
8	Should I go to my local ED?
9	Which hospitals are affected?
10	I was caught up in the incident and left the scene. I now have pain, where should I go?
11	Is my family at risk if I've been in the vicinity of the incident?

INFORMATION REQUIRED WITHIN FIRST 8 HRS OF INCIDENT OCCURRING:

12	My GP surgery won't see me, what should I do?
13	Is there a website I can use for information?
14	My mental health is deteriorated due to the vast media coverage. What should I do?
15	Where can I donate blood?
This information would be found at https://www.scotblood.co.uk/	
16	Concerns related to family and friends social care arrangements
17	Where can I find out if my family and friend were involved in the incident?
18	Will my hospital appointment be on tomorrow?
19	I'm due renal/cancer treatment, will it still be on, and will the ambulance service still pick me up? (Request information from SAS Strategic Operations Manager)

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**3 November 2023**
Title:	**Integrated Performance & Quality Report**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Bryan Archibald, Planning & Performance Manager**

1 Purpose

This is presented for:

- Assurance
- Discussion

This report relates to:

- Annual Delivery Plan

This aligns to the following NHS Scotland 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 generally up to the end of August, although there are some measures with a significant time lag and a few which are available up to the end of September.

2.2 Background

The Integrated Performance & Quality Report (IPQR) is the main corporate reporting tool for the NHS Fife Board and is produced monthly.

We have now transitioned to the Annual Delivery Plan for 2023/24. Improvement actions have been included in the IPQR: statuses for these actions are being collated and will be included in the IPQR and redistributed prior to going to the Committees. This streamlines

local reporting for governance purposes with quarterly national reporting to the Scottish Government.

Following the Active Governance workshop held on 2 November 2021, a review of the IPQR started with the establishment of an IPQR review group. The key early changes requested by this group were the creation of a Public Health & Wellbeing section of the report and the inclusion of Statistical Process Control (SPC) charts for applicable indicators.

The list of indicators has been amended, with the most recent addition being for Adverse Events Actions Closure Rate, in the Clinical Governance section. A further addition relating to Establishment Gap (Staff Governance) is being considered.

A summary of the Corporate Risks has been included in this report. Risks are aligned to Strategic Priorities and linked to relevant indicators throughout the report. Risk level has been incorporated into Indicator Summary, Assessment section and relevant drill-downs if applicable.

The final key change identified was the production of different extracts of the IPQR for each Standing Committee. The split enables more efficient scrutiny of the performance areas relevant to each committee and was introduced in September 2022.

2.3 Assessment

Performance has been hugely affected during the pandemic. To support recovery, NHS Fife is progressing the targets and aims of the 2023/24 Annual Delivery Plan (ADP), which was submitted to the Scottish Government at the end of July 2023. New targets are being devised for 2023/24.

The Clinical Governance aspects of the report cover Adverse Events, HSMR, Falls, Pressure Ulcers, HAI and Complaints. A summary of the status of these is shown in the table below.

Measure	Update	Local/National Target	Current Status
Adverse Events [1]	Monthly	50%	Not achieving
HSMR	Quarterly	1.00 (Scotland average)	Below Scottish average
Falls [2]	Monthly	6.95 per 1,000 TOBD	Achieving
Pressure Ulcers [2]	Monthly	0.89 per 1,000 TOBD	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	Achieving
Complaints (S1)	Monthly	80%	Not achieving
Complaints (S2) [3]	Monthly	50%	Not achieving

[1] Reporting on the closure rate of actions from Major & Extreme Adverse Events started in December 2022

[2] As part of ongoing improvement work, revised targets for Falls and Pressure Ulcers have been set for FY 2023/24. These are a 15% reduction on the FY 2021/22 target for Falls, and a 20% reduction on the actual achievement in FY 2022/23 for Pressure Ulcers.

[3] An improvement target of 50% by March 2023, rising to 65% by March 2024 was agreed by the Director of Nursing. However, performance has been very much lower than the 50% provisional target, generally due to closing long-term complaints. A further measure (Stage 2 Complaints Raised in Month and Closed Within 20 Working Days) has been added. This has no target.

2.3.1 Quality/ Patient Care

IPQR contains quality measures.

2.3.2 Workforce

IPQR contains workforce measures.

2.3.3 Financial

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

2.3.4 Risk Assessment/Management

A mapping of key Corporate Risks to measures within the IPQR is provided via a Risk Summary Table and the Executive Summary narratives.

2.3.5 Equality and Diversity, including health inequalities and Anchor Institution ambitions

Not applicable.

2.3.6 Climate Emergency & Sustainability Impact

Not applicable.

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 Clinical Governance extract of the Position at September IPQR will be available for discussion at the meeting on 03 November.

2.3.8 Route to the Meeting

The IPQR was ratified by EDG on 19 October and approved for release by the Director of Finance & Strategy.

2.4 Recommendation

The report is being presented to the Committee for:

- **Discussion** – Examine and consider the NHS Fife performance as summarised in the IPQR
- **Assurance**

3 List of appendices

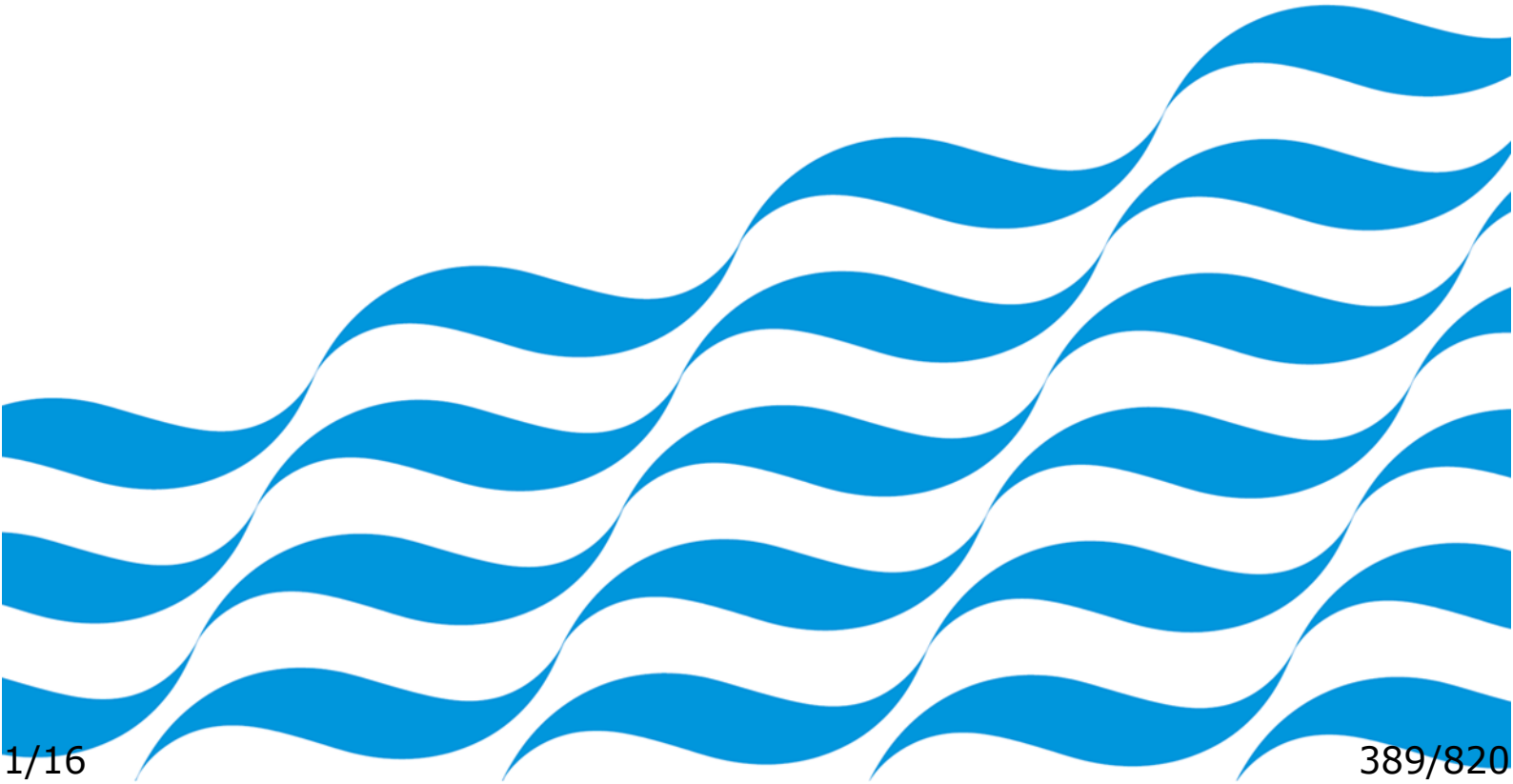
Appendix 1 – Integrated Quality & Performance Report

Report Contact
Bryan Archibald
Planning and Performance Manager
Email bryan.archibald@nhs.scot

Fife Integrated Performance & Quality Report

CLINICAL GOVERNANCE

Position (where applicable) at September 2023
Produced in October 2023



Introduction

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

Amendments have been made to the IPQR following the IPQR Review. This involves changes to the suit of key indicators, a re-design of the Indicator Summary, applying Statistical Process Control (SPC) where appropriate and mapping of key Corporate Risks.

At each meeting, the Standing Committees of the NHS Fife Board is presented with an extract of the overall report which is relevant to their area of Governance. The complete report is presented to the NHS Fife Board.

The IPQR comprises the following sections:

a. **Corporate Risk Summary**
   Summarising key Corporate Risks and status.

b. **Indicatory Summary**
   Summarising performance against National Standards and local KPI's. These are listed showing current, 'previous' and 'previous year' performance, and a benchmarking indication against other mainland NHS Boards, where appropriate. There is also a column indicating performance 'special cause variation' based on SPC methodology.

c. **Projected & Actual Activity**
   Comparing projected Scheduled Care activity to actuals.

d. **Assessment**
   Summary assessment for indicators of continual focus.

e. **Performance Exception Reports**
   Further detail for indicators of focus or concern. Includes additional data presented in tables and charts, incorporating SPC methodology, where applicable. Deliverables, detailed within Annual Delivery Plan (ADP) 2023/24, relevant to indicators are incorporated accordingly.

Statistical Process Control (SPC) methodology can be used to highlight areas that would benefit from further investigation – known as 'special cause variation'. These techniques enable the user to identify variation within their process. The type of chart used within this report is known as an XmR chart which uses the moving range – absolute difference between consecutive data points – to calculate upper and lower control limits. There are a set of rules that can be applied to SPC charts which aid to interpret the data correctly. This report focuses on the 'outlier' rule identifying whether a data point exceeds the calculated upper or lower control limits.

MARGO MCGURK
Director of Finance & Strategy
16 October 2023

Prepared by:
SUSAN FRASER
Associate Director of Planning & Performance

a. Corporate Risk Summary

Strategic Priority	Total Risks	Current Strategic Risk Profile				Risk Movement	Risk Appetite
To improve health and wellbeing	5	2	3	-	-	▲	High
To improve the quality of health and care services	5	5	-	-	-	◀▶	Moderate
To improve staff experience and wellbeing	2	2	-	-	-	◀▶	Moderate
To deliver value and sustainability	6	4	2	-	-	◀▶	Moderate
Total	**18**	**13**	**5**	**0**	**0**		

Risk Key

High Risk	15 - 25
Moderate Risk	8 - 12
Low Risk	4 - 6
Very Low Risk	1 - 3

Movement Key

▲ Improved - Risk Decreased

◀▶ No Change

▼ Deteriorated - Risk Increased

Summary Statement on Risk Profile

The current assessment indicates that delivery against 3 of the 4 strategic priorities continues to face a risk profile in excess of risk appetite.
Mitigations are in place to support management of risk over time with some risks requiring daily assessment.
Assessment of corporate risk performance and improvement trajectory remains in place.

b. Indicator Summary

Section	Indicator	Target 2023/24 2023/24 TBC	Reporting Period	Current Period	Current Performance	SPC Outlier	Vs Previous	Vs Year Previous	Benchmarking	
Clinical Governance	Major/Extreme Adverse Events - Number Reported	N/A	Month	Aug-23	31	○	▲	▲	●	
	Major/Extreme Adverse Events - % Actions Closed on Time	50%	Month	Aug-23	48.4%	●	▼	▼	●	
	HSMR	N/A	Year Ending	Mar-23	0.96	●	—	—	●	
	Inpatient Falls	6.95	Month	Aug-23	6.70	○	▲	▼	●	
	Inpatient Falls with Harm	1.44	Month	Aug-23	1.36	○	▲	▲	●	
	Pressure Ulcers	0.89	Month	Aug-23	0.77	○	▲	▲	●	
	SAB - HAI/HCAI	18.8	Month	Aug-23	14.0	○	▼	▼	●	QE Jun-23
	C Diff - HAI/HCAI	6.5	Month	Aug-23	3.5	○	▼	▲	●	QE Jun-23
	ECB - HAI/HCAI	33.0	Month	Aug-23	38.4	○	▲	▼	●	QE Jun-23
	S1 Complaints Closed in Month on Time	80%	Month	Aug-23	42.6%	●	▼	▼	●	2021/22
	S2 Complaints Closed in Month on Time	50%	Month	Aug-23	11.1%	○	▼	▲	●	2021/22
	S2 Complaints Due in Month and Closed On Time	N/A	Month	Aug-23	10.9%	●	▼	▲	●	
Operational Performance	IVF Treatment Waiting Times	90%	Month	Jun-23	100.0%	●	◀▶	◀▶	●	
	4-Hour Emergency Access (A&E)	95%	Month	Sep-23	73.3%	○	▼	▲	●	Aug-23
	4-Hour Emergency Access (ED)	82.5%	Month	Sep-23	65.0%	●	▼	▲	●	Aug-23
	Patient TTG % <= 12 Weeks	100%	Month	Aug-23	41.0%	●	▼	▼	●	Jun-23
	New Outpatients % <= 12 Weeks	95%	Month	Aug-23	44.7%	●	▼	▼	●	Jun-23
	Diagnostics % <= 6 Weeks	100%	Month	Aug-23	47.2%	●	▲	▼	●	Jun-23
	Cancer 31-Day DTT	95%	Month	Aug-23	90.6%	○	▼	▼	●	QE Jun-23
	Cancer 62-Day RTT	95%	Month	Aug-23	77.1%	○	▼	▼	●	QE Jun-23
	Detect Cancer Early	29%	Year Ending	Dec-22	27.6%	●	▼	▲	●	2020, 2021
	Freedom of Information Requests	85%	Month	Sep-23	86.5%	●	▲	▲	●	
	Delayed Discharge % Bed Days Lost (All)	N/A	Month	Sep-23	10.7%	●	▼	▲	●	QE Dec-22
	Delayed Discharge % Bed Days Lost (Standard)	5%	Month	Sep-23	6.7%	○	▼	▲	●	QE Dec-22
	Antenatal Access	80%	Month	Aug-23	81.8%	●	▼	▼	●	CY 2022
Finance	Revenue Resource Limit Performance	(£23m)	Month	Sep-23	(£15.868m)	●	—	—	●	
	Capital Resource Limit Performance	£11.551m	Month	Sep-23	£2.278m	●	—	—	●	
Staff Governance	Sickness Absence	4.00%	Month	Aug-23	6.91%	○	▼	▼	●	YE Jun-23
	Personal Development Plan & Review (PDPR)	55%	Month	Sep-23	41.3%	●	▲	▲	●	
	Vacancies - Medical & Dental	N/A	Quarter	Jun-23	9.6%	●	▲	▼	●	
	Vacancies - Nursing & Midwifery	N/A	Quarter	Jun-23	11.4%	●	▲	▼	●	
	Vacancies - AHPs	N/A	Quarter	Jun-23	8.3%	●	▲	▲	●	
Public Health & Wellbeing	Smoking Cessation (FY 2023/24)	473	YTD	May-23	44	●	—	—	●	YT Dec-22
	CAMHS Waiting Times	90%	Month	Aug-23	69.4%	○	▼	▼	●	QE Jun-23
	Psychological Therapies Waiting Times	90%	Month	Aug-23	64.8%	○	▼	▼	●	QE Jun-23
	Drugs & Alcohol Waiting Times	90%	Month	Jun-23	82.8%	●	▼	▼	●	QE Jun-23
	COVID Vaccination (Winter, Age 65+)	85%	Month	Sep-23	6.1%	●	—	—	●	
	Flu Vaccination (Winter, Age 65+)	85%	Month	Sep-23	8.9%	●	—	—	●	
	Immunisation: 6-in-1 at Age 12 Months	95%	Quarter	Jun-23	93.8%	○	▲	▼	●	QE Jun-23
	Immunisation: MMR2 at 5 Years	92%	Quarter	Jun-23	89.8%	○	▲	▼	●	QE Jun-23

Performance Key

- on schedule to meet Standard/Delivery trajectory
- behind (but within 5% of) the Standard/Delivery trajectory
- more than 5% behind the Standard/Delivery trajectory

SPC Key

- ○ Within control limits
- ○ Special cause variation, out with control limits
- ● No SPC applied

Change Key

- ▲ "Better" than comparator period
- ◀▶ No Change
- ▼ "Worse" than comparator period
- — Not Applicable

Benchmarking Key

- ● Upper Quartile
- ● Mid Range
- ● Lower Quartile
- ● Not Available

c. Projected and Actual Activity

Better than Projected | Worse than Projected
Better/Worse may be higher or lower, depending on context

		Month End			Quarter End	Month End			Quarter End	Quarter End	Quarter End
		Apr-23	May-23	Jun-23	Jun-23	Jul-23	Aug-23	Sep-23	Sep-23	Dec-23	Mar-24
ED 4-hour Performance (VHK only)	Projected	67.9%	69.1%	70.6%		71.8%	73.1%	74.6%			
	Actual	64.7%	66.5%	71.3%		69.0%	72.2%	65.0%			
	Variance	-3.2%	-2.6%	0.7%		-2.8%	-0.9%	-9.6%			
Elective Activity Diagnostics	Projected	5,121	5,121	5,121	15,363	5,121	5,121	5,121	15,363	15,363	15,363
	Actual	4,640	4,985	4,768	14,393	5,048	5,422				
	Variance	-481	-136	-353	-970	-73	301				
Elective Activity New Outpatients	Projected	7,573	7,372	7,364	22,309	7,565	7,340	7,432	22,337	22,274	22,308
	Actual	6,092	7,583	7,550	21,225	6,414	7,942				
	Variance	-1,481	211	186	-1,084	-1,151	602				
Elective Activity TTG	Projected	1,138	1,139	1,139	3,416	1,144	1,144	1,145	3,433	3,487	3,492
	Actual	957	1,204	1,242	3,403	918	1,294				
	Variance	-181	65	103	-13	-226	150				
Long Waits Diagnostics > 26 weeks	Projected	140	122	109	109	94	79	63	63	10	0
	Actual	164	171	171	171	152	165				
	Variance	24	49	62	62	58	86				
Long Waits New Outpatients > 104 weeks	Projected	0	0	0	0	0	0	74	74	212	352
	Actual	0	0	1	1	1	2				
	Variance	0	0	1	1	1	2				
Long Waits New Outpatients > 78 weeks	Projected	77	87	150	150	213	276	339	339	849	1358
	Actual	73	92	85	85	117	186				
	Variance	-4	5	-65	-65	-96	-90				
Long Waits TTG > 104 weeks	Projected	17	15	16	16	21	43	67	67	173	351
	Actual	14	15	20	20	20	20				
	Variance	-3	0	4	4	-1	-23				
Long Waits TTG > 78 weeks	Projected	99	128	159	159	203	258	305	305	547	893
	Actual	79	88	84	84	99	127				
	Variance	-20	-40	-75	-75	-104	-131				
Arthroplasty 4 joint sessions	Projected				25.0%				25.0%	25.0%	25.0%
	Actual	6.0%	12.0%	12.0%	10.0%	17.0%	14.0%				
	Variance				-15.0%						
Same Day Procedures Knee Arthroplasty	Projected				1.9%				1.9%	1.9%	1.9%
	Actual	0.0%									
	Variance				-1.9%						
Same Day Procedures Hip Arthroplasty	Projected				4.3%				4.3%	4.3%	4.3%
	Actual	15.2%									
	Variance				-4.3%						
Cancer Waiting Times 31-Day	Projected				93.8%				94.1%	94.3%	94.5%
	Actual	97.9%	94.5%	97.6%	96.5%	94.7%	90.6%				
	Variance				2.7%						
Cancer Waiting Times 62-Day	Projected				81.9%				82.8%	85.0%	85.4%
	Actual	84.4%	75.3%	74.4%	77.5%	77.9%	77.1%				
	Variance				-4.4%						
CAMHS 18 Weeks RTT	Projected	85.0%	85.0%	85.0%		85.0%	85.0%	70.0%			
	Actual	85.3%	84.8%	76.2%		71.0%	66.5%				
	Variance	0.3%	-0.2%	-8.8%		-14.0%	-18.5%				
CAMHS Waiting List <= 18 weeks	Projected	213	209	216	216	230	218	228	228	235	200
	Actual	249	268	224	224	201	179				
	Variance	36	59	8	8	-29	-39				
CAMHS Waiting List > 18 weeks	Projected	71	89	116	116	113	133	98	98	42	0
	Actual	43	48	70	70	82	90				
	Variance	-28	-41	-46	-46	-31	-43				
Psychological Therapies 18 Weeks RTT	Projected	67.5%	69.4%	66.1%		65.2%	65.1%	73.5%			
	Actual	56.2%	58.5%	55.5%		53.4%	54.3%				
	Variance	-11.3%	-10.9%	-10.6%		-11.8%	-10.8%				
Psychological Therapies Waiting List <= 18 weeks	Projected	888	888	888	888	888	888	888	888	888	888
	Actual	1448	1602	1460	1460	1408	1497				
	Variance	560	714	572	572	520	609				
Psychological Therapies Waiting List > 18 weeks	Projected	1394	1575	1660	1660	1625	1591	1569	1569	1680	1604
	Actual	1128	1136	1173	1173	1227	1260				
	Variance	-266	-439	-487	-487	-398	-331				
Psychological Therapies Waiting List > 52 weeks	Projected	255	237	219	219	201	183	165	165	111	57
	Actual	248	286	273	273	262	262				
	Variance	-7	49	54	54	61	79				

d. Assessment

CLINICAL GOVERNANCE

To improve the quality of health and care services

5

5	-	-	-

Moderate

		Target	Current
Major & Extreme Adverse Events	*50% of Action from Major and Extreme Adverse Events to be closed within time*	**50%**	**48.4%**

There were 30 actions relating to LAER/SAER closed on time in August 2023, from a total of 62, which equates to a performance of 48.4%: a decrease on the 73.5% seen in July but higher than the four previous months.

There were 31 Major/Extreme adverse events reported in August out of a total of 1,368 incidents.

69.9% of all incidents were reported as 'no harm'. Over the past 12 months, Pressure Ulcer developing on ward has been the most common major/extreme reported incident followed by Patient Fall.

On average, 47.1 actions have been closed per month in 2023 compared to 42.2 over the same period year prior. There was a total of 351 actions open at the end of August, with 74 (26.7%) being within time.

The SBAR process for cardiac arrests has move to fully electronic from 1st September 2023. This move is part of a wider piece of improvement work around the deteriorating patient. It is the intention that the electronic process will reduce delays in the completion and submission of Cardiac Arrest SBARs.

Work has commenced on compliance with closure of actions on time. The first step was sharing communications, widely on Blink, highlighting overdue actions and through targeted service reports. This approach has seen an initial improvement in action closure times. Improvement work is continuing in this area to ensure this improvement is sustained. A short life working group will be convened in November to identify the barriers to closure of actions on time and to develop the action module on Datix to improve usability.

HSMR		**1.00**	**0.96**

Data for 2021 and 2022 demonstrates a return to a typical ratio for NHS Fife, with the data for year ending December 2022 showing a ratio below the Scottish average.

Inpatient Falls	*Reduce **All Falls** (inpatient) rate by 15% in FY 2023/24 compared to baseline (YE Sep-21)*	**6.95**	**6.70**
	*Reduce **Falls with Harm** (inpatient) rate by 10% in FY 2023/24 compared to baseline (YE Sep-21)*	**1.44**	**1.36**

The number of inpatient falls in total was 192 in August, down slightly from 197 the month prior, which equates to a rate of 6.70 falls per 1,000 Occupied Bed Days (OBD). This takes the performance to within the target range of < 6.95. The majority of falls in the last 3 months (79.4%) were classified as 'No Harm' whilst 16.4% were classified as 'Minor Harm' and <3% were classified as 'Moderate Harm'. Falls classified as 'Major/Extreme Harm' accounted for 1.4% of the totals falls.

The number of falls within Acute Services increased from 78 in July to 93 in August. This equates to a rate of 7.51 per 1,000 OBD (6.33 in July). The number of falls within HSCP decreased from 119 to 99. This equates to a rate of 6.62 per 1,000 OBD (7.68 in July).

The number of inpatient Falls with Harm was 39 in August, one more than the month prior, and this equates to a rate of 1.36 falls per 1,000 OBD: thus, performance continues to remain within the target range of < 1.44.

Reviewed and revised the Falls meeting structure across NHS Fife with the development of a Falls oversight group, chaired by DoN Acute and Nurse Consultant (Older People). The Acute and Community Inpatient Falls groups will align their workplans to the national driver and falls reduction package. Link Practitioner role to be reviewed and revised. From the data above, work will be focussing on reducing the number of falls within Acute towards the 6.95 per 1000 OBD.

Pressure Ulcers	*Reduce pressure ulcer rate by 20% in FY 2023/24 compared to the rate in FY 2022/23*	**0.89**	**0.77**

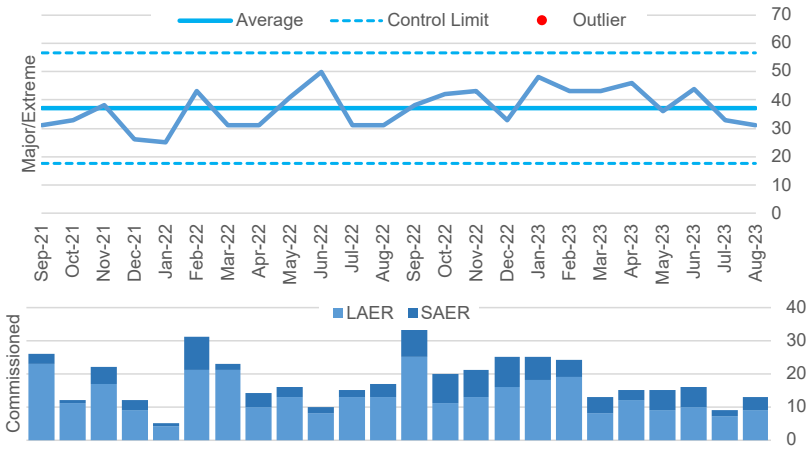
The total number of pressure ulcers in August 2023 was 22, equating to a rate of 0.77 per 1,000 Occupied Bed Days (OBD). This is an improvement on July 23 which saw a rate of 1.08 and takes the performance to within the target range of < 0.89.

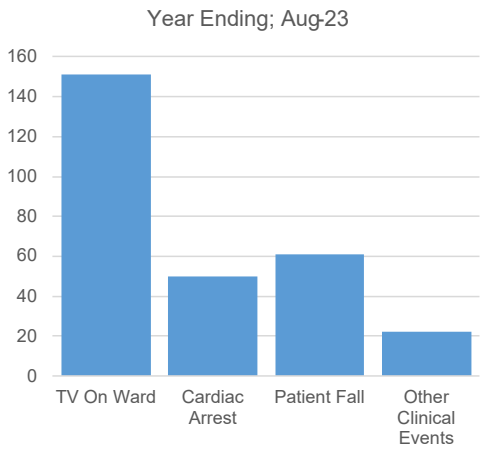
		Target	Current
The number of pressure ulcers in Acute Services decreased from 24 in July to 19 in August (24-month average is 24 and rate is 1.53). In the same timeframe, the number of pressure ulcers in HSCP decreased from 6 to 3 (24-month average is 7 and rate is 0.20). Most pressure ulcers continue to be in Acute Services with 62 between Jun-Aug 2023 compared with 19 in HSCP. The joint Acute/HSCP Tissue Viability steering group is chaired by Director of Nursing and directs the work of the joint Tissue Viability group co-chaired by a Head of Nursing from HSCP and Acute. The membership of this group includes the EiC lead who is supporting the implementation of EiC measures and reporting. The group provides a forum for review of current QI work and implementation of shared learning from Local Adverse Event Reviews learn summaries which supports the improvement of PU incidence as noted in the Q2 data. A review of monthly audit of SSKIN bundle compliance in HSCP in patient areas allows for early intervention and mitigating actions to any areas of concern. Podiatry service recently provided 4 awareness 'CPR for feet' sessions to inpatient ward nurses. Challenges: The unexpected HoN vacancy has delayed the target completion date of Aug 23 for Key deliverable 'Review of services and options for new service design'. A new target completion date will be agreed and included in the next return. All other key deliverables remain on track.			
SAB (MRSA/MSSA)	*We will reduce the rate of HAI/HCAI by 10% between March 2019 and March 2024*	**18.8**	**14.0**
The SAB infection rate increased from 10.2 in July 2023 to 14.0 in August meaning that performance whilst higher was still within target. The most recent quarterly HAI report from Health Protection Scotland, covering the quarter ending June 2023, showed that NHS Fife was in the mid-range of all Mainland Health Boards at 14.6, below the Scottish average. The cumulative number of SAB cases Jan-Aug 23 (n=64) is similar to the same time period in 2022 (n=63), but higher than 2021 (n=50). This trend is also reflected in the cumulative total of HCAI cases, when comparing Jan-Aug 23 to the previous 2 years. There has been 11 vascular access devices (VADs) related SABs; 8 dialysis line related SABs during Jan-Aug 23. Renal services carried out a CCR of each case (Jan-Apr cases) and the findings were discussed at a `Super SAER` meeting on 26th June 2023. The most recent case (August 2023) has been added to Datix by the Consultant Microbiologist. More positively, NHS Fife has achieved over 400 days since last CVC related SAB and over 300 days since last PVC related SAB. So far, during 2023 (up to end Aug 2023), there have been 6 People Who Inject Drugs (PWID) related SAB cases, there was a rise in the number of PWID related SAB cases during 2022 (n=11), when compared to the previous year 2021 (n =4). The IPCT continue to support Addiction Services.			
C Diff	*We will reduce the rate of HAI/HCAI by 10% between March 2019 and March 2024*	**6.5**	**3.5**
The C Diff infection rate increased from 3.4 in July 2023 to 3.5 in August. There were 2 infections reported in August 2023, 1 HAI/HCAI/Unknown, 1 Community The most recent quarterly HAI report from Health Protection Scotland, covering the quarter ending June 2023, showed that NHS Fife was above Scottish average and in the upper quartile of all Mainland Health Boards at 18.0. During July and August 2023, there was a reduction in the cumulative number of CDI cases, when compared to previous months in 2023. Despite this recent reduction, the cumulative total of CDIs Jan-Aug 2023 is higher than during the same time period in 2022 and 2021. This increase is also reflected in the number of HCAI cases Jan- Aug 2023, compared to the previous 2 years. Recent antibiotics (in the previous 12 weeks prior to infection) remains the most frequently occurring risk factor, amongst cases.			
ECB	*We will reduce the rate of HAI/HCAI by 25% between March 2019 and March 2024*	**33.0**	**38.4**
The number of infections decreased from 12 in July 2023 to 11 in August and the rate of infection decreased from 40.9 to 38.4 HAI/HCAI per 100,000 Occupied Bed Days (OBD). Urinary Catheter related infections have been responsible for 29 of the 112 infections in the last year (25.9%) and remains a key focus for improvement work although the 'Not Known' category accounts for 24 infections (21.6%). The most recent quarterly HAI report from Health Protection Scotland, covering the quarter ending June 2023, showed that NHS Fife (with a quarterly infection rate of 29.3) was in the lower quartile of Mainland Health Boards, below the Scottish average of 37.6. July and August saw the highest number of ECB monthly cases, so far, in 2023, demonstrating seasonality of ECB infections. Nonetheless, the cumulative total of ECBs (Jan-Aug) remains lower than during the same time period the previous 2 years. This improvement is also reflected in the number of HCAI cases, when comparing Jan-Aug 23 to the same time periods in 22 and 21.			

		Target	Current
The majority of ECB infections occur in the community, the most common sources of infection are hepatobiliary and renal. The number of CAUTI related ECBs has reduced over the past couple of years and, so far, for 2023, this trend is continuing.			
Complaints – Stage 2	*At least 50% of Stage 2 complaints will be completed within 20 working days by March 2023, rising to 65% by March 2024*	**50%**	**11.5%**
There were 24 stage 2 complaints received in August, with 100% acknowledged within timescales, with 54 closed. Of those closed, 6 (11.1%) were within timescales with 30 greater than 40 days after due date, 18 of which were closed greater than 80 days after due date. 46 complaints were due to be closed in the month, 5 (10.9%) of which were closed on time. 63.2% of live complaints have been open for more than 40 days with 31.1% open for more than 80 days, this is a decrease of 4.5% from July. 38.7% of live complaints are awaiting statements with 30.2% approval of final response. The Patient Experience Team (PET) are currently working with a Senior Project Manager (SPM) to assist with quality improvements and to put together a project plan. Work is ongoing to progress the results and action of the MS Form questionnaire sent to Consultant colleagues. The data has been themed into three categories, Education and Training, Processes and Procedures and Support, and this will directly influence the quality improvement work to improve the understanding and compliance with the Complaint Handling Process and staff support. The Senior Project Manager is also assisting with analysing this data and a further MS Form questionnaire will be sent to the PET to understand their challenges. The new complexity scoring categorisation has now been applied to every Stage 2 complaint providing insight into the volume of complex complaints that NHS Fife receives and handles. The complexity categorisation has changed from complex and non complex to negligible, minor, moderate, major and extreme. We currently have 4 negligible, 19 minor, 49 moderate, 28 major and 5 extreme stage 2 complaints open. Digital and information have created a PET Dashboard, which is currently being tested and is available on the Data & Insight Hub. This has received positive feedback and will be reviewed over the next few months to agree on data metrics and reporting priorities. Further meetings have taken place with Digital and Information and changes to the test Dashboard. A "complaints escalation" standard operating procedure (SOP) is being drafted but has not progressed further due to challenges within the PET team. This will highlight and support processing complaints within the agreed national timescales, in line with the model handling complaint procedure. A new Patient Experience Team intranet page is being created to provide information and guidance about the Complaint Handling Process, with links to education, training and support. The Navigator's post has been extended by a further six months from within the existing funded establishment, and supports data collection, chasing and tracking complaints, and providing administration and organisational support to the PET Officers. There is currently a 0.29 WTE administration post vacancy within the PET which has been recruited into. There will be a further vacancy in October 2023 of a 1.0 WTE Band 6 PET Officer. This post is currently being advertised. The number of live Stage 2 complaints have improved from 140-150 to currently 107 in August 2023. There was an average of 40 complaints per month over 100 days this has reduced to 23. This demonstrates that some progress has been made clearing the existing backlog of complaints however this remains incredibly challenging. There are 8 stage 2's over 200 days and 1 over 300 days. Delays remain with obtaining statements and approval of final responses, and at the end of August 2023, 82% of all live complaints were awaiting statements or final approval by the Divisions. There are 21 Stage 2 complaints under 20 days; 2 are categorised as major, 18 moderate with 1 minor. It would be expected negligible and minor complaints would be completed within the 20-day standard timeframe which means that predicted compliance over the next few months will remain low. Historically the Band 6's PET Officers would have a mixed caseload of enquiries, concerns, Stage 1's and Stage 2's with at most 20 Stage 2's. There are 3.6 WTE Band 6 PET Officers, allowing them to work on a maximum of 74 Stage 2's. In June 2023 it was identified that there had been a significant increase (93%) in the team's workload. Compared with 2021/2022, there is also a 12 % increase in the total number of complaint contacts (enquiries, concerns, stage 1's and stage 2's). This continued increase in workload and pressure within the PET raises concerns regarding sustainability and retention.			

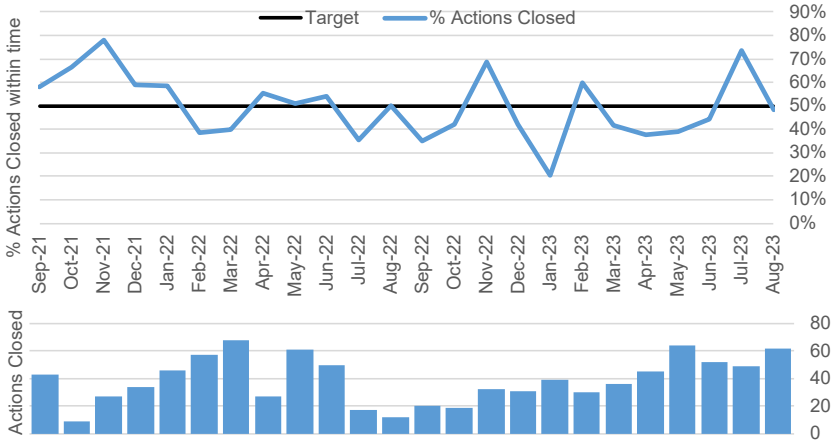
e. Performance Exception Reports

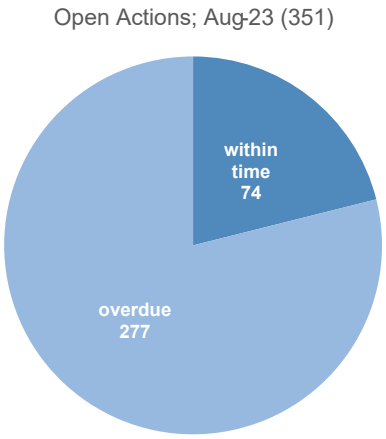
Adverse Events	Number 31





Actions from Significant and Local Adverse Event Reviews	Closure Rate 48.4%





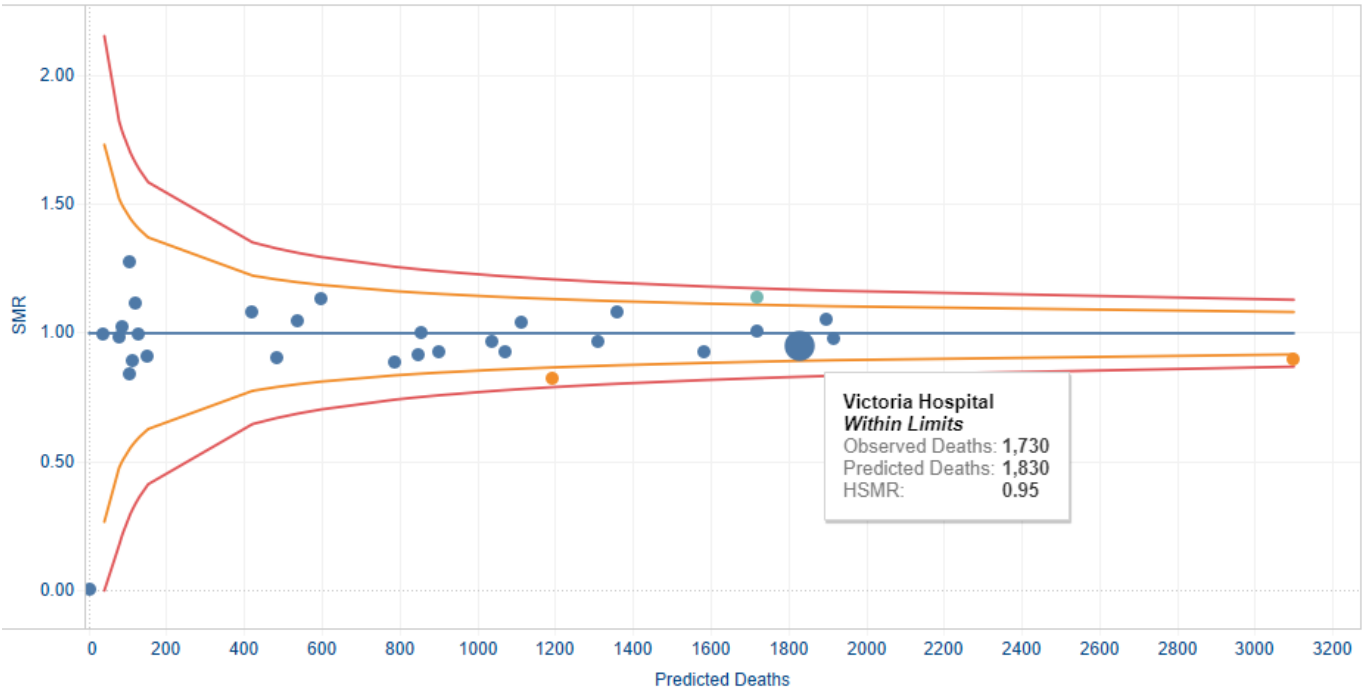
Key Deliverable		End Date
Off track / At risk / On track / Complete / Suspended		Proposed
Delivery of Clinical Governance Strategic Framework - Adverse Events		**Mar-24**
Key Milestones	Publication of updated Adverse Events Policy	Apr-23
	Adverse Events Management Resource Pack uploaded to Blink	Dec-23
	Deliver bespoke training session, where requested, to complement the e-learning package for review teams	Aug-23
	Facilitate short life working group to identify changes required to Datix action module	Mar-24
	Review and refresh of Datix Action Module to support improvement to the theming of action types to enhance identification and inform on themes of learning	Dec-23
	Implementation of updated Adverse Events policy and related procedures	Jan-24

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.*	**Performance 0.96**

Reporting Period: April 2022 to March 2023

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

Data for 2021 and 2022 demonstrates a return to a typical ratio for NHS Fife, with the data for year ending December 2022 showing a ratio below the Scottish average.

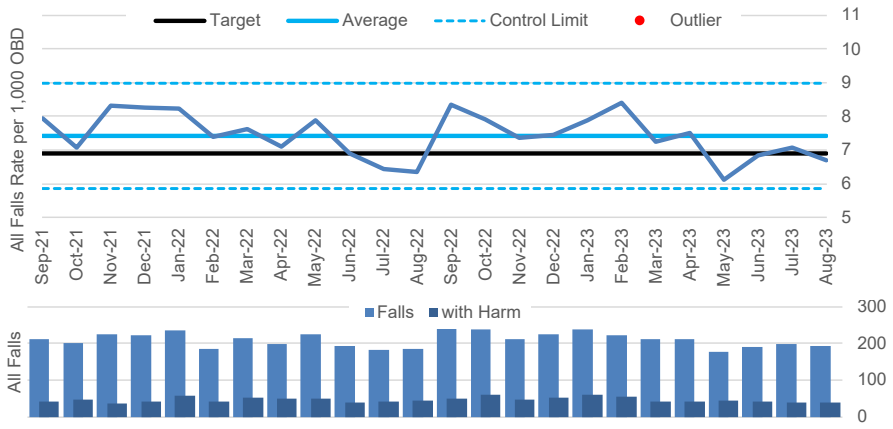
Inpatient Falls

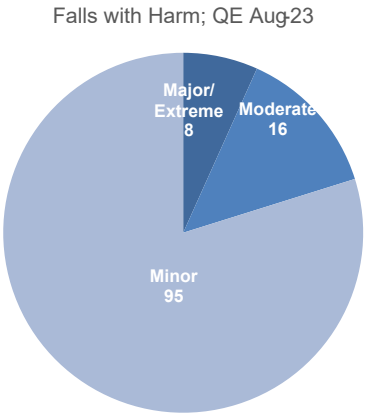
*Reduce **All Falls** rate across Acute & HSCP by 15%*

Target Rate (by end March 2024) = 6.95 per 1,000 Occupied Bed Days (OBD)

Performance 6.70

Local Performance





Performance by Service Area

	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
NHS Fife	8.34	7.90	7.37	7.44	7.88	8.39	7.24	7.50	6.12	6.83	7.08	6.70
Acute	9.33	7.53	8.21	7.20	8.22	9.73	6.52	8.90	5.70	6.76	6.33	7.51
HSCP	7.47	8.24	6.64	7.65	7.58	7.28	7.82	6.33	6.48	6.89	7.68	6.62

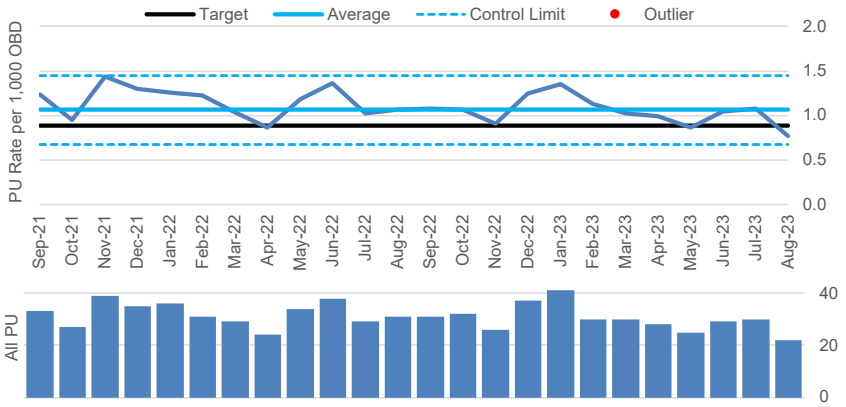
Key Deliverable		End Date
Off track / At risk / On track / Complete / Suspended		Proposed
Reduce Falls across all hospital inpatient setting		**Mar-24**
Key Milestones	Review and confirm falls link practitioners for each ward area on every hospital site.	Dec-23
	Ensure that falls related data is discussed and displayed in the ward to strengthen awareness across multi-disciplinary team.	Dec-23
	Rollout revised Falls toolkit including related policies e.g.: Boarding, Supervision, Bed rail.	Nov-23
	Support shared learning from incidents and share good practice	Dec-23
	Align all NHS work with the newly updated SPSP National Inpatient Falls driver diagrams	Dec-23
	Develop a national Falls education module within TURAS system	Mar-24
	Rollout new patient information leaflet and endeavour to audit the impact and benefit for patients	Dec-23
	Consider a Falls Co-ordinator Role to support the rollout of the revised toolkit and the Link Practitioners	Mar-24

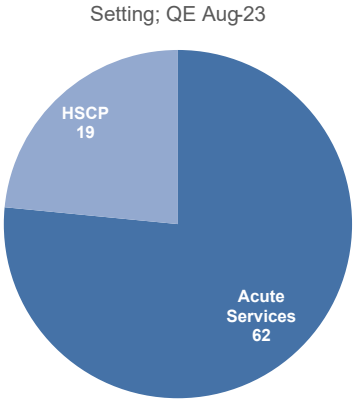
Pressure Ulcers

Reduce pressure ulcers (grades 2 to 4) developed in a healthcare setting
Target Rate (by end March 2024) = 0.89 per 1,000 OBD

Performance 0.89

Local Performance





Performance by Service Area

	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
NHS Fife	1.08	1.07	0.91	1.24	1.35	1.13	1.02	1.00	0.87	1.05	1.08	0.77
Acute	1.94	1.97	1.28	2.29	2.39	2.33	1.82	1.41	1.44	1.51	1.95	1.53
HSCP	0.32	0.25	0.59	0.32	0.44	0.14	0.37	0.65	0.38	0.66	0.39	0.20

Key Deliverable		End Date
Off track / At risk / On track / Complete / Suspended		Proposed
Reduce Pressure Ulcers (PU) developed on case load across all health care settings		**Mar-24**
Key Milestones	Acute TVNT - Provide training to over 1000 staff	Mar-24
	Acute TVNT - Re-launch the service (updating service spec, training resources, TVN link programme)	Jul-23
	Embed the use of the CAIR resource	Mar-24
	Embed the revised HIS Pressure Ulcer Standards (October 2020)	Mar-24
	Review of services and options for new service design	Mar-24

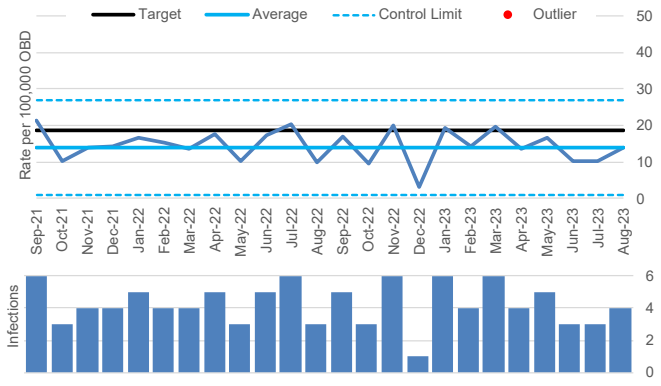
HAI/HCAI

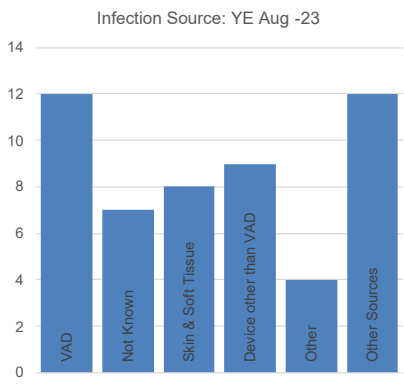
SAB

Reduce Hospital Infection Rate by 10% (baseline 2018/19) by the end of 2022/23

Performance 14.0

Local Performance





National Benchmarking

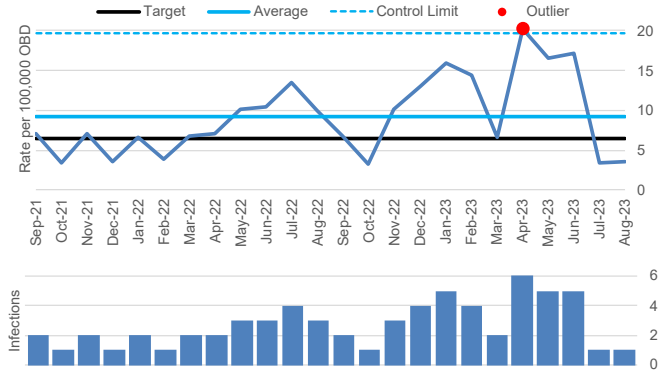
Quarter Ending	2020/21	2021/22				2022/23			
	Mar	Jun	Sep	Dec	Mar	Jun	Sep	Dec	Mar
NHS Fife	17.8	6.3	16.6	12.7	15.2	14.9	15.7	10.9	17.9
Scotland	18.4	18.6	18.3	17.3	16.3	17.3	17.1	19.2	19.1

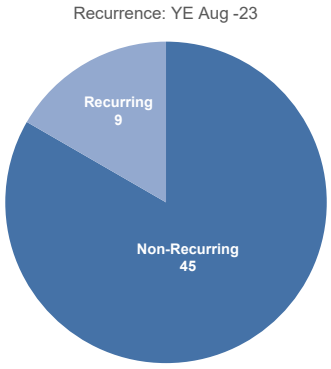
C Diff

Reduce Hospital Infection Rate by 10% (baseline 2018/19) by the end of 2022/23

Performance 3.5

Local Performance





National Benchmarking

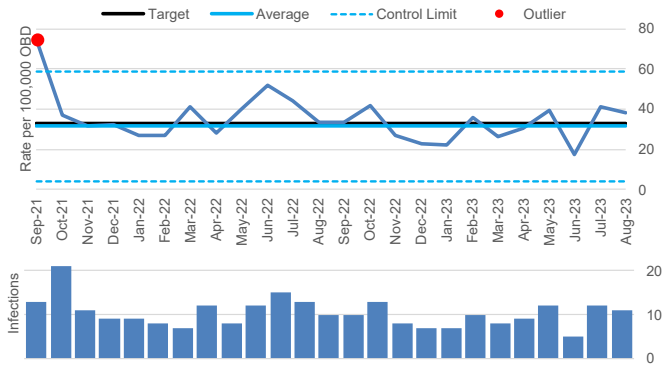
Quarter Ending	2020/21	2021/22				2022/23			
	Mar	Jun	Sep	Dec	Mar	Jun	Sep	Dec	Mar
NHS Fife	14.0	10.0	9.5	4.6	7.0	9.2	10.1	8.7	13.4
Scotland	15.8	14.6	16.8	13.3	12.6	14.3	13.1	13.5	13.4

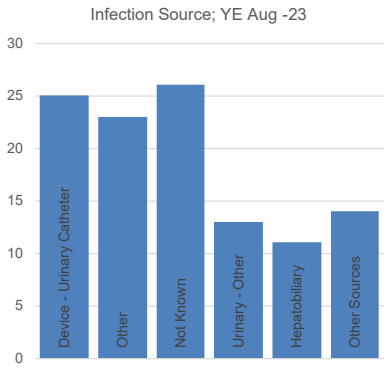
ECB

Reduce Hospital Infection Rate by 25% (baseline 2018/19) by the end of 2022/23

Performance 38.4

Local Performance





National Benchmarking

Quarter Ending	2020/21	2021/22				2022/23			
	Mar	Jun	Sep	Dec	Mar	Jun	Sep	Dec	Mar
NHS Fife	21.6	37.6	60.3	33.6	31.6	40.2	36.9	30.4	27.9
Scotland	34.7	38.2	41.5	34.1	30.5	34.8	36.2	34.5	37.3

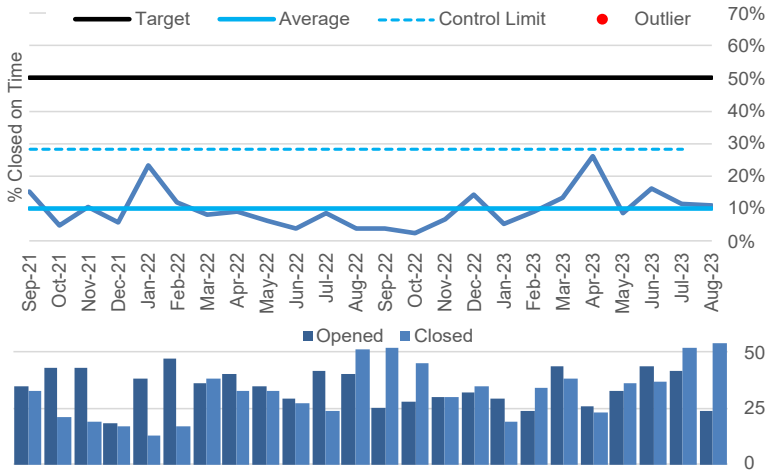
Key Deliverable		End Date
Off track / At risk / On track / Complete / Suspended		Proposed
Implement IPC Workforce Strategy 2022-24		**Sep-24**
Key Milestones	Complete a GAP analysis of the NHS Fife IPCT with regards to recommendations for local Boards	Apr-23
	Awaiting updates to national deliverables which are currently delayed. Recommendations 1, 9, 10,12, 14 and 15	Oct-23
	Engage with other key stakeholders outlined in the strategic plan (HPT and AMR) to begin discussions to determine roles and remits	Oct-23
	Oversight Board shall include an options appraisal of models of support for Primary Care and strategic plan developed. Including a subgroup, with collaboration with all key stakeholders (GP and Dental)	Dec-23
	Delivery date of September 2023 - SG to lead on discussions to improve quality and coverage of national - level workforce data for a functional IPC programme at the national and facility level	Mar-24
	Business case for additional resources and funding to be developed for consideration and Board approval	Oct-23
	Final implementation paper to be presented to February 2024 ICC	Feb-24
Implement IPC Interim Strategy 2023-25		**Apr-25**
Committed to controlling, reducing, and preventing Healthcare Associated Infections (HAI) and Antimicrobial Resistance (AMR) to maintain individual safety within our healthcare settings.		**Apr-24**
Key Milestones	Aim for the pilot of the eCatherter insertion and maintenance bundle to have been completed and plan for role out to other areas in NHS Fife	Mar-24
	Complete QI project with D&I to improve data capture of ePVC	Dec-23
	Support roll-out of eCatheter insertion and maintenance bundles	Dec-23

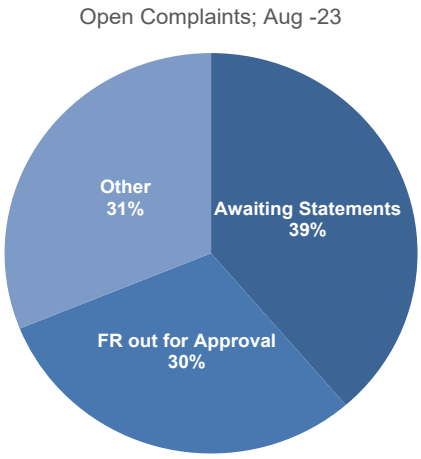
Complaints | Stage 2

At least 50% of Stage 2 complaints are completed within 20 working days by March 2023, rising to 65% by March 2024

Performance 11.5

Local Performance





Performance by Service Area

		Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
NHS Fife	Opened in Month	25	28	30	32	29	24	44	26	33	44	42	24
	% Acknowledged on time	96.0%	96.4%	93.3%	96.9%	100.0%	95.8%	97.7%	96.2%	97.0%	93.2%	90.5%	100.0%
	Due in Month	37	21	30	27	32	30	28	38	29	35	43	46
	% Closed on time	5.4%	4.8%	3.3%	14.8%	6.3%	13.3%	14.3%	15.8%	6.9%	17.1%	16.3%	10.9%
	Closed in Month	52	45	30	35	19	34	38	23	36	37	52	54
	% Closed on time	3.8%	2.2%	6.7%	14.3%	5.3%	8.8%	13.2%	26.1%	8.3%	16.2%	11.5%	11.1%
Acute	Closed in Month	34	29	22	26	17	23	23	16	27	23	43	36
	% Closed on time	0.0%	0.0%	9.1%	19.2%	5.9%	13.0%	13.0%	31.3%	7.4%	21.7%	11.6%	16.7%
HSCP	Closed in Month	16	16	7	9	2	10	15	7	9	14	6	18
	% Closed on time	6.3%	6.3%	0.0%	0.0%	0.0%	0.0%	13.3%	14.3%	11.1%	7.1%	0.0%	0.0%

Key Deliverable		End Date
Off track / At risk / On track / Complete / Suspended		Proposed
Adherence to the NHS Scotland Model Complaints Handling Procedures (DH 2017) and compliance with National targets		**Mar-24**
Key Milestones	PET to meet regularly with Acute and H&SCP to discuss Model Complaint Handling process improvements to assist with meeting target	Oct-23
	Implement complexity scoring system to categorise complaints	Oct-23
	Supportive escalation process to be implemented to highlight delays within the Model Complaint Handling Process	Dec-23
	New weekly complaint report to be created and shared with services to provide data and highlight delays within the Model Complaint Handling Process	Oct-23
	Testing of focused Multidisciplinary Team Meeting (MDT) within Acute to respond to complex complaints in a view to negate the requirement for statements and reduce service response time	Dec-23
Deliver Patient Experience focused work across NHS Fife, gathering patient feedback and lived experiences		**Apr-24**
Key Mileston	Review current Patient Experience Team's funded establishment to recruit a Bank Band 4 Patient Experience Officer 0.26 WTE	Oct-23
	Perform workforce review of Patient Experience Team	Oct-23

Digital Solution for reporting Live Patient Experience (Complaint) data		Apr-24
Key Milestones	Meet with Information Services to discuss and develop Dashboard	Apr-23
	Liaise with other Health boards regarding their Dashboards	May-23
	Discuss and agree data to be displayed with Acute, Corporate and H&SCP	Oct-23
	Discuss and agree data to be displayed within Patient Experience Team screen	Dec-23
	Identify test area prior to roll out	Dec-23
	Education and training	Dec-23
	Test implementation of dashboard	Nov-23
	Communication, promotion and raise awareness of dashboard	Jan-24
	Roll out Dashboard within NHS Fife	Jan-24

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**3 November 2023**
Title:	**Position statement- In patient Falls**
Responsible Executive:	**Janette Keenan, Director of Nursing**
Report Author:	**Norma Beveridge Director of Nursing Acute / Joy Reid Consultant Nurse for Older people**

1 Purpose

This is presented for:

- Assurance

This report relates to a:

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

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

An overview of in patient falls and work to reduce falls with harm in NHS Fife and H&SCP inpatient settings and promote safer mobilisation.

2.2 Background

The World Health Organisation notes falls are the second leading cause of unintentional injury deaths worldwide. Falls are generally not accidental but result of complex interplay between:

- Functional decline and the normal aging process
- Medical decline
- Social factors
- The environment

Falls are considered in two ways; those that don't result in any harm and those that incur harm.

The current falls definition used within Fife is the World Health Organisation definition which states *"A fall is defined as an event which results in a person coming to rest inadvertently on the ground or floor or other lower level."*

A fall with harm is defined by the Scottish Patient Safety Indicator (SPSI) as:
"Any instance where a fall with harm is identified. Harm will be where another secondary care intervention is necessary (steri-strip, suture, and/or management of dislocation, fracture, head injury, death), and/or a patient has fallen and received harm or injury requiring radiological investigation (x-ray, ultrasound, MRI or CT) with a confirmed harm."

Over the past year a national multi-professional group of falls experts has been working to develop a consensus definition of a fall and fall with harm which will be adopted by all NHS boards and HSCPs. This work was originally commissioned by SEND and has been co ducted in collaboration with HIS/SPSP and Excellence in Care. This involved a four round Delphi study and further questionnaires with a SLWG. The final definition will be agreed by early 2024 and shared across Scotland to allow effective data comparison across Scotland as currently regions are using different definitions.

Falls and fall-related injuries are a common and serious problem for older people. People aged 65 and older have the highest risk of falling, with 30% of people older than 65 and 50% of people older than 80 falling at least once a year (NICE 2013) * Falls can occur across a broader age range particularly where there are underlying conditions. Falls can result in the need for a stay in hospital and, when there is a fall in an in-patient setting it is likely to prolong an admission period and that comes with the associated impact on patient experience, additional risks because of a prolonged in patient stay as well as the financial implications.

**Falls in older people: assessing risk and prevention Clinical guideline [CG161] Published: 12 June 2013*

2.3 Assessment

Data
A monthly falls report from information services is shared with the In-Patient Falls Steering Group and cascaded through clinical structures to MDTs including SCNs in ward areas. Local awareness of this is evidenced through local audit on falls data being displayed for ward staff to review and consider for their area and subsequently supporting improvement activity. Table 1 and Table 2 are taken from the August 2023 report and illustrate the trends over the previous two years*.

When considering the data, it is important to consider data over time as there will be fluctuations month by month and the overall trend provides the direction of travel.

Table 1 - All Falls rate across all In-Patient settings

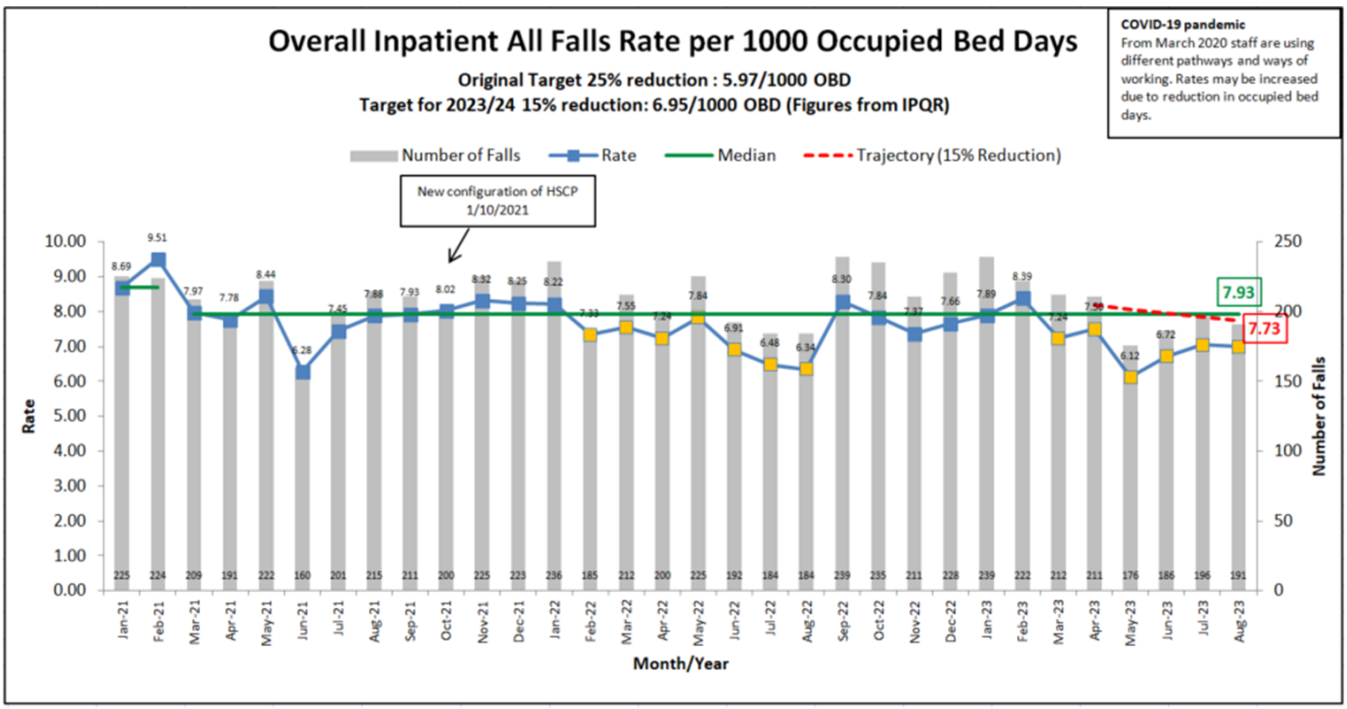
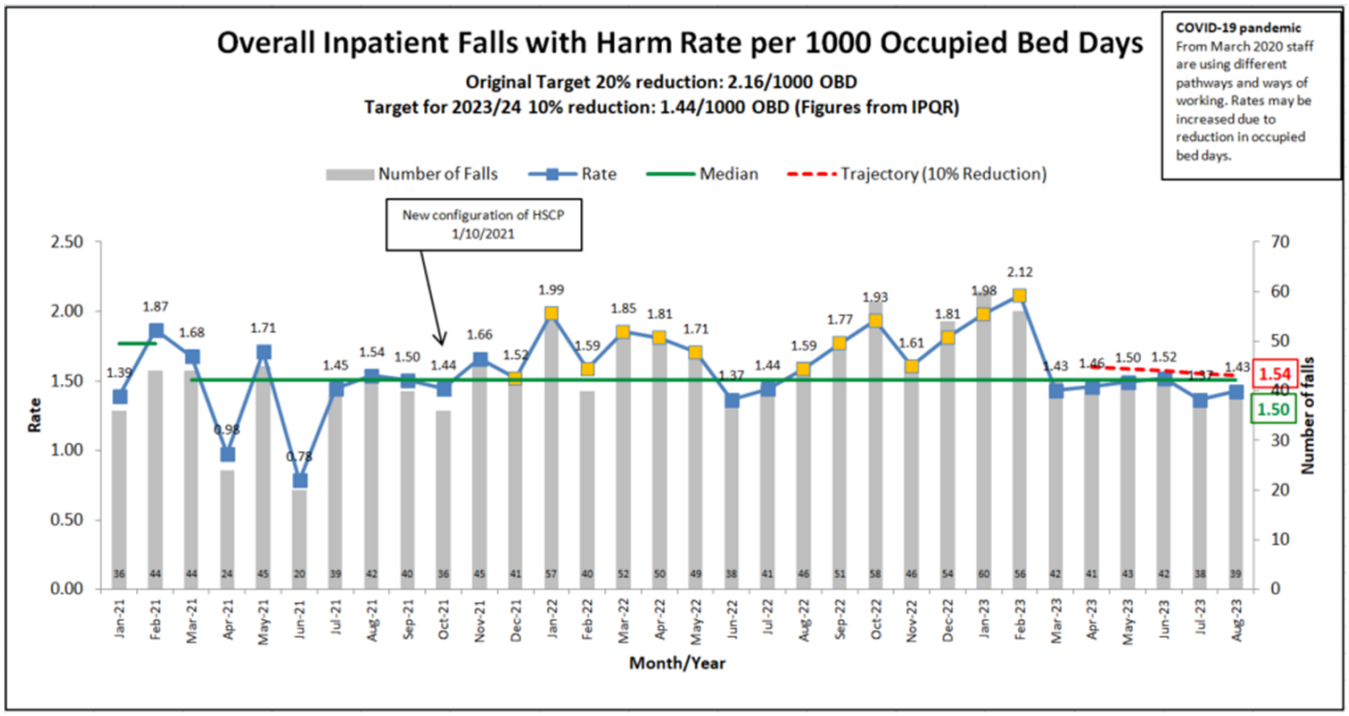


Table 2 - Falls with harm rate across all In-Patient settings



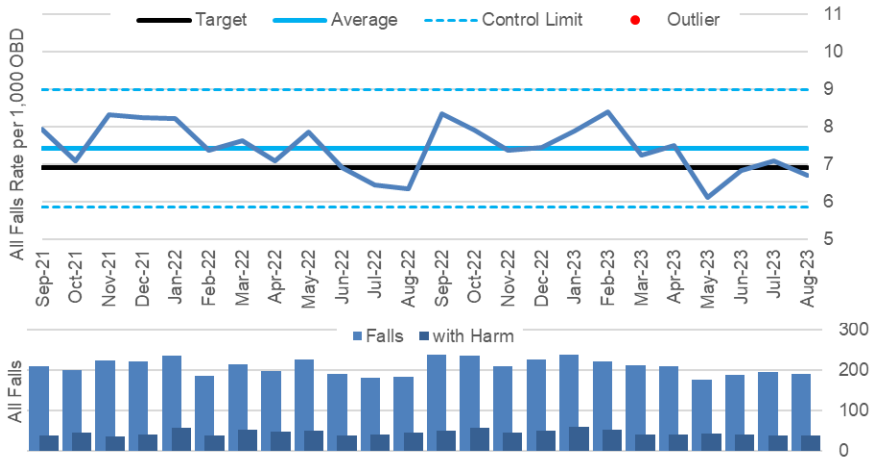
Integrated Performance & Quality Report (IPQR)

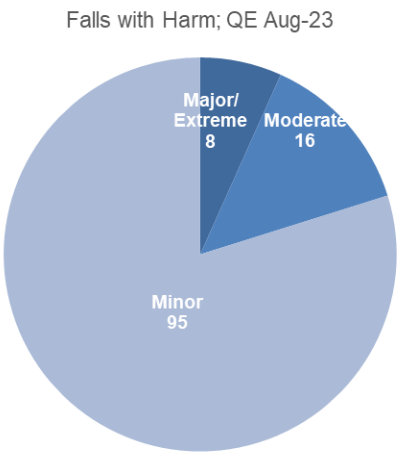
The IPQR data demonstrates an improving trend for all falls and falls with harm across NHS Fife.

All falls as of August 2023 was a rate of 6.7 (previous year 7.40)

Falls with harm as of August 2023 was a rate of 1.36 (previous year 1.64)

Table 3 extract from IPQR August 2023





**Rates are calculated by determining the numerator (total number of in patient falls for the month) and dividing it by the denominator (total number of occupied bed days for the month) then multiplying this figure by 1000 to give the number of falls per 1000 occupied bed days.*

The current national aim is to reduce all falls by 20% and falls with harm by 30% however Boards were asked to identify local targets based on local context. A review of the falls data in NHS Fife was undertaken and local target agreed to reflect realistic and achievable outcomes.

Local targets are a reduction to 6.95 (rate per occupied bed days) by end of March 2024 for All Falls representing a 15% reduction and to a rate of 1.44 of Falls with Harm by the same time which represents a 10% reduction.

Severity

With regard to harm it is important to recognise that the majority of falls within NHS Fife result in no harm or minor harm as demonstrated in data below.

NHS Fife reported 2582 falls in total (all severities) in the past 12 months

Patient Fall Category All Hospital Sites 011022 to 300923 - All Severities Site by Incident Date (Monthly)	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Total
Adamson Hospital	6	5	5	6	1	5	7	11	7	7	4	9	73
Cameron Hospital	18	10	11	17	8	8	4	9	9	4	9	4	111
Glenrothes Hospital	14	4	17	19	6	23	4	9	8	16	12	10	142
Lynebank Hospital	1	2	3	1	0	2	2	0	0	1	0	0	12
National Treatment Centre - Orthopaedics	0	0	0	0	0	0	0	0	1	4	4	5	14
Queen Margaret Hospital	40	36	56	50	48	48	43	26	32	38	15	28	460
Randolph Weymss Memorial Hospital	0	0	0	0	0	0	1	0	0	0	0	0	1
St. Andrews Community Hospital	19	17	8	10	13	7	10	17	15	15	20	12	163
Stratheden Hospital	33	29	19	25	28	34	28	24	35	39	41	23	358
Victoria Hospital	120	110	108	124	123	92	120	83	86	77	93	102	1238
Whyteman's Brae Hospital	2	1	2	0	1	0	0	3	0	0	0	1	10
Total	253	214	229	252	228	219	219	182	193	201	198	194	2582

Victoria Hospital had the highest number of falls (all severities) in the last 12 months (1238 falls) with 1003 resulting in no harm and 172 in minor harm.

Patient Fall Category All Hospital Sites 011022 to 300923 - All Severities Site by Severity	No outcome in terms of harm	Minor outcome in terms of harm	Moderate outcome in terms of harm	Major outcome in terms of harm	Total
Adamson Hospital	57	13	1	2	73
Cameron Hospital	71	26	5	9	111
Glenrothes Hospital	105	31	3	3	142
Lynebank Hospital	9	3	0	0	12
National Treatment Centre - Orthopaedics	12	0	2	0	14
Queen Margaret Hospital	344	100	10	6	460
Randolph Weymss Memorial Hospital	0	1	0	0	1
St. Andrews Community Hospital	124	34	1	4	163
Stratheden Hospital	253	90	11	4	358
Victoria Hospital	1003	172	29	34	1238
Whyteman's Brae Hospital	3	6	1	0	10
Total	1981	476	63	62	2582

Victoria hospital had the highest number of falls with no harm on the past 12 months with fluctuation in numbers month by month.

Patient Fall Category All Hospital Sites 011022 to 300923 - No Harm Site by Incident Date (Monthly)	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Total
Adamson Hospital	5	4	4	4	1	5	5	9	6	5	4	5	57
Cameron Hospital	14	5	9	10	1	7	3	6	4	3	8	1	71
Glenrothes Hospital	9	4	10	13	5	17	4	6	6	12	10	9	105
Lynebank Hospital	1	1	2	1	0	1	2	0	0	1	0	0	9
National Treatment Centre - Orthopaedics	0	0	0	0	0	0	0	0	1	4	4	3	12
Queen Margaret Hospital	29	28	43	33	35	41	31	21	23	32	10	18	344
St. Andrews Community Hospital	13	15	7	5	8	6	8	12	15	11	15	9	124
Stratheden Hospital	23	18	13	13	22	25	22	13	26	30	31	17	253
Victoria Hospital	92	90	86	106	100	73	101	67	68	63	78	79	1003
Whyteman's Brae Hospital	0	0	1	0	0	0	0	2	0	0	0	0	3
Total	186	165	175	185	172	175	176	136	149	161	160	141	1981

Similarly falls with harm fluctuate in number of the course of the past 12 months.

Patient Fall Category All Hospital Sites 011022 to 300923 - With Harm Site by Incident Date (Monthly)	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Total
Adamson Hospital	1	1	1	2	0	0	2	2	1	2	0	4	16
Cameron Hospital	4	5	2	7	7	1	1	3	5	1	1	3	40
Glenrothes Hospital	5	0	7	6	1	6	0	3	2	4	2	1	37
Lynebank Hospital	0	1	1	0	0	1	0	0	0	0	0	0	3
National Treatment Centre - Orthopaedics	0	0	0	0	0	0	0	0	0	0	0	2	2
Queen Margaret Hospital	11	8	13	17	13	7	12	5	9	6	5	10	116
Randolph Weymss Memorial Hospital	0	0	0	0	0	0	1	0	0	0	0	0	1
St. Andrews Community Hospital	6	2	1	5	5	1	2	5	0	4	5	3	39
Stratheden Hospital	10	11	6	12	6	9	6	11	9	9	10	6	105
Victoria Hospital	28	20	22	18	23	19	19	16	18	14	15	23	235
Whyteman's Brae Hospital	2	1	1	0	1	0	0	1	0	0	0	1	7
Total	67	49	54	67	56	44	43	46	44	40	38	53	601

The largest number of falls categorised as resulting in harm is graded as minor harm.

Patient Fall Category All Hospital Sites 011022 to 300923 - With Harm Site by Severity	Minor outcome in terms of harm	Moderate outcome in terms of harm	Major outcome in terms of harm	Total
Adamson Hospital	13	1	2	16
Cameron Hospital	26	5	9	40
Glenrothes Hospital	31	3	3	37
Lynebank Hospital	3	0	0	3
National Treatment Centre - Orthopaedics	0	2	0	2
Queen Margaret Hospital	100	10	6	116
Randolph Weymss Memorial Hospital	1	0	0	1
St. Andrews Community Hospital	34	1	4	39
Stratheden Hospital	90	11	4	105
Victoria Hospital	172	29	34	235
Whyteman's Brae Hospital	6	1	0	7
Total	476	63	62	601

Laceration or bruising/ swelling are the most frequent harms reported with only 20 falls resulting in a fracture.

Patient Fall Category All Hospital Sites 011022 to 300923 - With Harm Injury by Incident Date (monthly)	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Total
Abrasion	12	5	5	9	6	6	4	6	5	7	4	5	74
Bite	0	0	0	0	0	1	0	0	0	0	0	0	1
Bruise / Swelling	12	7	5	10	5	8	9	13	4	6	6	15	100
Burn / Scald	0	0	1	0	0	0	0	0	0	0	0	0	1
Concussion	2	0	0	0	0	0	0	0	0	0	0	0	2
Dislocation	1	1	0	0	0	0	0	0	0	0	1	0	3
Emotional Upset/Trauma	0	0	0	0	1	0	0	0	0	0	0	0	1
Fracture	3	1	3	1	3	1	2	3	1	1	1	0	20
Laceration	18	15	18	19	20	14	11	12	13	12	11	17	180
Musculoskeletal	0	1	1	2	0	0	1	1	1	1	0	1	9
Punch / Push	0	0	0	1	0	0	0	0	0	0	0	0	1
Spit	0	0	0	0	1	0	0	0	0	0	0	0	1
Sprain / Strain	0	1	1	0	3	0	0	0	3	0	0	2	10
Tissue Damage	4	4	3	4	2	2	2	1	2	1	2	2	29
Total	52	35	37	46	41	32	29	36	29	28	25	42	432

NOTE: Incidents can have multiple injuries logged

National Work

The national falls workstream, as part of the wider SPSP Acute Adult Collaborative National work is focussed on creating a culture for change for Falls in Scotland and a move towards falls reduction and safer mobilisation rather than Falls prevention. There is a desire to reframe the language we use around falls prevention and focus on prevention of deconditioning within care settings and promotion of activity particularly within hospital. Deconditioning can begin very early in a hospital admission, even within the first day and for older people one week in hospital would result in 20% loss of muscle strength, 10% reduction in aerobic capacity and 5 fold increase of requiring long term care following discharge (Manas et al 2020). Many other harms are associated with deconditioning including reduction in function (Arora and Dolan 2020). By promoting activity and exercise we can reduce the risk of falls by 23% (Sherrington et al 2020) however there is a perception that we are keeping patients safe by not allowing them, to mobilise and encouraging sedentary behaviour as a way of reducing falls (McCarter-Bayer et al 2005).

The National Falls Network and Falls Expert Group have recently reviewed and re-launched the National falls driver diagram and change package to reflect this change in language and how we consider positive risk taking as part of person centred care and safer mobilisation within our care settings. (Appendix 1) As part of the national work, SPSP ran webinar sessions for boards to consider how we should develop a culture for change for falls in Scotland sharing presentations from recognised experts in the field of promoting activity, safer mobilisation and prevention of deconditioning. This has been shared with colleagues across NHS Fife inpatient areas and will be reflected in our local work going forward.

The National Acute Falls Network meet virtually four times a year to share learning and practice. This is shared through the Inpatient Falls Group to clinical teams

This connects with local work and the plan to establish a multi-professional group to review and refresh the NHS Fife inpatient falls documentation, however due to challenges described and clinical pressures this has been delayed. The revised documentation will reflect the national change package.

Local Work

NHS Fife Inpatient Falls representatives have recently met with colleagues from SPSP and HIS and will now share our falls data so that we can participate in the shared learning across Scotland.

NHS Fife Falls toolkit update

SPSP in collaboration with national falls group developed a revised driver diagram and change package which highlighted key primary drivers to achieve the national and local aims of reducing falls and falls with harm. The primary drivers were:

- Person centred care
- Promote safer mobility
- Multidisciplinary team intervention and communication
- Leadership to promote a culture of safety

This driver diagram also aligns with the SPSP Essentials of Safe Care programme.

The existing toolkit required revision and a local short life multidisciplinary working group was set up to revise the existing documentation to support the principles of the new driver diagram and primary drivers, specifically around person centred care, acknowledging information will be captured in another way and not form part of the specific falls documentation. This included revising the Patient information leaflet to incorporate the importance of collaborative working with patients and carers and highlighting key things that can be done to reduce deconditioning and increase activity. The draft documentation has been tested across clinical areas within the acute hospital and the HSCP inpatient areas with positive feedback. There has been a delay in finalising the documentation due to changes in guidance related to post falls management. This documentation will be finalised in the next month and will be sent to the CG committee for approval prior to launch across the organisation in conjunction with the launch of the revised supervision documentation. (Appendix 2)

The revised documentation captures elements within other primary drivers such as Promote safer mobility and Multidisciplinary team intervention and communication.

Key elements	**NHS Fife Response**
Patient/family/carer involvement	Updated patient information leaflet (appendix 3)
Individualised assessment and early identification of those at risk	Frailty Screening Tool
Targeted evidence based falls risk reduction	Falls and bedrail assessment and intervention care plan Care Rounding Supervision protocol (now updated)
Regular review	Multidisciplinary falls and bedrail assessment and intervention care plan Post falls review

The purpose of this toolkit is to provide health care professionals working in the hospitals within NHS Fife the essential tools to identify patients who are at risk of falls in hospital; manage those who are at risk of falls and support and manage those who have had a fall in hospital.

Key factors in this process are the identification and management of risk. There are many different falls risk assessment tools available, and it is recognised in the literature that falls risk assessment tools vary in their sensitivity and specificity depending on the setting in which they are used. However, there is good evidence around multi-factorial risk assessment and intervention, and NHS Fife has aligned the falls risk assessment with an initial Fife Frailty Screen and every person who is admitted to a Fife hospital should be

screened for Frailty (this is now on Patientrack for all clinical areas and will be removed from the paper patient care records when they are reviewed)

The revised falls and bedrail assessment and intervention care plan must be completed on admission and transfer to a new clinical area to identify any changes to the patient's risk of falling.

As the frailty screen will now be completed solely on Patientrak once removed from the patient care records a request has been submitted to create a Frailty flag in Patientrack. This will allow clinical areas to identify easily those patients who are at higher risk of falls due to frailty.

If the patient is identified as a falls risk:

- a frailty assessment should be completed (comprehensive geriatric assessment or CGA)
- Falls and bedrail assessment intervention care plan should be initiated

Registered Nurses should implement appropriate comfort round frequency in relation to falls risk and this toolkit is used in all in patient settings in Fife.

A large aspect of improvement work focuses on compliance with this aspect.

Challenges

As highlighted in previous IPQR reports there are significant challenges in the current clinical context that have impacted on the progress on falls reduction. Many clinical areas are being staffed by a range of staff not familiar with the area and supplementary staffing. This can mean less familiarity with the toolkit and clinical environment as well as speciality Over and above this, clinical areas have been working with fewer staff and the ability to support formal update and education has also been impacted by the collective clinical pressures.

As a result of the pandemic and COVID restrictions there has been a significant increase in deconditioning of older people living in their own homes due to reduced physical activity and therefore an increase in frailty. This has led to an increase in falls and falls risk (Public Health England 2021). Locally there is also a growing sense that patients being admitted to hospital are frailer as a result of COVID restrictions and lack of physical activity and as part of discussions regarding staffing plans a higher acuity and dependency of patients has been observed. Deconditioning can quickly occur within the hospital setting and there has been work undertaken by Physiotherapy to encourage mobility and avoid sedentary behaviours. A poster has been developed for use across the organisation (Appendix 4).

In line with reduction in deconditioning and promotion of activity and safer mobilisation work is about to commence on the development of the active ward initiative which has been successfully developed in NHS GGC and also adopted in other boards across Scotland. The key principles for this initiative are:

Principle1: All patients and those involved in their care are supported to understand the benefits of being active in hospital and on discharge.

Principle 2: We take every opportunity to encourage patients to be physically active.
Principle 3: We minimise environmental barriers to promote physical activity^
Principle 4: We have a culture where enabling physical activity^ is everyone's* responsibility.

This will be led by our Physiotherapy team but in collaboration with the wider MDT piloted within one of our MOE wards with a plan to roll out more widely

Education

Falls education is encouraged for all staff working within NHS Fife. Manual Handling (patient handling) is a core skill requirement within TURAS and currently NES is working on developing a suite of modules as a "Once For Scotland" approach in relation to falls and bone health education. This is expected to be available by March 2024

Audit/ care assurance

There is a new Care Assurance programme being developed in the Acute Division which includes a documentation audit that supports a review of compliance with the Falls assessment and intervention process.

Examples of current activity describes workplan and meeting structure

- In line with the change in culture around falls and reframing the language the Inpatient Falls Steering group is considering a change of name to the Fife Inpatient Safer Mobility Oversight Group and has membership from inpatient services across the system with Nursing, AHP and Medical representation and is supported by a public member. There are now 2 operational action groups (Acute Inpatients and Community Inpatients) reporting into the Oversight Group. These groups will adopt the SPSP change package and national measurement plan
- Community and Acute Inpatient subgroups focus on specific specialties meet to drive local improvement and review activity and provide a Flash Report to update the steering group. Learning points are shared and any success is noted.
- A full network of falls champions/link practitioners will be re-established to champion this work As a result of staff movement and challenges noted as above this had become less robust with gaps in some areas.
- Development of more frequent data sets available at a number of levels to support more "real time" review. This is in place in the H&SCP and at time of writing is almost complete for the Acute Services Division.

Summary

This paper is intended to provide an illustration of the range of activity that considers the data, promotes, and supports action intended to reduce falls and in particular falls with harm. The challenges outlined have meant a change in progress toward 23/24 agreed target but the summary is presented to provide an overview for assurance to committee that this is an area that continues to be in focus across all in patient areas.

2.3.1 Quality/ Patient Care

Any fall but particularly a fall with harm will impact on the experience of care for the patient as well as the staff providing the care as there is a continued focus to reduce falls in spite of the challenges outlined.

2.3.2 Workforce

Ongoing workforce challenges have contributed to the progress to reduce falls with harm.

2.3.3 Financial

This paper does not seek to quantify specific costs but any extended stay in an inpatient setting as a result of a fall carries a financial implication

2.3.4 Risk Assessment/Management

Nothing specific to add beyond the risk management aspect of individual patients.

2.3.5 Equality and Diversity, including health inequalities

An impact assessment has not been completed as this improvement work is a consistent approach for all inpatients.

2.3.6 Other impact

The impact on the patient may include ongoing health care needs as well as their lifestyle due to both physical and psychological factors.

2.3.7 Communication, involvement, engagement and consultation

N/A

2.3.8 Route to the Meeting

This paper was produced as a result of a request by the NHSF Clinical Governance Committee for a Deep Dive into Falls within NHS Fife.

2.4 Recommendation

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

3 Appendices

Appendix 1: SPSP Acute Adult Programme Falls Reduction Change Package and measurement plan

Appendix 2: Draft version of NHS Fife/Fife HSCP Falls Toolkit

Appendix 3: Revised patient information leaflet

Appendix 4: Deconditioning poster NHS Fife

References:

Arora, A and Dolan, B (2020). Avoiding Deconditioning

Harvey J.A, et al (2018) What happened to my legs when I broke my arm? AIMS Medical Science 5(3), 252-258

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McCarter-Bayer A et al (2013). Preventing falls in acute care: an innovative approach. Journal of Gerontological Nursing 31(3), 25-33

Sherrington C et al (2020). Evidence on physical activity and falls prevention for people aged 65+ years: systematic review to inform WHO guidelines on physical activity and sedentary behaviour. International Journal of Behavioural Nutrition and Physical Activity 17, 144

https://assets.publishing.service.gov.uk/media/6114f852d3bf7f63b45df099/HEMT_Wider_Impacts_Falls.pdf

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SPSP Acute Adult Programme Falls Reduction Change Package

Improvement Hub
Enabling health and
social care improvement

Introduction

Welcome to the falls reduction change package

The aim of the falls change package is to provide evidence-based guidance to support the delivery of falls reduction for patients in acute hospital settings. A change package consists of a number of high-level outcomes supported by activities that when tested and implemented, bring about improvement. It brings together what is known about best practices and processes based on evidence from literature, research, and the experiences of others.

Why have we developed this change package?

This change package is for acute hospital teams participating in falls improvement work. It will support teams to use quality improvement methods to improve falls reduction in their service.

How it was developed?

This change package was co-designed and co-produced with clinical and quality improvement experts from NHS boards. The clinical experts were from a range of disciplines such as nursing, including Excellence in Care Leads, physiotherapy, occupational therapy and medicine. A Falls Expert Reference Group (ERG) was convened in October 2020 with representation from across NHS Scotland. A benefit of working in a virtual space was the inclusion and contribution from colleagues in remote, rural and island NHS boards.

Contents and how to use the package

What is included in this change package?

- Driver diagram
- Change ideas
- Guides, tools and signposts to the supporting evidence and examples of good practice, and
- Guidance to support measurement

Guidance on using this change package

This change package is a resource to support NHS boards with falls improvement work to reduce falls. It is not expected for teams to work simultaneously on all aspects of the driver diagram. It is designed to assist teams in the identification of areas for improvement relevant to their local context. The change ideas and measures are not exhaustive and it is expected that teams will develop their own to support their identified areas for improvement. We would encourage teams to seek support from their local quality improvement teams in the development of additional measures if required.

Using this package

This is an interactive document, if you click on the primary/secondary driver it will take you to additional information including tools and resources relating to that driver. At the top of each page of the secondary drivers, there is an arrow and home button . The arrow button will take you back to the primary driver page and the home button will take you to the main Driver Diagram page.

Project aim

Setting a project aim

All quality improvement projects should have an aim that is: **S**pecific, **T**ime bound, **A**ligned to the NHS board's objectives and **N**umeric (STAN).

The national aims for the SPSP Falls Improvement Programme are:

- Reduce inpatient falls by 20%
- Reduce inpatient falls with harm by 30%

by March 2024.

NHS boards are encouraged to set their own local aims specific to their context.

National Aim:

- reduce all falls by 20%
- reduce falls with harm by 30%

by Mar 2024

Local Aim:

- reduce all falls by ….
- reduce falls with harm by ….

by Mar 2024

Driver diagram and change ideas

What is a driver diagram?

A driver diagram visually presents an organisation or teams' theory of how an improvement goal will be achieved. It articulates which parts of the system need to change, in which way, and includes ideas of how to make this happen. It is used to help plan improvement projects and ensure team engagement.

The primary drivers are the key components of the system that need to change to deliver the aim. The secondary drivers are the processes that influence the primary drivers. Changing the processes outlined in the secondary drivers should change the primary drivers and deliver the aim.

Change ideas

Change ideas are specific practical changes the project team can make to alter the processes in the secondary drivers.
The following pages provide a list of change ideas for the early recognition and response for the prevention of falls. They are grouped by the primary driver that they influence. Project teams should select change ideas to implement. A range of change ideas will be needed to ensure there are changes to all primary drivers.

This change package does not contain an exhaustive list of change ideas. Project teams can also generate their own change ideas that will help drive change in the secondary drivers. One way of generating ideas is to use the question "How might we?" For example, "How might we engage with patients and their families to improve the experience of care when in hospital?"

2023 Falls Reduction Driver Diagram

What are we trying to achieve…	We need to ensure…	Which requires…
National Aim: • reduce all falls by 20% • reduce falls with harm by 30% by Mar 2024	Person centred care*	Patient and family inclusion and involvement* Individualised assessment Targeted evidence based falls risk interventions Regular review of falls risk interventions
	Promote safer mobility	Patient / family / carer involvement* Maintain a safe environment Meaningful activity Maximise opportunities for supported positive risk taking
Local Aim: • reduce all falls by …. • reduce falls with harm by …. by Mar 2024	Multidisciplinary Team intervention and communication*	Management of communication in different situations* Communication between primary and secondary care Multidisciplinary falls risk assessment and intervention
	Leadership to support a culture of safety*	Psychological safety* Staff wellbeing* Safe staffing* System for learning*

*Essentials of Safe Care

Primary Driver
Person centred care

Secondary drivers	Change ideas				
Patient and family inclusion and involvement	Provision of person centred visiting	Conversation with patient / family about falls history	Provide falls risk and safer mobility information to patient / family	What matters to you conversations to inform patient care	
Individualised assessment	Implementation of agreed tool for early identification of frailty *	Implementation of agreed tool for early identification of delirium *	Standard comprehensive assessment with multifactorial interventions	Local policy and procedure to support commencement of enhanced obs/1:1	Monitor patterns of behavior
Targeted evidence based falls risk interventions	Timely CGA	Implementation of agreed tool to manage delirium *	Delivery of person centred care planning documentation		
Regular review	Daily review of person centred care plan	Post-fall review and care plan updated	Structured ward round	Local policy and procedure to support review of and stopping enhanced obs/1:1	

Use of reliable tools

Person centred care

Patient and family inclusion and involvement

Provision of person centred visiting

Conversation with patient / family about falls history

Provide falls risk and safer mobility information to patient/ family

What matters to you conversations to inform patient care

Evidence and Guidelines:

- Ciufo D, Hader R, Holly C. University of York. A Comprehensive Systematic Review of Visitation Models in Adult Critical Care Units within the Context of Patient and Family-Centred Care [online] 2011; 9(4):362-387. https://www.crd.york.ac.uk/CRDWeb/ShowRecord.asp?ID=12012011211&ID=12012011211
- Luxford K, Axam A, Hasnip F et al. Improving Clinician Carer Communication for Safer Hospital Care: Study of 'TOP 5' Strategy Patients with Dementia [online] 2015; 27(3):175-182. https://academic.oup.com/intqhc/article/27/3/175/2357330
- Morris ME, Webster K, Jones C, Hill A-M, Haines T, et al. Interventions to reduce falls in hospitals: a systematic review and meta-analysis [online] 2022; 1;51(5). https://pubmed.ncbi.nlm.nih.gov/35524748/
- Scottish Government. Practicing Realistic Medicine: Chief Medical Officer for Scotland annual report [online] 2018; https://www.gov.scot/publications/practising-realistic-medicine/

Tools and Resources:

- Healthcare Improvement Scotland. Virtual Visiting [online]. 2020; https://www.hisengage.scot/virtual-visiting
- Hyslop B. 'Not safe for discharge'? Words, Values, and Person-Centred Care [online] 2020; https://academic.oup.com/ageing/article/49/3/334/5685757
- NHS Education for Scotland. The Health Literacy Place, Tools and Techniques [online] 2021; https://www.healthliteracyplace.org.uk/toolkit/techniques/
- NHS England. Always Events - Co-production using the Always Events® quality improvement methodology [online] 2021; https://www.england.nhs.uk/always-events/
- Picker. A toolkit for Improving Compassionate Care [online] 2017; https://picker.org/how-we-can-help/care-experience-tools/improving-compassionate-care/
- Scottish Government. Shared Decision Making in Realistic Medicine: What Works [online] 2019; https://www.gov.scot/publications/works-support-promote-shared-decision-making-synthesis-recent-evidence/pages/1/
- Scottish Government. Coronavirus (COVID-19): Hospital Visiting Guidance [online] 2022; https://www.gov.scot/publications/coronavirus-covid-19-hospital-visiting-guidance/
- Social Care Institute for Excellence. Care Planning, Involvement and Person-Centred Care [online]. 2017; https://www.scie.org.uk/mca/practice/care-planning/person-centred-care
- What Matters to you?. What Matters to you? [online] 2020; https://wmty.world/

Person centred care

Healthcare Improvement Scotland | Every Person Every Time 24/7 Scottish Patient Safety Programme

Individualised assessment | Implementation of agreed tool for early identification of frailty * | Implementation of agreed tool for early identification of delirium * | Standard comprehensive assessment with multifactorial interventions | Monitor patterns of behaviour | Local policy and procedure to support commencement of enhanced obs/1:1

Evidence and Guidelines:

- Graham C, Kasbauer S, Cooper R, King J, Sizmur S, et al. Health Services and Delivery Research. An Evaluation of a Near Real-time Survey for Improving Patients' Experiences of the Relational Aspects of Care [online] 2018; https://pubmed.ncbi.nlm.nih.gov/29595933/
- Healthcare Improvement Scotland. SIGN: Risk reduction and management of delirium [online] 2019; https://www.sign.ac.uk/sign-157-delirium
- Keuseman R, Miller D. A hospitalist's role in preventing patient falls [online] 2020; (16);15. https://www.tandfonline.com/doi/abs/10.1080/21548331.2020.1724473?journalCode=ihop20
- NICE. Comprehensive Geriatric Assessment NICE Quality standard QS136 [online] 2016; https://www.nice.org.uk/guidance/QS136/chapter/Quality-statement-2-Comprehensive-geriatric-assessment
- Royal College of Physicians. FallSafe resources - original [online] 2018; http://www.rcplondon.ac.uk/guidelines-policy/fallsafe-resources-original
- Tieges Z, Maclullich AMJ, Anand A, Brookes C, Cassarino M, et al. Diagnostic accuracy of the 4AT for delirium detection in older adults: systematic review and meta-analysis [online] 2021; 50(3):733-743 https://pubmed.ncbi.nlm.nih.gov/33951145
- World Falls Guidelines. World falls guidelines [online] 2022; https://worldfallsguidelines.com/

Tools and Resources:

- Afezolli D, Akpan A, Ardagh M, Arendts G, Banerjee J, et al. Silver book II in Holistic Assessment of Older People [online] 2021; https://www.bgs.org.uk/resources/resource-series/silver-book-ii
- Dalhousie University. Geriatric Medicine Research: Clinical Frailty Scale [online] 2005; https://www.dal.ca/sites/gmr/our-tools/clinical-frailty-scale.html
- Healthcare Improvement Scotland ihub Delirium Resources [online]; https://ihub.scot/improvement-programmes/acute-adult/older-people-in-acute-care/delirium/
- Healthcare Improvement Scotland ihub Frailty Resources [online]; https://ihub.scot/improvement-programmes/acute-adult/older-people-in-acute-care/frailty-at-the-front-door/
- James IA, Jackman L. Chapter 10 The Newcastle Model In James IA, Jackman L. Understanding Behaviour in Dementia that Challenges (2nd edn.). 2017. Jessica Kingsley Publishers. [online] https://www.researchgate.net/publication/340298479_The_Newcastle_Model
- Royal College of Physicians Acute Care Toolkit 3: Acute Care for Older People Living with Frailty [online] 2020; https://www.rcplondon.ac.uk/guidelines-policy/acute-care-toolkit-3-acute-care-older-people-living-frailty
- The 4at. Rapid Clinical Test for Delirium [online] 2022; https://www.the4at.com/

*Use of reliable tools

Person centred care

Healthcare Improvement Scotland | SCOTTISH PATIENT SAFETY PROGRAMME

Targeted evidence based falls risk interventions

Timely CGA

Implementation of agreed tool to manage delirium *

Delivery of person centred care planning documentation

Evidence and Guidelines:

- Coulter A, Entwistle V, Eccles A, Ryan S, Shepperd S et al. Personalised Care Planning for Adults with Chronic or Long-term Health Conditions [online] 2015:(3); https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD010523.pub2/full
- Ellis G, Gardner M, Tsiachristas A, Langhorne P, Burke O et al. Comprehensive Geriatric Assessment Older Adults Admitted to Hospital [online] 2017;(9); https://www.cochrane.org/CD006211/EPOC_comprehensive-geriatric-assessment-older-adults-admitted-hospital
- Healthcare Improvement Scotland SIGN: Management of Osteoporosis and the Prevention of Fragility Fractures [online] 2021; https://www.sign.ac.uk/our-guidelines/management-of-osteoporosis-and-the-prevention-of-fragility-fractures/
- Healthcare Improvement Scotland Care of Older People in Hospital Standards [online] 2015; https://www.healthcareimprovementscotland.org/our_work/standards_and_guidelines/stnds/opah_standards.aspx
- Sillner A, Holle C, Rudolph J. The Overlap Between Falls and Delirium in Hospitalized Older Adults: A Systematic Review [online] 2019; 35(2):221-236. https://pubmed.ncbi.nlm.nih.gov/30929884/
- World falls guidelines [online] 2022; https://worldfallsguidelines.com/

Tools and Resources:

- Bauernfreund Y, Butler M, Ragavan S, Sampson EL. TIME to think about delirium: improving detection and management on the acute medical unit [online] 2018; 7:(200); https://bmjopenquality.bmj.com/content/7/3/e000200.info
- Healthcare Improvement Scotland ihub SPSP Acute Adult - Falls Resources [online]; https://ihub.scot/improvement-programmes/acute-adult/spsp-acute-adult-collaborative-1/additional-programme-information-falls/
- My Home Life Scotland. Caring Conversations [online] 2021; https://myhomelife.uws.ac.uk/scotland/caring-conversations/
- NHS Education for Scotland. Realistic Medicine Module [online]; https://learn.nes.nhs.scot/18350/realistic-medicine
- NHS Education for Scotland Enhancing Person-centred Care [online]; https://www.effectivepractitioner.nes.scot.nhs.uk/clinical-practice/enhancing-person-centred-care.aspx
- Royal College of Physicians. Bedside Vision Check for Falls Prevention [online] 2017; https://www.rcplondon.ac.uk/projects/outputs/bedside-vision-check-falls-prevention-assessment-tool
- The 4AT. Guide to delirium care: detection, treatment, and prevention — 4AT - RAPID CLINICAL TEST FOR DELIRIUM (the4at.com) [online] 2022; https://www.the4at.com/deliriumguide/#top

*Use of reliable tools

Person centred care

Regular review

Daily review of person centred care planning documentation

Post-fall review and care plan updated

Structured ward round

Local policy and procedure to support review of and stopping enhanced obs/1:1

Evidence and Guidelines:

- Healthcare Improvement Scotland Care of Older People in Hospital Standards [online] 2015; https://www.healthcareimprovementscotland.org/our_work/standards_and_guidelines/stnds/opah_standards.aspx
- NICE Guideline Chapter 28 Structured Ward Rounds [online] 2017; https://www.nice.org.uk/guidance/ng94/documents/draft-guideline-28
- Royal College of Physicians FallSafe resources - original [online] 2018; http://www.rcplondon.ac.uk/guidelines-policy/fallsafe-resources-original
- Royal College of Physicians Supporting best and safe practice in post-fall management in inpatient settings [online] 2022; https://www.rcplondon.ac.uk/projects/outputs/supporting-best-and-safe-practice-post-fall-management-inpatient-settings
- World Falls Guidelines. World falls guidelines [online] 2022; https://worldfallsguidelines.com/

Tools and Resources:

- Clinical Excellence Commission Structured Ward Rounds – Patricia's Story [online YouTube] 2015; https://www.youtube.com/watch?v=fExlkV5jlUI
- Royal College of Physicians Modern Ward Rounds [online] 2021; https://www.rcplondon.ac.uk/projects/outputs/modern-ward-rounds

Primary Driver
Promote safer mobility

Secondary drivers	Change ideas			
Patient / family / carer involvement	What matters to you conversations to inform patient care	Personal outcomes discussions	Family involvement in therapy sessions	Promote 'reconditioning' with patient / family / carers
Maintain a safe environment	Work station positions for close observation of people at risk of falls	Seats placed around the ward for patients to rest	Bed rail assessment to inform plan of care	Test 'call don't fall' initiatives
Meaningful activity	Planned activity delivered by use of volunteers	Risk enablement to encourage patient mobility	Group based exercise/activity programmes	
Maximise opportunities for supported positive risk taking	Activities displayed around ward e.g. sit to stands at bed space	Communication of patient mobility needs e.g I Can	Daily plan for patients to get up and dressed	Individualised prescribed mobility plans with visual exercise prompts

Promote safer mobility

Healthcare Improvement Scotland | Scottish Patient Safety Programme

Patient / family / carer involvement | What matters to you conversations to inform patient care | Personal outcomes discussions | Family involvement in therapy sessions | Promote 'reconditioning' with patient/family/carers

Evidence and Guidelines:

- Avanecean D, Calliste D, Contreras T, Yeogyeong L, Fitzpatrick. Effectiveness of Patient-centered Interventions on Falls in the Acute Care Setting Compared to Usual Care: A Systematic Review [online] 2017; 15(12); https://journals.lww.com/jbisrir/Abstract/2017/12000/Effectiveness_of_patient_centered_interventions_on.14.aspx
- Harvey J A, Chastin S FM, Skelton D. What Happened to my Legs when I Broke my Arm [online] 2018; 5(3): 252-258. http://www.aimspress.com/article/10.3934/medsci.2018.3.252
- Liu B, Moore J, Ummukulthum A, Wai-Hin C, Khan S, et al. Outcomes of Mobilisation of Vulnerable Elders in Ontario (MOVE ON): A Multisite Interrupted Time Series Evaluation of an Implementation Intervention to Increase Patient Mobilisation [online] 2018; 47(1) 112-119; https://academic.oup.com/ageing/article/47/1/112/3970847
- Rossiter C, Levett-Jones T, Pich J. The Impact of Person-centred Care on Patient Safety: An Umbrella Review of Systematic Reviews [online] 2020; 109:103658; https://pubmed.ncbi.nlm.nih.gov/32593882/#:~:text=The%20selected%20reviews%20examined%20the%20impact%20of%20person-centred,often%20demonstrating%20limited%20evidence%20of%20impact%20on%20safety.
- The Royal Health Foundation Person Centred Care: from Ideas to Action [online] 2014; https://www.health.org.uk/publications/person-centred-care-from-ideas-to-action

Tools and Resources:

- British Geriatrics Society. Deconditioning information for providers of services for older people and the public [online] 2022; https://www.bgs.org.uk/resources/deconditioning-information-for-providers-of-services-for-older-people-and-the-public
- Healthcare Improvement Scotland What Matters to You [online] 2021; https://wmty.world/
- Health Service 360 The Last 1000 days [online] 2022
- Moving Medicine. Hospital Associated Deconditioning - Moving Medicine [online] 2022; https://movingmedicine.ac.uk/consultation-guides/condition/adult/hospital-associated-deconditioning-2/
- Realistic Medicine. Shared decision making, reducing harm, waste and tackling unwarranted variation [online] 2023; https://www.realisticmedicine.scot/
- Royal College of Physicians. Falls Prevention in Hospital: a Guide for Patients, their Families and Carers [online] 2016; https://www.rcplondon.ac.uk/projects/outputs/falls-prevention-hospital-guide-patients-their-families-and-carers
- Arora A, Dolan B. (2021) Avoiding Deconditioning in O'Hanlon S, Smith M (Eds) A comprehensive guide to rehabilitation. London, Elseiver (4edn) (Free book chapter) [online] 2021; https://ihub.scot/media/9706/arora-dolan-2021-avoiding-deconditioning-chapter.pdf

Promote safer mobility

Healthcare Improvement Scotland | Every Person Every Time | Scottish Patient Safety Programme

Maintain a safe environment

Work station positions for close observation of people at risk of falls

Seats placed around the ward for patients to rest

Bed rail assessment to inform plan of care

Test 'call don't fall' initiatives

Evidence and Guidelines:

- Cameron ID, Dyer SD, Panagoda CE, Murray GR, Hill K, et al. Interventions for Preventing Falls in Older People in Care Facilities and Hospitals [online] 2018; 2018(9); https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6148705/
- Hartung B, Lalonde M. The Use of Non-slip Socks to Prevent Falls among Hospitalized Older Adults: A Literature Review [online] 2017; 38(5):412-416. https://pubmed.ncbi.nlm.nih.gov/28285830/
- Brewer B, Carley K, Reminga J, Benham-Hutchins M, Effken J A. Nursing Unit Design, Nursing Staff Communication Networks, and Patient Falls: Are they Related? HERD; [online] 2018; 11(4): 82-94 https://journals.sagepub.com/doi/full/10.1177/1937586718779223
- Royal College of Physicians and Clinical Medicine. Morris R, O'Riordan S. Prevention of Falls in Hospital [online] 2017; 17(4): 360–362. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6297656/#__ffn_sectitle

Tools and Resources:

- Ali U M, Judge A, Foster C, Brooke A, James K, et al. Do Portable Nursing Stations within Bays of Hospital Wards Reduce the Rate of Inpatient Falls [online] 2018; https://academic.oup.com/ageing/article/47/6/818/5054440
- Royal College of Physicians. Fall Safe Resources – Bed Rail Assessment [online] 2022; https://www.rcplondon.ac.uk/guidelines-policy/fallsafe-resources-original
- UK Government Bed Rails: Management and Safe Use [online] 2021; https://www.gov.uk/guidance/bed-rails-management-and-safe-use

Promote safer mobility

Healthcare Improvement Scotland | Scottish Patient Safety Programme

Meaningful activity | Planned activity delivered by use of volunteers | Risk enablement to encourage patient mobility | Group based exercise/activity programmes

Evidence and Guidelines:

- Liu B, Moore J, Ummukulthum A, Wai-Hin C, Khan S, et al. Outcomes of Mobilisation of Vulnerable Elders in Ontario (MOVE ON): A Multisite Interrupted Time Series Evaluation of an Implementation Intervention to Increase Patient Mobilisation [online] 2018; 47(1) 112-119; https://academic.oup.com/ageing/article/47/1/112/3970847
- Royal College of Occupational Therapists Occupational Therapy in the Prevention and Management of Falls in Adults [online] 2020; https://www.rcot.co.uk/practice-resources/rcot-practice-guidelines/falls
- Thomas E, Battaglia G, Patti A, Brusa J, Leonardi V, et al. Physical Activity Programs for Balance and Fall Prevention in Elderly: A systematic Review [online] 2019; 98(27):pe16218; https://journals.lww.com/md-journal/Fulltext/2019/07050/Physical_activity_programs_for_balance_and_fall.47.aspx
- Tricco A, Thomas SM, Veroniki AA, et al. Comparisons of Interventions for Preventing Falls in Older Adults: A Systematic Review and Meta-analysis [online] 2017; 318(17):1687-1699. https://jamanetwork.com/journals/jama/fullarticle/2661578

Tools and Resources

- Care Inspectorate Care about Physical Activity [online]; http://www.capa.scot/
- McInally L, Black F. Using Activity Passports to Support People to Improve their Health and Wellbeing [online] 2018; https://www.careopinion.org.uk/blogposts/753/thinkactivity---using-activity-passports-to-s
- Care Opinion, McInally L. Improving Patient Activity in Hospital [online] 2017; https://www.careopinion.org.uk/blogposts/646/improving-patient-activity-in-hospital
- Faculty of Sport and Exercise Medicine UK. Moving Medicine [online] 2021; https://movingmedicine.ac.uk/
- Public Health England, UK Government. Active Hospitals [online] 2020; https://www.gov.uk/government/case-studies/active-hospitals
- The King's Fund The Role of Volunteers in the NHS [online] 2018; https://www.kingsfund.org.uk/publications/role-volunteers-nhs-views-front-line
- The King's Fund Volunteering in Health and Care [online] 2013; https://www.kingsfund.org.uk/publications/volunteering-health-and-care

Promote safer mobility

Maximise opportunities for supported positive risk taking

Activities displayed around ward
e.g. sit to stand at bed space

Communication of patient mobility needs
e.g. I Can

Daily plan for patients to get up and dressed

Individualised prescribed mobility plans with visual exercise prompts

Evidence and Guidelines:

- Wald HL, Ramaswamy R, Perskin MH, Roberts L, Bogaisky M, Suen W, Mikhailovich. The Case for Mobility Assessment in Hospitalized Older Adults American Geriatric Society [online] 2018; https://agsjournals.onlinelibrary.wiley.com/action/downloadSupplement?doi=10.1111%2Fjgs.15595&file=jgs15595-sup-0002-supinfo.pdf
- Hartung B, Lalonde M. The Use of Non-slip Socks to Prevent Falls among Hospitalized Older Adults: A Literature Review [online] 2017; 38(5):412-416. https://pubmed.ncbi.nlm.nih.gov/28285830/
- NIHR Older People & Frailty Policy Research Unit. COVID-19 Technology for Strength and Balance [online] 2021; https://www.opfpru.nihr.ac.uk/our-research/covid-19-research/technology-for-strength-and-balance/
- Taylor N, Harding K, Dennett A, Febrey S, Warmoth K, et al. Behaviour change interventions to increase physical activity in hospitalised patients: a systematic review, meta-analysis and meta-regression [online] 2022; 51(1):afab154; https://pubmed.ncbi.nlm.nih.gov/34304267/

Tools and Resources:

- End PJ Paralysis [online] 2020; https://endpjparalysis.org/
- Faculty of Sport and Exercise Medicine UK. Moving Medicine [online] 2021; https://movingmedicine.ac.uk/
- NHS England East of England's Deconditioning Games [online]; https://www.england.nhs.uk/east-of-england/east-of-englands-deconditioning-games/
- The Chartered Society of Physiotherapy East Kent trust rolls-out 'I can' scheme to help mobilise and empower patients [online] 2019; https://www.csp.org.uk/news/2019-08-15-east-kent-trust-rolls-out-i-can-scheme-help-mobilise-empower-patients

Primary Driver
Multidisciplinary Team intervention and communication

Secondary drivers	Change ideas					
Management of communication in different situations	Highlight falls related safety issues during hospital huddles	Ward safety briefs to highlight issues and concerns	Use of standardised communication tools * to reduce risk with transitions of care			
Communication between primary and secondary care	Test mechanisms for all inpatient falls communicated via Immediate Discharge Letter	Standardised handover from ambulance to hospital	Joint primary and secondary care falls groups			
Multidisciplinary Team falls risk assessment and intervention	Multidisciplinary Team standard comprehensive assessment	Multidisciplinary Team multifactorial interventions	Polypharmacy reviews e.g. adopt 7 steps	Multidisciplinary Team ward huddles	Assess concerns about falling *	Assess and treat orthostatic hypotension

Use of reliable tools

Multidisciplinary Team intervention and communication

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Management of communication in different situations

Highlight falls related safety issues during hospital huddles

Ward safety briefs to highlight issues and concerns

Use of standardised communication tools * to reduce risk with transitions of care

Evidence and Guidelines:

- Jones K, Crowe J, Allen J, Skinner A, High R, et al. The Impact of Post-fall Huddles on Repeat Fall Rates and Perceptions of Safety Culture: A Quasi-experimental Evaluation of a Patient Safety Demonstration Project [online] 2019, 19:650; https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-019-4453-y
- Muller M, Jurgens, J, Redaelli M, Klingberg K, Hautz WE, et al. Impact of the Communication and Patient Hand-off Tool SBAR on Patient Safety: A Systematic Review [online] 2018; 8:e022202; https://bmjopen.bmj.com/content/bmjopen/8/8/e022202.full.pdf
- Nagrecha R, Sing Rait J, McNairn K. Weekend Handover: Improving Patient Safety During Weekend Services [online] 2020; 56:77-81; https://www.sciencedirect.com/science/article/pii/S2049080120301412#:~:text=Weekend%20handovers%20are%20a%20valuable%20tool%20to%20increase,one%20of%20the%20most%20high-risk%20processes%20within%20medicine.
- Royal College of Physicians. Supporting best and safe practice in post-fall management in inpatient settings [online] 2022; https://www.rcplondon.ac.uk/projects/outputs/supporting-best-and-safe-practice-post-fall-management-inpatient-settings
- Ryan S, Ward M, Vaughan D, Murray B, Zena M, et al. Do Safety Briefings Improve Patient Safety in the Acute Hospital Setting? A Systematic Review [online] 2019; 75(10); 2051-2259; https://onlinelibrary.wiley.com/doi/full/10.1111/jan.13984

Tools and Resources:

- 1000 Lives Plus, NHS Wales Tools for Improvement - Improving Clinical Communication Using SBAR [online] 2011; https://documents.pub/document/improving-clinical-communication-using-sbar-1000-lives-plus.html?page=1
- East London NHS Foundation Trust SBAR - Situation-Background-Assessment-Recommendation [online] 2008; https://qi.elft.nhs.uk/resource/sbar-situation-background-assessment-recommendation/
- Institute for Healthcare Improvement Safety Briefings [online]; https://www.ihi.org/resources/Pages/Changes/ConductSafetyBriefings.aspx
- Institute for Healthcare Improvement Huddles [online]; https://www.ihi.org/resources/Pages/Tools/Huddles.aspx
- NHS Education Scotland QI Tools – SBAR [online] 2022; https://learn.nes.nhs.scot/3408/quality-improvement-zone/qi-tools/sbar

Multidisciplinary Team intervention and communication

Communication between primary and secondary care

Test mechanisms for all inpatient falls communicated via Immediate Discharge Letter

Standardised handover from ambulance to hospital

Joint primary and secondary care falls groups

Evidence and Guidelines:

- Healthcare Improvement Scotland. SIGN – The SIGN Discharge Document [online] 2012; https://www.sign.ac.uk/media/1066/sign128.pdf

Tools and Resources:

- NHS Health Scotland Up and About [online] 2019; https://www.healthscotland.com/uploads/documents/23464-Up%20and%20about-Taking%20positive%20steps%20to%20avoid%20trip%20and%20falls-April%202019-English.pdf
- Social Care Institute for Excellence. Delivering integrated care: the role of the multidisciplinary team [online] 2022; https://www.scie.org.uk/integrated-care/workforce/role-multidisciplinary-team

Multidisciplinary Team intervention and communication

Healthcare Improvement Scotland | Scottish Patient Safety Programme

Multidisciplinary Team falls risk assessment and intervention | Multidisciplinary Team standard comprehensive assessment | Multidisciplinary Team multifactorial interventions | Polypharmacy reviews e.g. adopt 7 steps | Multidisciplinary Team ward huddles | Assess concerns about falling * | Assess and treat orthostatic hypotension

Evidence and Guidelines:

- Delbaere K, Close JCT, Mikolaizak, S, Sachdev PS, Brodaty H, et al. The Falls Efficacy Scale International (FES-I): A comprehensive longitudinal validation study. Age and Ageing [online] 2010; 39(2): 210-216; https://academic.oup.com/ageing/article/39/2/210/40898
- Frith J. The association of orthostatic hypotension with falls—an end to the debate? Age and Ageing [online] 2017; 46(4)540-541; https://academic.oup.com/ageing/article/46/4/540/3748456
- Hartog LC, Schrijnders D, Landman GWD, Groenier K, Kleefstra N, et al. Is orthostatic hypotension related to falling? A meta-analysis of individual patient data of prospective observational studies Age and Ageing [online] 2017; 46(4):568-575; https://academic.oup.com/ageing/article/46/4/568/3052927
- RCPCH Implementing Multidisciplinary Ward Safety Huddles To Improve Situation Awareness [online] 2019; https://qicentral.rcpch.ac.uk/resources/safety/implementing-multidisciplinary-ward-safety-huddles-to-improve-situation-awareness-the-royal-free-hospital-experience/
- World falls guidelines [online] 2022; https://worldfallsguidelines.com/

Tools and Resources:

- Gibbon J, Frith J. PHSI Orthostatic Hypotension: a pragmatic guide to diagnosis and treatment Drug Ther Bull. [online]; https://dtb.bmj.com/content/58/11/166.long
- NHS Scotland 7 steps to appropriate polypharmacy NHS Scotland [online] 2022; https://managemeds.scot.nhs.uk/for-healthcare-professionals/7-steps/#:~:text=7%20Steps%201%20Step%201%3A%20What%20matters%20to,and%20able%20to%20take%20drug%20therapy%20as%20intended%3F
- Royal College of Occupational Therapists Occupational Therapy in the Prevention and Management of Falls in Adults [online] 2020; https://www.rcot.co.uk/practice-resources/rcot-practice-guidelines/falls
- Royal College of Physicians Measurement of lying and standing blood pressure: A brief guide for clinical staff [online] 2017; https://www.rcplondon.ac.uk/projects/outputs/measurement-lying-and-standing-blood-pressure-brief-guide-clinical-staff
- The Chartered Society of Physiotherapy Clinical Update: Preventing Falls in Hospital [online] 2017; https://www.csp.org.uk/frontline/article/clinical-update-preventing-falls-hospital
- The University of Manchester Falls Efficacy Scale International [online] 2006; https://sites.manchester.ac.uk/fes-i/

***Use of reliable tools**

Primary Driver
Leadership to support a culture of safety

Secondary drivers	Change ideas			
Psychological safety	Structured 1:1 time	Process to access senior support and discussion	Structured hospital huddles to raise concerns	
Staff wellbeing	Listening to the workforce and identifying areas for improvements	Test ideas for improvements in a timely manner	Celebrate success	Use of standardised feedback tools e.g. iMatter
Safe staffing	Staff education and awareness	Mechanism for effective rostering	Process for mitigation of staffing shortfalls	Process to escalate staffing shortfalls which impact on safe delivery of care
System for learning	Post-falls staff debrief	Quality improvement and measurement support	Involvement of falls coordinators in improvement work	Establish local falls groups with MDT representation

Leadership to support a culture of safety

Psychological safety

Structured 1:1 time

Process to access senior support and discussion

Structured hospital huddles to raise concerns

Evidence and Guidelines:

- Grailey KE, Murray E, Reader T, Brett SJ. The presence and potential impact of psychological safety in the healthcare setting: an evidence synthesis. BMC Health Services Research [online] 2021;21(1):773; https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-021-06740-6
- Institute of Healthcare Improvement. Three ways to create psychological safety by Amy Edmondson [online] [video] 2022; https://www.youtube.com/watch?v=jbLjdFqrUNs
- O'Donovan R, McAuliffe E. A systematic review of factors that enable psychological safety in healthcare teams Int J Qual Health Care [online] 2020; (4):240-250; https://academic.oup.com/intqhc/article/32/4/240/5813852

Tools and Resources:

- Edmondson A The importance of psychological safety [online] [video] 2021; https://www.youtube.com/watch?v=eP6guvRt0U0
- Healthcare Improvement Scotland Leadership Walk-rounds and Safety Conversations [online]; https://ihub.scot/project-toolkits/safety-principles/safety-principles/leadership-and-culture-principle/leadership-walk-rounds-and-safety-conversations/
- Healthcare Improvement Scotland Essentials of Safe Care, Readiness for Change Assessment & Prioritisation Tool [online] 2021; https://ihub.scot/media/8197/20210308-eosc-readiness-tool-v012.pdf
- Institute for Healthcare Improvement Why Is Psychological Safety So Important in Health Care? [online] 2022; http://www.ihi.org/education/IHIOpenSchool/resources/Pages/AudioandVideo/Amy-Edmondson-Why-Is-Psychological-Safety-So-Important-in-Health-Care.aspx - new reference
- West M, Eckert R, Collins B, Chowla R. Caring to change: how compassionate leadership can stimulate innovation in health care [online] 2017; https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Caring_to_change_Kings_Fund_May_2017.pdf

Leadership to support a culture of safety

Staff wellbeing

Listening to the workforce and identifying areas for improvements

Test ideas for improvements in a timely manner

Celebrate success

Use of standardised feedback tools e.g. imatter

Evidence and Guidelines:

- NHS Education for Scotland National Trauma Training Programme [online] 2020; https://www.nes.scot.nhs.uk/news/the-national-trauma-training-programme-nttp/
- Perlo j, Balik B, Swensen S, Kabcenell A, Landsman J, et al. Institute for Healthcare Improvement Framework for Improving Joy in Work [online] 2017; https://www.ihi.org/resources/Pages/IHIWhitePapers/Framework-Improving-Joy-in-Work.aspx

Tools and Resources:

- NHS Education for Scotland and Healthcare Improvement Scotland ihub Ready to Lead: Lesson 7 – Celebrating Success webpage [online] [video] 2021; https://ihub.scot/project-toolkits/ready-to-lead/ready-to-lead/lesson-7-celebrating-success/
- National Wellbeing Hub National Wellbeing Hub for Health and Social Care Staff [online]; https://wellbeinghub.scot/
- Picker Institute Europe Understanding staff wellbeing, its impact on patient experience and healthcare quality [online] 2015; https://picker.org/research_insights/staff-wellbeing-its-impact-on-patient-experience-and-healthcare-quality/
- The Scottish Social Service Council Coaching for Wellbeing Resources [online]; https://news.sssc.uk.com/news/coaching-for-wellbeing

Leadership to support a culture of safety

Healthcare Improvement Scotland | Every Person Every Time | Scottish Patient Safety Programme

Safe staffing | Staff education and awareness | Mechanism for effective rostering | Process for mitigation of staffing shortfalls | Process to escalate staffing shortfalls which impact on safe delivery of care

Evidence and Guidelines:

- Griffiths P, Recio-Saucedo, Dall'Ora C, Briggs J, Maruotti A, et al. The Association Between Nurse Staffing and Omissions in Nursing Care: A Systematic Review Journal of Advanced Nursing. [online] 2018; 74(7): 1474–1487; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6033178/
- Shekelle PG Nurse-Patient Ratios as a Patient Safety Strategy: A Systematic Review Ann Intern Med.[online] 2013; 158(5):2:404-409; https://www.acpjournals.org/doi/10.7326/0003-4819-158-5-201303051-00007?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub++0pubmed&

Tools and Resources:

- Healthcare Improvement Scotland Staffing Workload Tools [online]; https://www.healthcareimprovementscotland.org/our_work/patient_safety/healthcare_staffing_programme/staffing_workload_tools.aspx
- Healthcare Improvement Scotland Safe Staffing [online]; https://ihub.scot/improvement-programmes/scottish-patient-safety-programme-spsp/essentials-of-safe-care/safe-clinical-and-care-processes/safe-staffing/
- Learning from Excellence A Call to Learn from What Works Well [online]; https://learningfromexcellence.com/
- NHS England Safe Sustainable and Productive Staffing [online]; https://www.england.nhs.uk/wp-content/uploads/2021/05/safe-staffing-adult-in-patient.pdf

Leadership to support a culture of safety

Healthcare Improvement Scotland | Every Person Every Time | Scottish Patient Safety Programme

System for learning | Post-falls staff debrief | Quality improvement and measurement support | Involvement of falls coordinators in improvement work | Establish local falls groups with MDT representation

Evidence and Guidelines:

- Jones KJ, Crowe J, Allen JA. et al. The Impact of Post-Fall Huddles on Repeat Fall Rates and Perceptions of Safety Culture: A Quasi-Experimental Evaluation of a Patient Safety Demonstration Project [online] 2019; 19:650; https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-019-4453-y
- Leonard M, Frankel A. How Can Leaders Influence a Safety Culture? The Health Foundation. [online] 2012;
- Morris ME, Webster K, Jones C, Hill A-M, Haines T, et al. Interventions to reduce falls in hospitals: a systematic review and meta-analysis [online] 2022; 51(5):afac077; https://pubmed.ncbi.nlm.nih.gov/35524748/
- Sujan M. An Organisation Without a Memory: A Qualitative Study of Hospital Staff Perceptions on Reporting and Organisational Learning for Patient Safety Reliability Engineering & System Safety [online] 2015; 144:45-52; https://www.sciencedirect.com/science/article/pii/S095183201500201X
- https://www.health.org.uk/sites/default/files/HowCanLeadersInfluenceASafetyCulture.pdf
- The Health Foundation Measuring Safety Culture [online] 2011; https://www.health.org.uk/sites/default/files/MeasuringSafetyCulture.pdf
- Vincent C, Burnett S, Carthey J. The Measuring and Monitoring of Safety The Health Foundation [online] 2013; https://www.health.org.uk/publications/the-measurement-and-monitoring-of-safety

Tools and Resources:

- Learning from Excellence A call to learn from what works well [online]; https://learningfromexcellence.com/
- NHS Education for Scotland Achieving Sustainable Change [online]; https://learn.nes.nhs.scot/60970
- The Health Foundation Quality Improvement Made Simple, What Everyone Should Know about Health Care Quality Improvement [online] 2021; https://www.health.org.uk/sites/default/files/QualityImprovementMadeSimple.pdf

Measurement

Measurement is an essential part of improvement as it helps the project team understand if the changes they are making are leading to improved care. Below you will see an outline of three types of measures used in improvement and a link to the measurement framework.

Outcome measures
Outcome measures are used to understand if the changes are resulting in improvements towards the aim.

Process measures
Process measures demonstrate that change ideas are improving the underlying processes that contribute towards falls prevention.

Balancing measures
Balancing measures are used to determine if the changes are affecting things elsewhere in the system (unintended consequences).

More detailed information can be found in the measurement framework on the ihub website.

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FALLS & BEDRAILS ASSESSMENT AND INTERVENTION CARE PLAN

F: has patient had a fall since last review? **A: is the patient agitated or confused today?** **L: is the patient likely to forget instructions?** **L: is the patient likely to mobilise without supervision?** **S: Ensure SAFE environment every time you leave patient/call bell to hand/walking aid**	**Patient Label CHI:**

Admission / Transfer to Ward (MUST BE COMPLETED FOR EVERY TRANSFER)	**Date** **Ward**								
	Yes	**No**	**N/A**	**Yes**	**No**	**N/A**	**Yes**	**No**	**N/A**
Provide FALLS leaflet to patient carer/family									
Check E + S BPs completed on Patient Trak									
Medical staff asked to complete falls assessment									

Record you answer in the grid below with Y= Yes and N= No – If Yes to any of these, activate daily bundle overleaf

Date	Time	F	A	L	L	S	Signature

Date	Time	Why has the FALLS daily bundle not been implemented?	Signed

BEDRAIL ASSESSMENT MATRIX -

MENTAL		MOBILITY		
		Patient is very immobile (bed fast or hoist – dependent)	**Patient is neither independent nor immobile**	**Patient can mobilise without help from staff**
	Patient is confused & disorientated	**Use bed rails with care A**	**Bed rails not recommended B**	**Bed rails not recommended C**
	Patient is drowsy	**Bed rails recommended D**	**Use bedrails with care E**	**Bed rails not recommended F**
	Patient is orientated and alert	**Bed rails recommended G**	**Bed rails recommended H**	**Bed rails not recommended I**
	Patient is unconscious	**Bed rails recommended J**	**N/A**	**N/A**

Bed Rails Assessment Matrix – The matrix must be used in conjunction with NHS Fife Bed Rail Policy as combination of clinical judgement and awareness**.** Patients with capacity can make their own decisions about bed rail use. Patients with visual impairment may be more vulnerable to falling from bed. Patients with involuntary movements (e.g. spasms) may be more vulnerable to falling from bed and if bed rails are used, may need padded covers. **Discuss with welfare POA/NOK if patient does not have capacity and document in notes**

Name **CHI:** **Address:**	**F: has patient had a fall since last review?** **A: is the patient agitated or confused today?** **L: is the patient likely to forget instructions?** **L: is the patient likely to mobilise without supervision?** **S: Ensure SAFE environment every time you leave patient/call bell to hand/walking aid**

KEY – YES = Y: NO = N: NOT APPLICABLE = N/A

	Falls and Bedrail Care Planning Daily Bundle / Post Fall Date														
F	Patient uses - glasses /hearing aid **(circle as appropriate)**														
	Advise patient to take time when rising from sitting/lying to standing														
	Ask medical staff to complete medical falls review														
A	Complete 4AT and start TIME bundle if 4AT 4 or above														
	Consider placement in the ward and patients orientation to ward														
	Ask/encourage patient to sit-stand. Change position														
	Call bell within reach														
L	Care and comfort frequency **(1 / 2/ 3/ 4 hourly) (add number to box)**														
	Consider whether enhanced or 1:1 supervision or use of Chair/Bed alarm **(circle appropriate)**														
L	Follow mobility risk assessment/care plan. Consider referral to Physiotherapy and/or OT														
	If patient requires walking aid is it within easy reach?														
	Assess continence. Document support required in care plan.														
S	Area hazard free, personal belongings within easy reach														
	Select suitable seating														
	Bed at lowest level and brakes applied														
	Consider suitability and appropriateness of clothing / footwear /referral to podiatry														
	BEDRAIL ASSESSMENT														
	Bedrails Appropriate, as per Matrix **(Yes/No)**														
	Bedrails used **(Yes/No)** * document professional judgement on page 3														
	Bedrail Bumpers Appropriate **(Yes/No)** *document rationale on page 3														
	Discuss with Patients Next of Kin **(Yes/No)** *document outcome														
	Matrix Code														
	Signed														

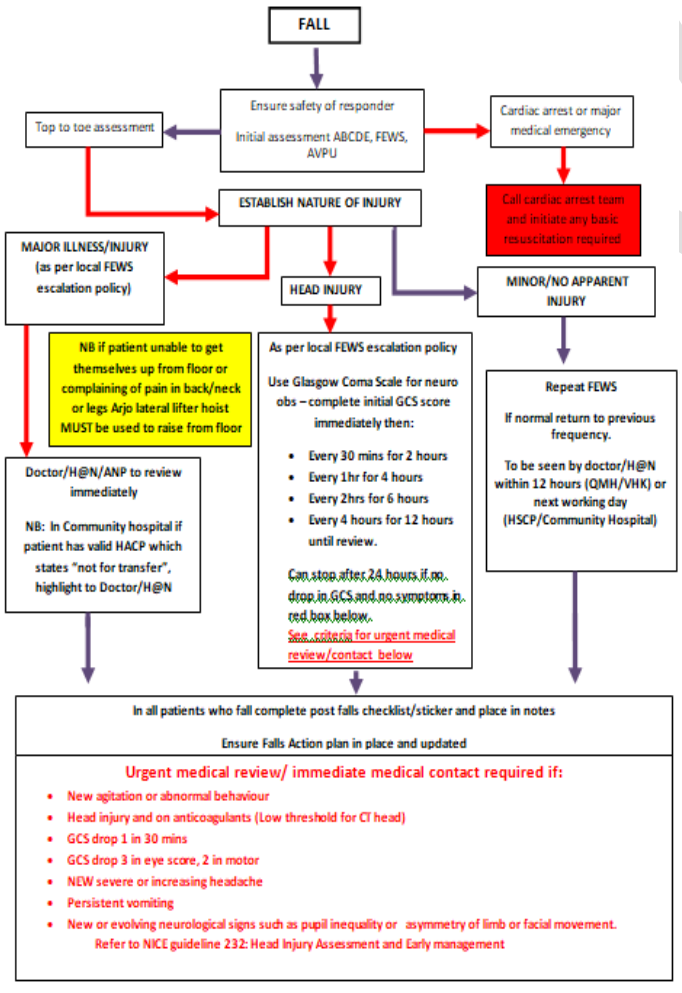
Name CHI: Address:	F: has patient had a fall since last review? A: is the patient agitated or confused today? L: is the patient likely to forget instructions? L: is the patient likely to mobilise without supervision? S: Ensure SAFE environment every time you leave patient/call bell to hand/walking aid

INDIVIDUALISED PERSON CENTRED FALLS CARE PLAN

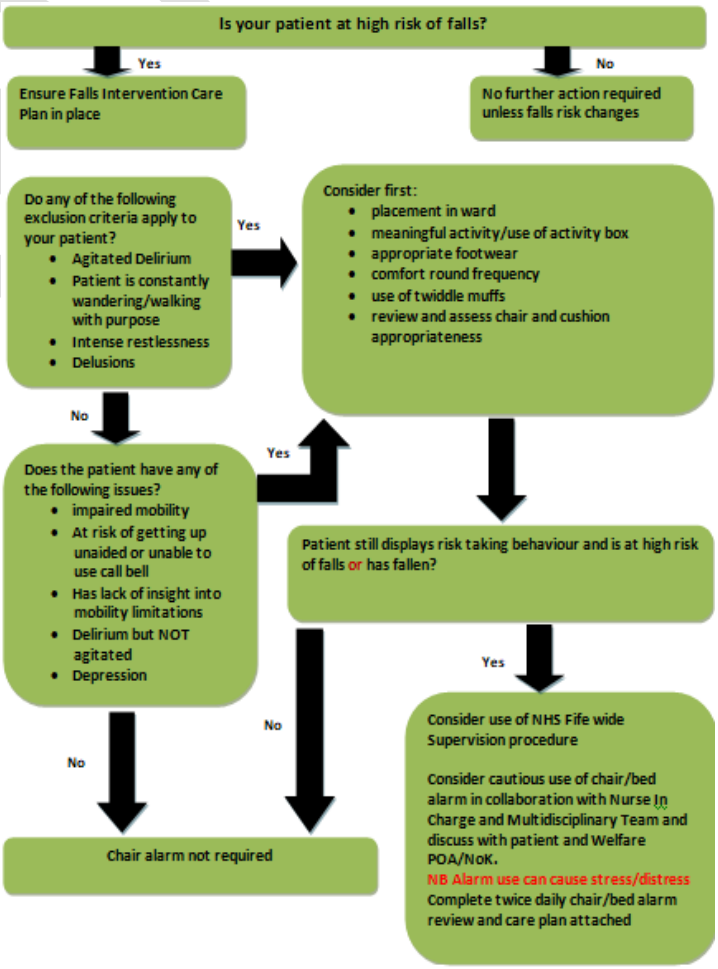
Date	Time	F.A.L.L.S and bedrail Ax	Evaluation (Please include changes to care planned and information about any difficulties delivering care accordingly to FALLS bundle)	Signature

	Bed & Chair Alarm Risk Assessment Date														
	Do any of the following exclusion criteria apply? **Yes/No** Delirium / walk with purpose / restlessness														
	Are any of the following a risk? **Yes/No** Impaired mobility/mobilise unsupervised/unaware of limitations/Depression														
	Consider the following – patient placement/ activities/care & comfort round frequency/ MDT approach /call bell within reach														
	Supervision Policy required **Yes/No**														
	Use chair and bed alarm with caution & discuss with Nurse in Charge, patient, P.O.A **Yes/No**														
	Chair alarm in use & in working order **Yes/No**														
	Bed & Chair alarm to be used **Yes/No** *Document rationale on page 3														
	Time														
	Signed														

NHS Fife Inpatient Post Fall Flow Chart



NHS Fife Bed and Chair Alarm Risk Assessment and Care Plan



NHS Fife

Staying Active

Avoiding Falls in hospital

An information Leaflet for patients, relatives and carers

449/820

Falls Prevention in NHS Fife

Preventing patients falling in hospital is a key priority for patients and staff. NHS Fife is taking part in the Scottish Patient Safety Programme (SPSP). This is a national programme that aims to improve safety and reduce harm. A key part of this work is providing information on preventing falls in hospital to patients, their families and carers.

Can we prevent falls?

Just like in general life, it is not possible to prevent all falls in hospital. However we can work together to reduce the chances of this happening.

When in hospital you are at greater risk of falling as you are unwell and in an unfamiliar environment. We know that when we all work together this can help. Being aware of the risks and the actions that you can take can help reduce your risk of falling.

This leaflet contains simple and practical advice for you and your family members or carers which will help all of us keep you safe during your stay with us.

What Can I do?

Please!

- Let us know if you are concerned about falling or have been falling at home or when out and about.

- Tell us if you if you take alcohol or recreational drugs at home.

- Tell us if you are having trouble seeing.

- Tell us if you have trouble with your feet.

- Do not be afraid to ask us for help - we would much rather you call than fall.

- Tell us if you are worried or anxious about falling.

- Tell us if you feel dizzy or lightheaded.

- Let us know if you are experiencing any side effects from your medications e.g. dizziness or light headedness.

- Tell us if you notice any hazards such as a spillage or obstacles in your way.

- Use your night light.

- Never lean on hospital furniture as it's often on wheels so will move.

My personalised falls prevention advice

Following discussion with staff and my family or carer it has been agreed that I will:

Complete any exercises and work with the therapist to stay active and keep moving. ☐

Get dressed in comfortable day clothes (not too loose or long) which I can move around in easily. ☐

Use my walking aid as instructed and keep it close to me at all times. ☐

Make sure that I wear my glasses and that they are clean. ☐

Make sure I wear my hearing aids and that they are working and switched on. ☐

Use my call bell when I need help, in particular if I need help to go to the toilet. ☐

Always wear well-fitting footwear that is comfortable and that I am confident to walk in. If I don't have these with me I will ask if they can be brought in for me. ☐

Take my time when sitting up or getting out of bed. ☐

Try to eat and drink regularly. ☐

Take care in the bathroom and toilet. I will make sure to allow plenty of time and call for help if needed. ☐

Keep everything I need close by but try to keep my space tidy. ☐

I will regularly stand up from my chair to avoid sitting for too long. ☐

Our commitment to you

When you are in hospital we will do everything we can to prevent you falling.

- We will assess your risk of falling on admission to hospital.
- We will make you a plan of care to reduce this risk and promote safer mobility.
- We will check you regularly, to ensure you have everything you need.
- We will support and encourage you to get up out of bed, get dressed and maintain your independence as much as you are able to.
- We will make sure your call bell is within easy reach, and we will respond to your calls promptly.
- We will review your medication to see if anything that you are taking increases your risk of falling, and we will talk to you about it.
- We will talk to you about any worries that you may have about falling in hospital or at home.

Bedrails

Bedrails attached to the sides of hospital beds can reduce the risk of you accidently slipping, sliding, falling or rolling out of bed. However, bedrails are not suitable for all patients.

If you are well enough then you can decide whether you want the bed rails up or down. However due to illness there may be times where you are unable to make that decision, in this case the nurses will use a risk assessment to decide whether it is safe to use bedrails or not.

The reason for this risk assessment is that there is a possibility of you being harmed whilst a bed rail is in use. This can be simply bumping your arm or legs against the rails or more seriously getting an arm or leg trapped between the bars. You should never attempt to climb over the bed rail or try and put them up or down yourself.

Low Beds

If you are very restless and at very high risk of falling out of bed, we may consider using a low bed. A low bed is designed to reduce the risk of serious injury due to falling out of bed. We will place protective mats on the floor on either side of the bed. We would use this type of bed only when there is no safer option.

Relatives and carers – how can you help?

- Tell us if you feel your relative is more confused, agitated or drowsy.
- Bring in safe footwear and day clothes.
- Reduce clutter by taking home any unnecessary items – it can be good for patients to have some things from home as this can help them settle in hospital.
- On leaving please make sure that they have their call bell and that their room or bed space is tidy. If you notice any possible hazards such as spills or trailing wires please tell us.
- If you have any questions then please ask.

What about when I go home?

Here are a few points to consider to help prevent falls when you get home.

- Keep as active as you can
- Have regular eye tests
- Maintain good foot health
- Talk to your doctor or nurse if you are having dizzy spells or hearing problems
- Avoid or limit your alcohol intake /recreational drug
- Avoid using furniture for support/use your walking aid if one is needed
- Make sure there are no loose rugs or uneven floor coverings or trailing wires
- Be aware of pets when walking around at home
- Make sure your house has good lighting

Where can I find out more about falls?

NHS Inform –
🌐 www.nhsinform.scot/healthy-living/preventing-falls

Age UK –
Avoiding a fall | Elderly fall prevention | Age UK

Up and About Leaflet –
Up and About Taking Positive steps to avoid trips and falls
(✉ healthscotland.com)

Extra information to help keep me stay active and stay safe.

Review Date: October 2025
MI • 294588 v2.0 • GGC0235

Deconditioning in Hospital

What can we do about it?

Sandie Drummond
Specialist Physiotherapist
Charlotte Kay
Rotational Physiotherapist

NHS Fife

One week in bed for patients >80 years old can result in :

- 20% reduction in quads
- 1.5 kgs of muscle loss
- 10% reduction in aerobic capacity
- 5 x Increased risk of needing long term care on discharge

Manas et al 2020

Upon discharge...

Patients are 15% less active following a hospital admission

Harvey et al 2018

Fear of Falling

Fear of falling is worsened following a hospital admission. This is linked to poorer functional outcomes - such as future falls and increased dependence.

Visschedijk et al 2015

Sedentary behaviour

Fear of falling is linked with restriction or avoidance of activities. This is where we can help to break the cycle

De Souza et al 2022

Get up, Get Dressed

Being in bed and wearing pyjamas re-enforces feeling unwell. So lets get up, get dressed and get moving!

Encourage Mobility

Older adults should aim for 8000 steps per day.

Studies have shown whilst in hospital our patients can do as little as 881 steps per day!

Scott J et al 2021

Sit less, Move more

Simply by standing up from your chair once per hour we can significantly improve patients mobility and strength.

Exercise reduces risk of falls by 23%. Simple chair exercises such as chair marching and sit to stand.

Harvey et al 2018
Sherrington et al 2020

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**Friday 3 November**
Title:	**Medicines Safety in NHS Fife: Review and Improvement**
Responsible Member:	**Benjamin Hannan, Director of Pharmacy and Medicines**
Report Author:	**Fiona Forrest, Deputy Director of Pharmacy and Medicines**

1 Purpose

This is presented for:

- Assurance

This report relates to a:

- Local policy

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

- Safe
- Effective

2 Report summary

2.1 Situation

Medicines safety is the responsibility of everyone, and requires a robust multidisciplinary approach to ensure that we fulfil our responsibilities appropriately.

Medicines safety is a key priority for NHS Fife and is the focus of corporate objective for the Board this year. A coordinated medicines safety programme is an important component in delivering assurance that our patients are as safe as possible, and our teams continue to build on their culture of improvement around medicines.

The attached paper (Medicines Safety in NHS Fife, Review and Improvement) provides a comprehensive update on current analysis and detail of the programme and wider actions being delivered.

2.2 Background

There were an estimated 2.9m administrations of medicine in the acute hospital setting last year, and 6.9m medicines prescribed in primary care, in Fife. There are over 125,000 people in Fife with at least one item prescribed in the last year. More widely, medicines related issues are one of the top causes of hospital admission in Scotland.

NHS Fife has a well embedded governance structure to respond to and improve following medicines incidents. There is also substantial local expertise across professional groups in both reactive and proactive improvement approaches.

The attached report provides analysis of available data around local medicines incidents and summarises the associated actions. This includes a focus on controlled drugs and important actions to enhance communications.

2.3 Assessment

Please see attached Medicines Safety in NHS Fife: Review and Improvement report in appendix 1

2.3.1 Quality/ Patient Care

The medicines safety programme contains four key areas of focus for the coming year. This programme and wider medicines safety improvement, will be supported and enhanced by delivery of improved digital systems, including HEPMA (Hospital Electronic Prescribing and Medicines Administration) over the coming months and years. The four areas are: anticoagulants; lithium; insulin and sodium valproate.

The report also details a range of actions which are being taken or will be taken over the coming months to enhance quality and safety of care. This includes actions developed in response to ongoing review of incidents and associated learning, alongside the system priorities noted above.

2.3.2 Workforce

Responsibility for safe and high-quality use of medicines sits with healthcare professionals across all care settings – the actions and programme of work will impact upon all of them, and require their support and engagement. Particularly, medical staff are the largest prescribers of medicines in Fife, and nursing staff administer most medicines. Pharmacists are recognised as medicines experts who take leadership of medicines governance in all care settings and who optimise therapeutic outcomes for individual patients. Medicines governance structures in NHS Fife are all multidisciplinary with excellent engagement from medical, nursing and pharmacy staff.

It is of critical importance that the Board maintains a focus and culture of improvement in medicines safety. There are currently no plans to recruit additional workforce towards delivery – use of existing experienced teams will be vital.

To support the workforce with compliance against policies and procedures a number of presentations and supporting documents have been developed and are available on BLINK. New medicine safety minute bulletins are uploaded onto BLINK every Friday to support staff with learning from incidents.

2.3.3 Financial

There are no additional significant budgetary implications. Some limited directorate spending may be required on communications. Workload will be undertaken within existing resource.

2.3.4 Risk Assessment/Management

NHS Fife has an adverse event policy (GP19) that outlines how to report an adverse event and the process that will follow in terms of reviewing and grading the event to ensure any lessons are learnt and improvements are made for the future. Specific events must also be reported to external agencies. Major medication incidents are monitored by Safe and Secure use of Medicine group.

2.3.5 Equality and Diversity, including health inequalities and anchor institution ambitions

And Equality Impact Assessment is in development. Use of medicines is more prevalent in deprived areas, and therefore these groups may be more likely to be affected by medicines safety issues. The programme of work is therefore to the benefit of health equality and should an EQIA be required as this programme evolves this will be completed.

2.3.6 Climate Emergency & Sustainability Impact

This piece of work has no significant impact although reduction in error will have a causal link in reduction of wase. All work which reduces use of medicines will have a small environmental impact. There are other streams of work, most notably around inhalers and use of medical gases, which aim to have a significant environmental benefit – these are managed via other routes.

2.3.7 Communication, involvement, engagement and consultation

All adverse events are reviewed and the level of the review will be determined by the category of the event as detailed in the adverse event policy.

Following clinical governance committee, the report, intent and detailed communications plan for the programme will ensure this is given sufficient

2.3.8 Route to the Meeting

Paper has been previously been considered by

- Safe and secure use of medicines group 19 July 2023
- Area Drug and Therapeutics Committee – 16 August 2023
- Pharmacy Senior Leadership team 11 October 2023
- Executive Directors Group – 19 October 2023

2.4 Recommendation

The committee are asked to consider this report for **assurance** with regard to the current position with medicines safety in Fife and the summary of actions for the next 12 month work plan.

3 List of appendices

- Appendix one - Medicines Safety in NHS Fife: Review and Improvement

Report Contact
Ben Hannan
Director of Pharmacy and Medicines

Medicines Safety in NHS Fife:

Review and Improvement

October 2023

CONTENTS

1. INTRODUCTION FROM THE DIRECTOR OF PHARMACY AND MEDICINES

The safety of care with our most common healthcare intervention has always been of critical importance to patients and clinicians in Fife. As Director of Pharmacy and Medicines, my role is to work with my colleagues to ensure it remains a consistent focus across all clinical teams and registered healthcare professionals, and that our programmes of work deliver, ensuring everyone we care for is as safe as possible and we continue to improve.

While process and policy are important, we must also retain and develop our culture in medicines safety. Learning from incidents is vital, but we only learn if we report on incidents and build on our culture of review and improvement, wherever possible without blame.

With an estimated 2.9m administrations of medicines in the acute hospital setting, and 6.9m prescribed in primary care in Fife over the last year, we must all appreciate the importance of having a structure which allows a learning culture to flourish, and robust, connected processes and policies in support of this investment in safe care.

This report describes the current position with medicines safety in Fife, contextualises this both locally and nationally, and goes on to detail the programme of work to be undertaken over the coming year which will assure the Board that our patients are as safe as possible, and our teams continue to build on their culture of improvement.

The approach comprises an overarching focus on medicines safety, learning from incidents and the ongoing development of resources which keep all our patients safe. It links very closely with the Board's work on High-Risk Pain Medicines. Alongside this, we have identified four key clinical areas for targeted improvement: anticoagulants, insulin, lithium, and sodium valproate. All this will be supported by a comprehensive and robust audit programme, underpinned by the governance structures which assure the Board of ongoing safety and improvement.

BEN HANNAN

Director of Pharmacy and Medicines

2. MEDICINES IN NHS FIFE – Context

Hospital admissions and medicine related issues

Within NHS Scotland, in 2020/21, over 10,300 individuals under the age of 75 were admitted to hospital for issues related to their medicines.

The rate of medicines-related hospital admissions has shown a general upward trend since 1996/97 and is currently the second highest it has been, with 213.2 admissions per 100,000 population, compared to 64.0 admission per 100,000 in 1996/97.

In their annual medicines-related hospital statistics in Scotland report, Public Health Scotland noted that there was a marked decrease in medicines-related hospital stays at the time of the first national COVID-19 lockdown. The number of medicines-related hospital stays in April 2020 was 29% lower than the average number of stays in April 2018 and 2019, likely due to the measures put in place in response to the COVID-19 pandemic. It is therefore likely that the impact of the pandemic will have contributed to the decrease in medicines-related hospital admissions seen for this indicator between 2019/20 and 2020/21, which is inconsistent with the recent upward trend.

In 2020/21 the admission rate in Scotland's most deprived areas was more than 21 times greater than that of the least deprived (655.4 cases per 100,000 compared to 30.2 per 100,000).

Between 2019/20 and 2020/21 the rate of hospital admissions for those living in the most deprived areas decreased by 10%, whilst the rate stayed the same for those living in the least deprived areas. This decrease in the most deprived areas goes against the upward trend that was observed in the previous seven years and it is therefore possible that the reduction is a result of hospital admissions policies associated with the COVID-19 pandemic.

The most frequent medications which are associated with medication related hospital readmission are antiplatelet medications, diuretics, anti-coagulants and anti-hypertensive drugs.

Common themes arising from medication related admissions and readmissions include polypharmacy with multiple medication (i.e. >10), older age, adverse drug reactions, low adherence to medication regimens and additional diseases. Known interventions that could possibly lead to a

decrease in medication related hospital readmissions are sparingly used, such as the involvement of a pharmacist.

THE IMPACT ON A PATIENT

A man (51 years) was admitted to hospital with infected limbs and had been transferred from Edinburgh Royal Infirmary to Victoria Hospital for ongoing care. During his admission he had been prescribed rifampicin for her infection. This patient had an organ transplant which is normally treated with ciclosporin (an immunosuppressant working to prevent any rejection from the new organ). Rifampicin had interacted with ciclosporin (the main immunosuppressant) which led to very low ciclosporin levels and eventual organ rejection. The levels had not been followed up or communicated appropriately within primary and secondary care. This led to a significant analysis team meeting and on review the following action plans were taken:

- Stickers would be added to patient medication charts for any patient prescribed oral ciclosporin (regardless of which brand prescribed) to highlight that the patient may be a transplant patient
- On discussion with microbiology team the practitioner would have to communicate the drugs prescribed on the patient's drug chart therefore a check of interactions could be undertaken before making recommendation on alternative antibiotics
- The infectious diseases pharmacist had discussed implementing a system whereby any individual patient supply requests for rifampicin would be checked by a clinical pharmacist to reduce any risk of interactions
- The team have Ciclosporin Thursdays when transplant patients can be admitted to clinic for level checks.

The importance of Polypharmacy

The population in Fife benefits from 53 GP Practices and 87 Community Pharmacies. There are over 394,000 people registered locally, and just over 20% of them are aged 65 years or over. In 2021/22, there were a total of 6.9m prescriptions dispensed in the community in Fife. Table 1 below provides data on the amount of people who benefit from different numbers of medicines in Fife. This is particularly important in the context of errors reported – the reality is that the vast majority of medicines are prescribed and taken safely.

Table 1 - Number of patients in Fife currently prescribed medication

No of items prescribed	No of patients	% of treated patients
Dispensed at least 1 medicine	126,243	
1-4 medicines	68,841	55%
5- 9 medicines	43,396	34%
10+	14,006	11%

The clinical approach to Polypharmacy is crucial to safe care, as the table above makes clear. At the interface between general practice and hospital, the culture of medicines reconciliation (increasingly led and delivered by Pharmacy teams) focuses on Polypharmacy considerations. This clinical expertise provides assurance at a patient level, that drug interactions are considered and minimised, and that patients are benefitting from each of their medicines.

3. MEDICINES GOVERNANCE: Roles and Structures

As a Health Board, NHS Fife is required to appoint a Controlled Drugs Accountable Officer (CDAO). The roles and responsibilities of CDAOs are governed by the Controlled Drugs (Supervision of Management and Use) Regulations 2013 and are responsible for all aspects of controlled drug management. A Controlled Drug Governance group was established to strengthen scrutiny and assurance and reports to the Safe and Secure Use of Medicine Group. Certain classifications of controlled drugs by law require increased level of security and recording to prevent them from being misused, obtained illegally, or causing harm. When accessing the secure storage area and administration the medication, requires two registered health care professionals within the hospital setting. 27% of all medication incidents in 22/23 involved controlled drugs.

NHS Fife has an adverse event policy (GP19) that outlines how to report an adverse event and the process that will follow in terms of reviewing and grading the event to ensure any lessons are learnt and improvements are made for the future. All categories of controlled drug incidents are monitored in more detail through the Controlled Drug Governance group, including any controlled drug incidents from community pharmacy or General Practice. The Safe and Secure Use of Medicine Group currently reviews all *Major* medication incidents, and a medicine safety bulletin is produced on a weekly basis to support learning through the previous week's incidents.

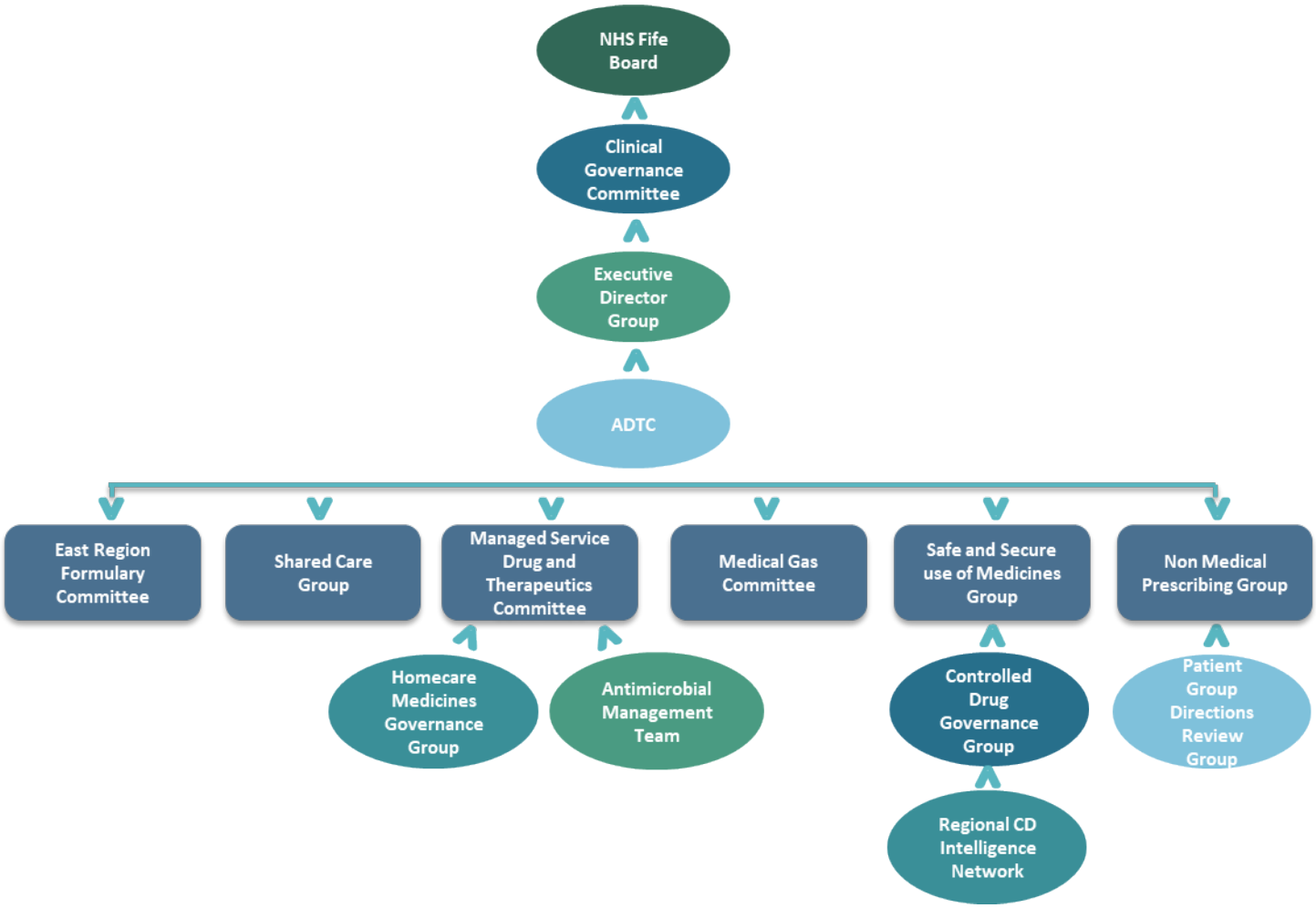
Fife Area Drug and Therapeutics Committee's (ADTC) remit is to set the strategic direction for all aspects of good quality prescribing, cost-effective prescribing, medicines use and medicines governance in all care settings in line with the NHS Fife Clinical Strategy, the HSCP Strategic Plan and relevant legislation. The ADTC has the responsibility of advising the NHS Fife Board on all aspects of medicines utilisation in Fife, including rational, safe and cost-effective prescribing. Below in diagram 1 details medicine governance structure. In addition, Acute Service Division Clinical Governance Committee and Quality Matters assurance group receive all audit reports relating to their area for assurance.

A revised approach to rapid learning was launched in January 23. Medicines Safety Minute is a weekly safety briefing designed for quick dissemination of lessons learned from the previous week's medication incidents across clinical teams in Fife. An MDT group review recent incidents and compile the short and supportive update, which is circulated across the full organisation to a range of

professional groups. It is also publicised on Blink. As well as addressing any immediate learning, it embeds a culture of regular and routine focus on medicines safety across clinical teams.

Diagram 1 - NHS Fife Medicine Governance Structure

NHS Fife has had a long-standing involvement in national safety programmes and continues to learn, adapt, and create innovative solutions that improve safety.



The Scottish Patient Safety Programme (SPSP) is one such example and is a national quality improvement programme co-ordinated by Healthcare Improvement Scotland (HIS) that aims to improve the safety and reliability of care, and reduce harm. NHS Fife Pharmacy and Medicines Directorate joined the programme in 2014 as a member of the SPSP-Community Pharmacy Collaborative. The collaborative was run as a Break Through Series (BTS) collaborative and aimed to reduce adverse patient outcomes associated with non-steroidal anti-inflammatory drugs (NSAIDs) and warfarin. Fife's contribution and key outputs from this programme included a suite of national High Risk Medicine (HRM) safety resources, the development of an electronic SBAR tool that was incorporated into the national Patient Care Record (PCR) system and influencing the addition of quality improvement activity as part of the national community pharmacy contract.

Since the launch of the Scottish Patient Safety Programme SPSP in 2008, the programme has expanded to support improvements in safety across a wide range of care settings including Acute and Primary Care, Mental Health, Maternity, Neonatal, Paediatric services, and medicines safety. HIS are currently scoping further work in relation to high-risk medicines and high-risk situations as part of work to support the implementation of the Pharmacotherapy level two and three elements of the 2018 General Practitioner contract. This will build on existing work on Pharmacotherapy level one services including the Serial Prescriptions and Acute Prescribing toolkits; facilitating the safe and timely access to medicines including regular, person centred, medication reviews. An SPSP national learning system will also be launched in the summer of 2023 providing a catalogue of previous and upcoming events/recordings and resources along with a comprehensive SPSP resource library pulling together evidence and tools from across the SPSP programmes.

Quality Improvement knowledge and skills are seen as essential capabilities for all pharmacy teams in NHS Fife; in order to improve the quality of care; including patient safety. The Pharmacy and Medicines Directorate's Strategic Framework acknowledges this and aims to increase its workforce capacity. Members of staff have been supported to enrol on the Scottish Improvement Leadership (ScIL) programme and those that are QI practitioners continue to support internal programmes of work (e.g the co-design of a safety bundle in Community Pharmacies that supports the High Risk Pain Medicine Programme).

4. MEDICATION INCIDENTS IN NHS FIFE – April 2022 to March 2023

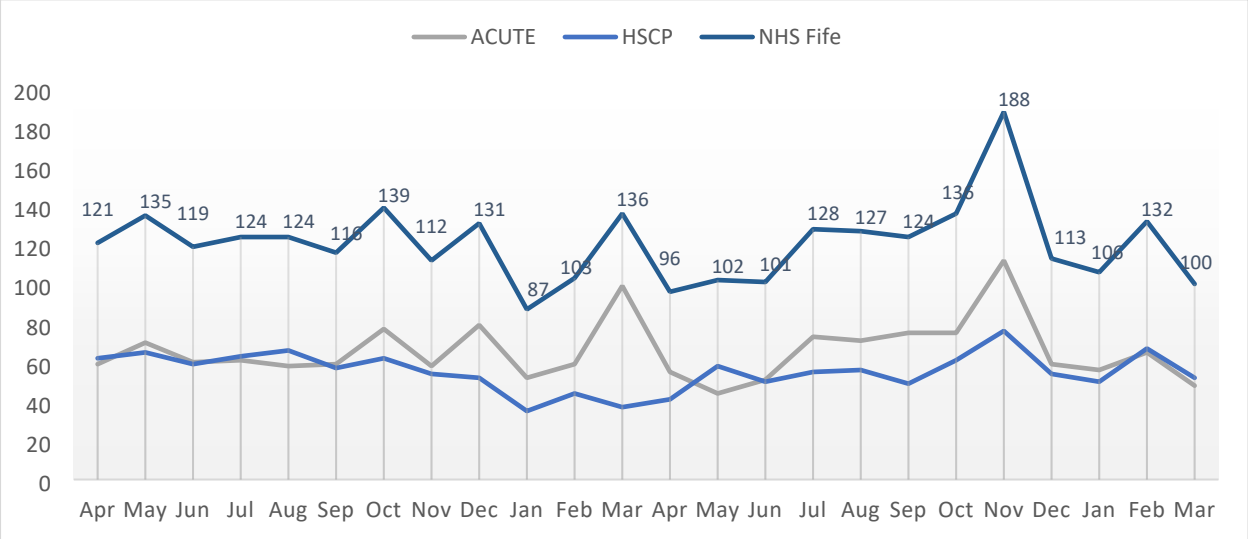
In line with its responsibilities to Government and individual patients, the Board reviews medication incidents on an ongoing basis. Data was analysed from the period of April 22 to March 23. A total of 1446 (previous year 1435) medicine incidents were recorded on Datix.

The importance of continuing to develop and promote a learning culture cannot be overstated. Each Datix report is an opportunity to learn and improve, and the Board takes this obligation very seriously. The reports received have shaped the actions and programmes of work being delivered, and these will continue to evolve as evidence from local feedback and other sources is reviewed.

Medication Incidents Reported Across the Year

The graph below shows the spread of reported incidents from April 2021 to March 2023, for the Acute Service Division (ASD) and for Fife Health and Social Care Partnership (HSCP) respectively. It should be noted that number of incidents reported alone is not a metric which should be of concern; evidence suggests healthcare services with more frequent reporting and a good learning culture have less frequent occurrences of actual harm. What is essential is how learning is put into practice, shared across the system and used to drive improvement. The peak seen in November 2022 was due to the medical gas audit, which was conducted in this month, with 65 incidents recorded to allow each ward/ department to receive the detailed report and any actions required. The remainder of the graph is typical from previous years with peaks and troughs in reporting.

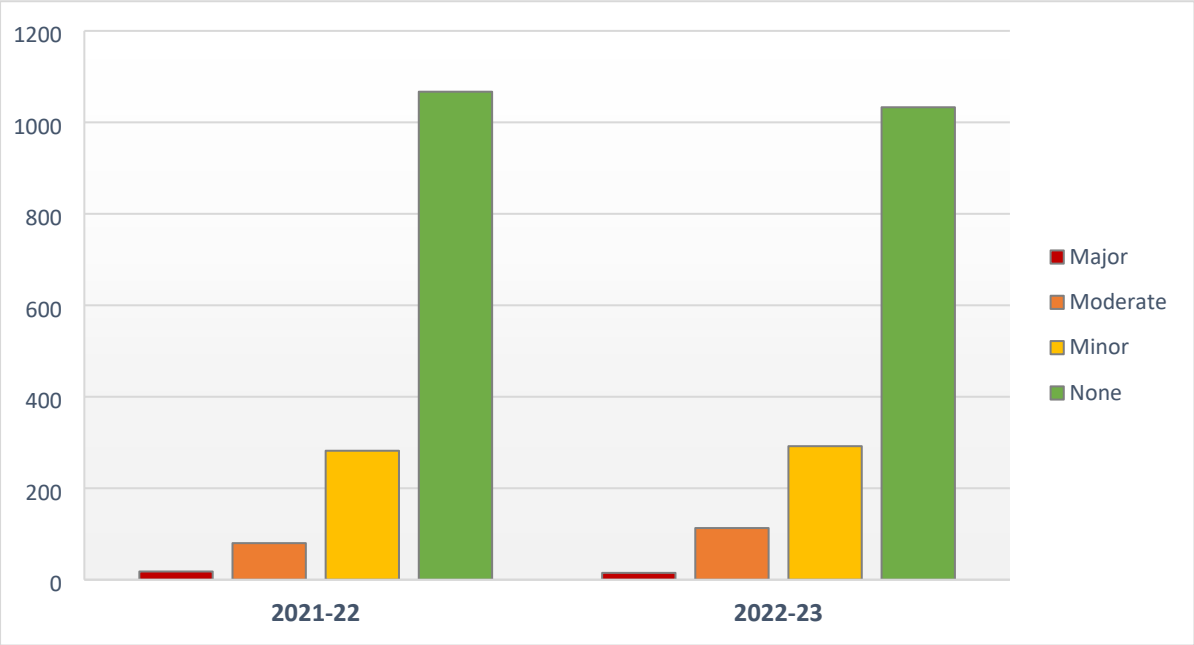
Graph 1 - Number of medication Incidents reported via Datix from April 21 to March 23



Severity of Medication Incidents

Reporters of incidents grade the immediate impact of the incident on the affected person. (In some cases, the final risk grading may change but the data below provides a robust estimation).

Graph 2 Medication incidents by Severity of Outcome: 2021-22/2022-23



Graph 2 details the number of medication incidents according to harm comparing the last 2 years. 71 % of medication incidents in 22-23 resulting in no harm compared with 72 % the previous year. 15 major medication incidents were reported in 2022-23 compared to 18 the previous year. Table 2 below describes the 15 major incidents reported in 22-23 , current status and learning outcomes.

Table 2 Major incidents reported in Datix 2022-23

Type of Major incident (number of incidents)	Status	Learning
Missing medication (6)	Closed	Action 1- Review of attractive stock dashboard
Wrong dose of paracetamol prescribed and administered (1)	Under review	
Failure to prescribe insulin on kardex, resulting in no insulin being administered	Closed	Action 2- Insulin safety program established

(2)		
Prescribing/administration incidents involving wrong dose of palliative medication being administered (4)	Closed	Action 3- Review of Just in case paperwork and anticipatory dose range kardex
Waste medication accidentally discarded from a moving van, as the door was left open (1)	Closed	The review resulted in new checking procedures for staff and a new log developed for movement of transported waste to ensure a clear audit trail from pick up to delivery.
Several patients were not administered their medication during the ward administration time (1)	Under review	

NHS Fife record incidents of missing medicines as *major* to ensure any incident is escalated immediately and appropriate action take. This has the advantage of bringing incidents to the attention of senior leaders at an early stage. The incidents are downgraded if the medication is subsequently found; for example, a calculation error was discovered in the controlled drug register resulting in the discrepancy being resolved. There is currently no national comparison between Boards regarding medication incidents due to the different ways in which we categorise and report.

ACTION 1:

An attractive stock dashboard has been developed by NHS Fife, which details all medication supplied to wards/depts. that may be desirable and therefore at increased risk of diversion. The use of the dashboard has been deployed and aims to ensure every ward/dept is monitored on a monthly basis.

ACTION 2:

An insulin safety programme has been established and work is being carried out with the Managed Clinical Network looking at procedures and protocols. An improvement plan has been developed with aim of finalising the programme of work in 2023.

ACTION 3:

A short life working group has been established which is reviewing the Just in Case policy and procedures, and supporting clinicians with education and training regarding medications involved in end of life care.

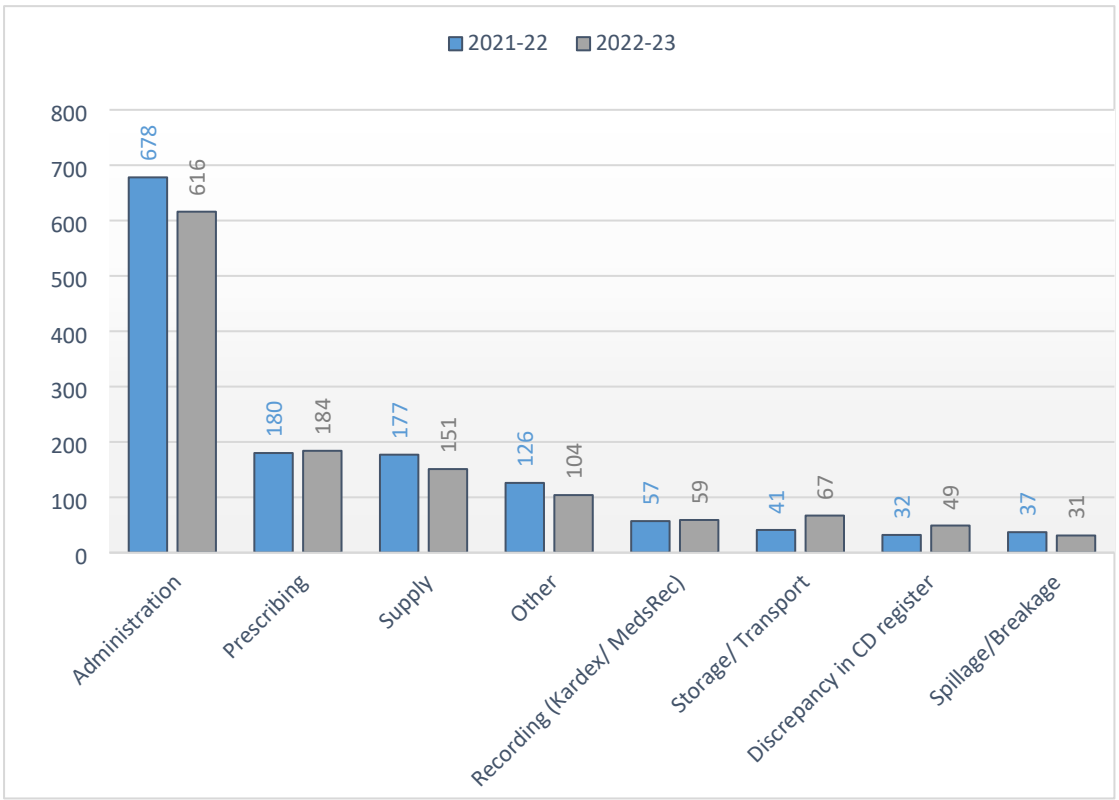
Categories of Medication Incidents

Graph 3 details the type of medication incidents reported with administration errors continuing to be the most common, followed by prescribing. The top three types of medication incidents have remained the same since last year. Supply issues can be challenging to resolve, often take clinicians away from patient care for extended periods of time and can involve multidisciplinary team to try and resolve. There are often multifactorial reasons as to why the incidents happened.

ACTION 4:

A revised approach to analysis of supply incidents will be undertaken this year incorporating historic incidents and common learning/ themes, as part of the action plan for the Controlled Drugs Governance Group.

Graph 3 Type of Medication Incidents: 2021-22/2022-23



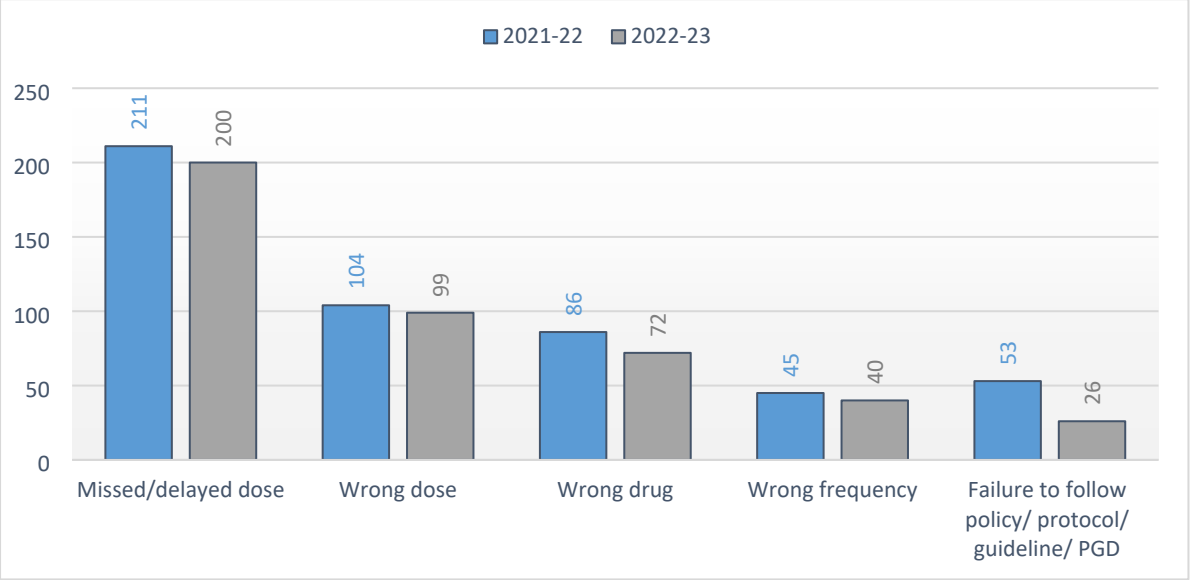
Graph 4 breaks down the type of administration error with missed /delayed dose accounting for 36% of administration errors. A detailed review of the Safe and Secure use of Medicine Policy and Procedure (SSUMPP) missed dose section was undertaken, resulting in a new prevention of omitted dose flowchart to support staff along with detailed guidance for staff to support them with actions to take to prevent omitted doses, which was launched in version 10 of the SSUMPP in April 23.

The top three types of errors have continued to be the same over the last few years. To support staff with learning from administration incidents the following presentations are available on BLINK from the medicine safety huddle. Brand vs Generic, Medication Incidents; Gentamicin and Vancomycin; safe administration; missed doses.

Graph 4 Top 5 Administration Incidents: 2021-22/2022-23

ACTION 5:

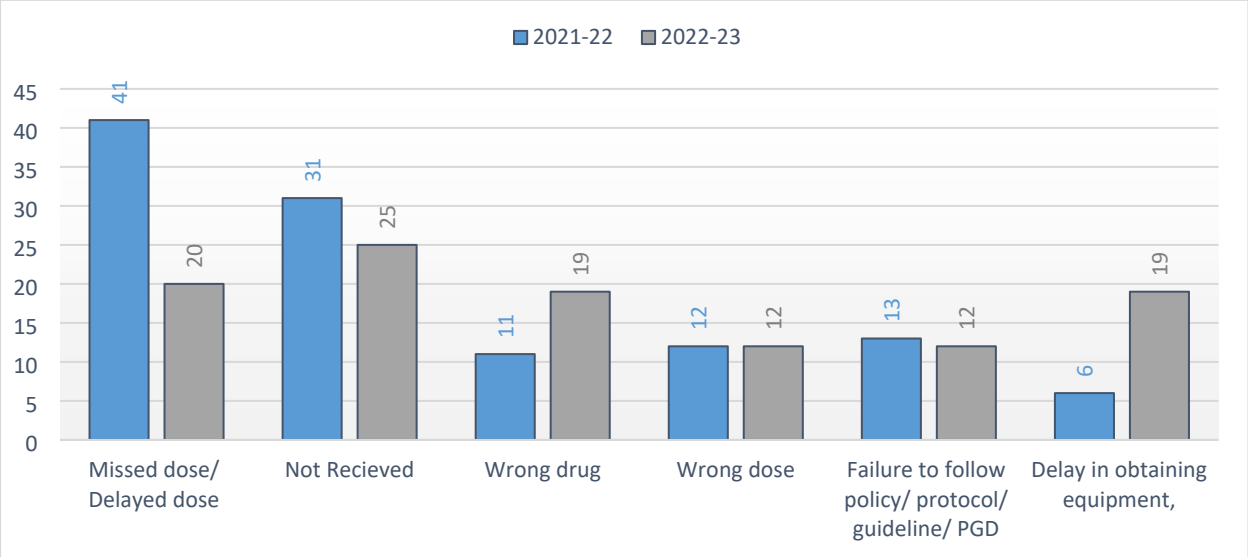
Education and training resources are being developed to support staff with administration errors and will be overseen by the Safe and Secure use of Medicines Policy and procedures. These are communicated via a range of channels.



Graph 5 breaks down the types of supply incidents with *not received* being the most common and *missed delayed dose* being the next most common, which is the reverse of the previous year, with both categories reducing. There has been an increase in wrong drug supplied and a delay in obtaining equipment, which may reflect the pressures the hospital was under and volume of

patients. The supply can either be from pharmacy or from the ward. A presentation on transfer of medicines and the discharge process was developed to support learning from supply incidents and is available to all staff on BLINK.

Graph 5 Supply Incidents: 2021-22/2022-23

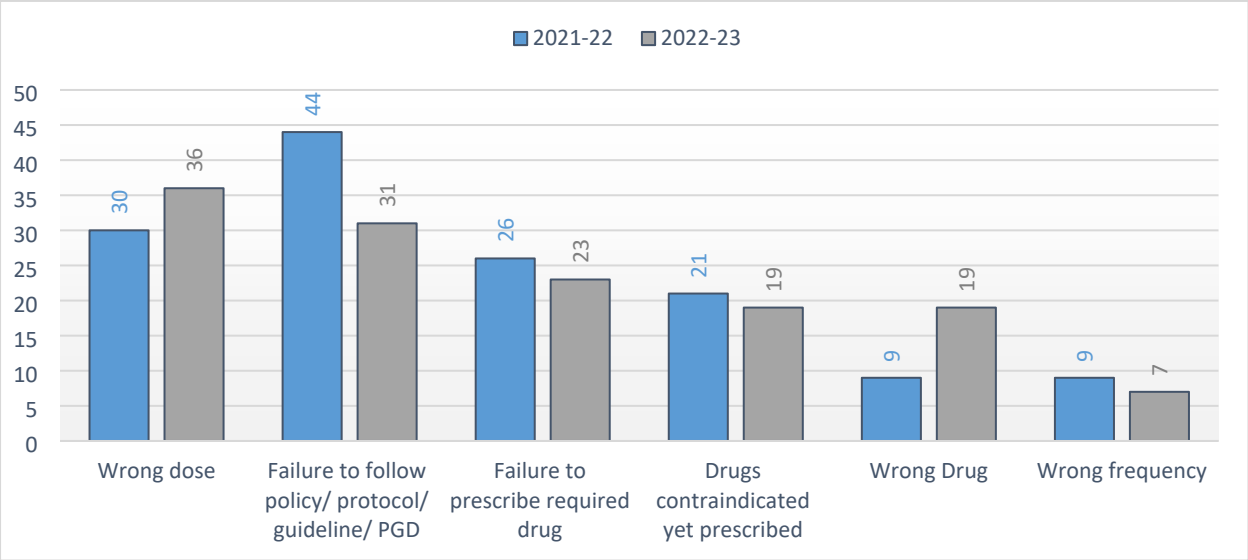


ACTION 6:

A discharge audit tool was developed as part of the SSUMPP audit and assurance programme, with results and recommendations being implemented.

Graph 6 breaks down the type of prescribing errors. Wrong dose is the most common at 36 (30 last year). Failure to follow guideline/policy/procedure/PGD was the next most common at 31 (44 last year) then failure to prescribe at 23 (26 last year). The top 3 remains the same as last year although wrong dose is now the most common type of prescribing error. Prescribing errors are reviewed by the medical education team and learning disseminated. Medication safety minute also contains learning from prescribing errors and a new East Regional Formulary Website has been launched to support clinicians.

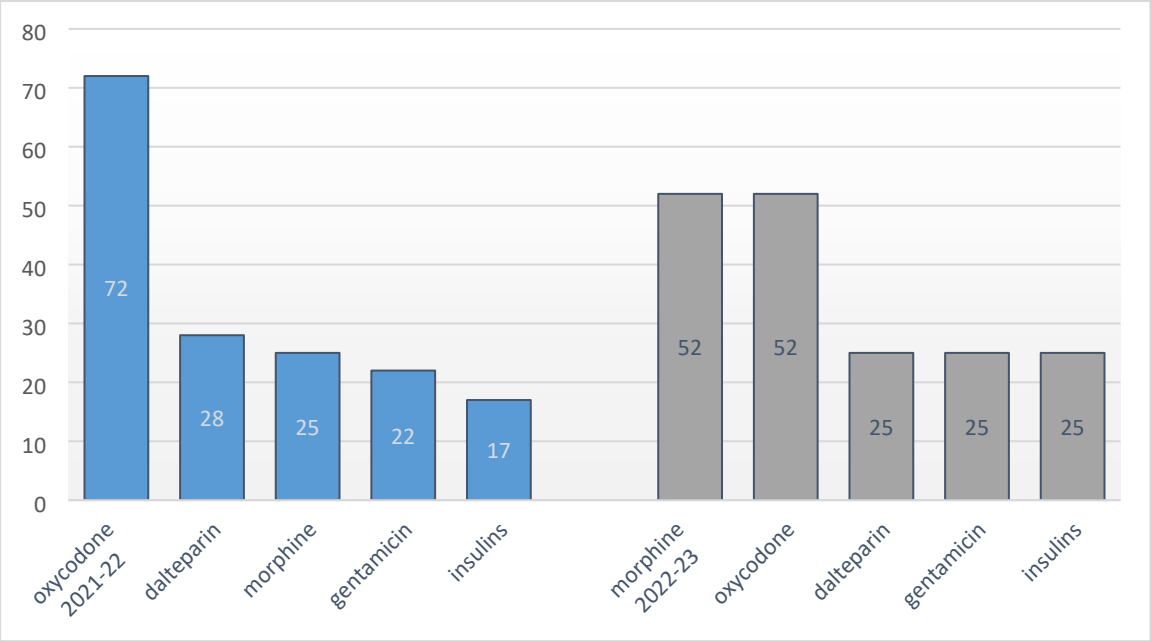
Graph 6 Prescribing Incidents: 2021-22/2022-23



Medications Involved in Incidents

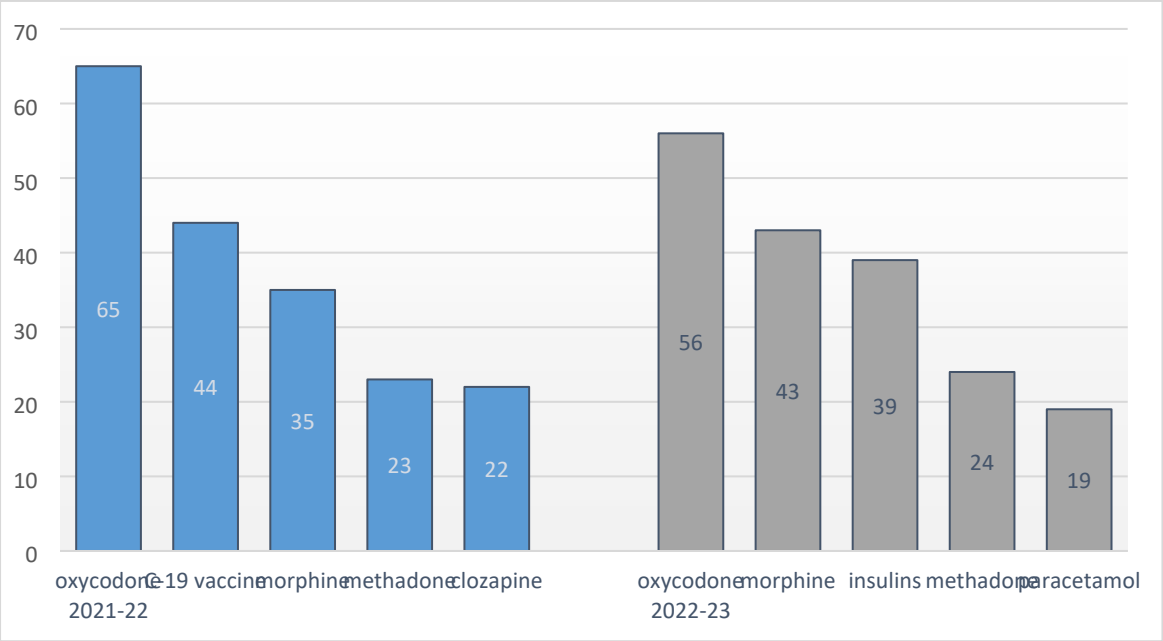
Graph 7a demonstrates the top 5 medications involved in incidents in Acute Services Division. Oxycodone (52) continues to be the most reported medication involved in incidents, although has reduced from 72 last year, with morphine incidents rising to be equal with oxycodone. Morphine is the first line choice for prescribing and oxycodone is second line. Many areas that were high prescribers of oxycodone were targeted last year to support compliance with the formulae and reduce oxycodone prescribing. Daltaparin (low molecular weight heparin), which is a blood clotting treatment and insulin are in the top 5 and will form part of the medication safety program described in section 5.

Graph 7a – Top 5 Drugs involved in Incidents (2021-22/2022-23): Acute Services Division



Graph 7b demonstrates the top 5 medications involved in incidents in Health and Social Care Partnership. Oxycodone (56) continues to be the most commonly reported medication involved in incidents. Morphine (43) and insulin (39) are in the top 3. The remaining top 5 differs from the Acute Services division due to the number of patients being treated for a longer term illness rather than the acute condition. Covid-19 vaccines are no longer in the top 5, as Datix reports were reviewed in detail and lessons learnt were disseminated or new processes put in place, with assurance provided to the Immunisation, Quality and Care assurance group.

Graph 7b Top 5 Drugs involved in Incidents (2021-22/2022-23): HSCP



ACTION 7:

A working group has been established to review anticoagulant use, to address any safety issues and support staff with education and training. This is included within the Medicines Safety Programme described later in this report.

ACTION 8:

A package of improvement tools is being enhanced to support the MDT. A new controlled drug (CD) administration video is currently being prepared to support staff. A CD administration audit tool is available for SCN to review practice in their area. As part of the safe use of medicine audit and assurance program an observational audit of administration is due to take place in all areas this year. Each ward should also be displaying the guide to correct selection of morphine and oxycodone. Promotional materials are also being developed to support staff with oxycodone / morphine selection. This work is closely linked and complementary to Action 4 above.

ACTION 9:

Medication incidents involving contrast media have entered the top 10 reported incidents for the first time within the Acute Services Division - a holistic review of extravasation event, including those for SACT, will be conducted and learning/ actions shared with the organisation.

ACTION 10:

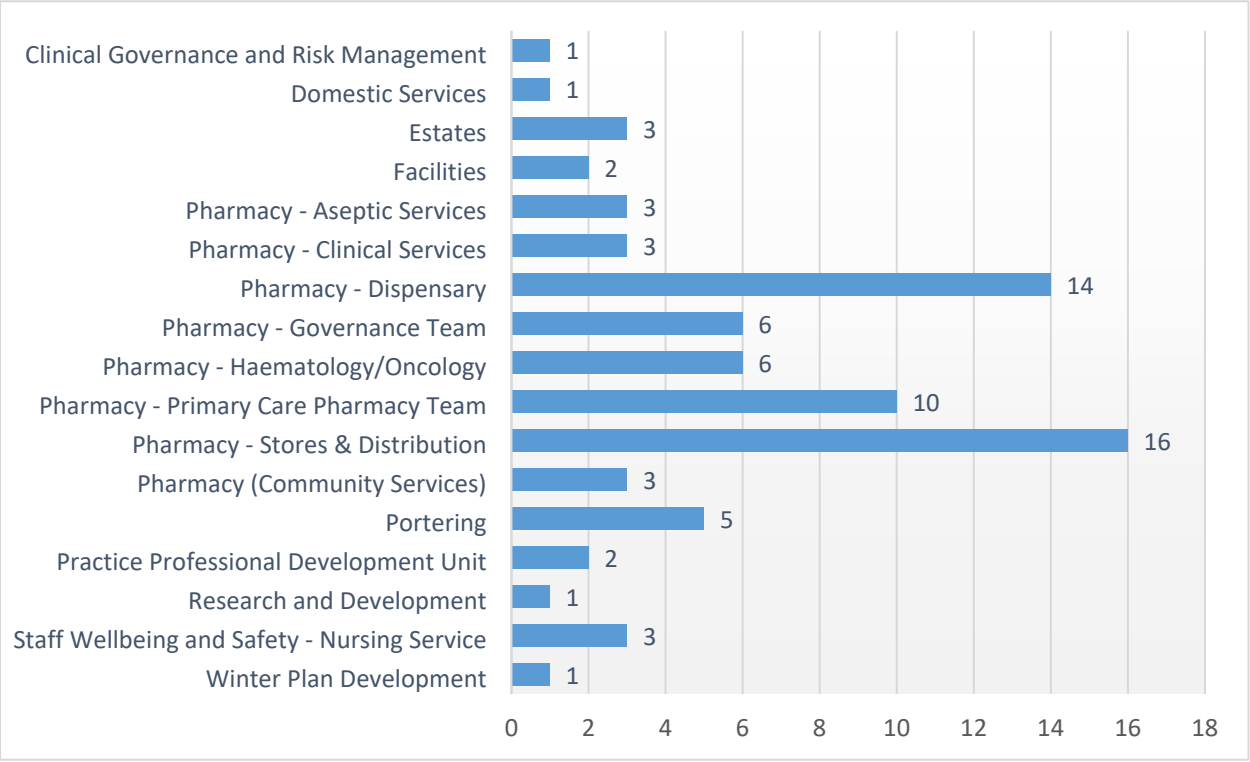
The function of the Safe and Secure use of Medicine Group is being transformed to establish a learning system approach to medicine safety. It has a key role in oversight of the Medicines Safety Programme described below.

ACTION 11:

A detailed review of all CD incidents is discussed at the newly formed CD Governance group, which is a subgroup of the Safe and Secure use of Medicine group. This focuses on identifying key themes and actions for the organisation. A new CD SWAY newsletter has been developed to support staff with key learning points regarding the safe use and handling of controlled drugs.

Corporate Medication Incidents

Graph 8 - Corporate medication Incidents 22-23



Graph 8 demonstrates the speciality involved in a total of 80 medication incidents reported under Corporate Directorate. Twelve of the incidents were reported by the speciality but the incident occurred either in a community pharmacy, GP practice or care home, to support any shared learning across the organisations. The graph demonstrates that all services report medication incidents, to ensure improvement and learning is shared across all specialities as well as support services.

32 medication incidents were reported by Pharmacy. All pharmacy incidents are fully investigated and are often multifactorial. Lessons learned are shared across the system or a new process/ procedure put in place, ultimately overseen by Pharmacy Senior Leadership Team. 22 of the incidents were categorised as supply issues.

ACTION 12:

A short life working group will be formed to look at the whole system approach to ordering and supply of medication.

4. MEDICINES SAFETY IN NHS FIFE – 2023 AND BEYOND

What has been described so far in this paper relates to the overarching approach to medicines safety and governance, as well as the organisational learning strategy. This provides assurance that the overall governance and learning system is in place, functioning appropriately and reacting to incidents a culture which is open to improvement.

There are number of areas in which a proactive preventative agenda is required – these represent foundations of medicines safety improvement. The Board is committed to a robust and coordinated approach. At the highest level, there are five clinical areas which are interlinked and complementary:

1. High Risk Pain Medicines Programme – a strategic objective of the Board for the coming years
2. Medicine Safety Programmes – to be developed over the coming months
    a. Anticoagulants
    b. Insulin
    c. Lithium
    d. Sodium valproate

The following sections describe this preventative agenda which will be overseen by appropriate MDT groups, with clear links through Pharmacy Senior Leadership Team and other governance forums with the HSCP and Managed Service. In addition, reporting will be made through the medicines governance structure noted above. The chapters following provide more detailed information on these priorities.

Alongside this, there are a number of developments which support the whole system:

1. Revamp of the SSUMPP, incorporating an improved content layout and a medicines section on BLINK, supporting usability and adherence across the MDT
2. Ease of access to Policy and Guidelines – focussed around the revised section on BLINK, and including formulary information and other medicines policies
3. Audit and Assurance measures, which are detailed in table three below
4. Controlled drugs management, through the Controlled Drug Governance group which oversees the annual controlled drugs report
5. Medicines safety drumbeat, as noted above, an ongoing review of incidents by the MDT with a

focus on administration, prescribing and supply of medicines. This approach produces a weekly *medicines safety minute* available to clinicians across Fife

6. A focus on organisational learning which underpins the approach across all staff groups, and drives the culture of improvement in the Board.

5. HIGH RISK PAIN MEDICINES

The High Risk Pain Medicine (HRPM) Patient safety programme is a three year programme with the aim of changing the culture in two key areas:

- How we support patients managing pain
- How we prescribe pain medicines

Pain is a universal condition in that everyone understands what pain is and have had some experience of it. Everyone's experience is different though and many people, including some healthcare professionals, don't realise that we need to manage acute pain (pain lasting less than 3 months) and chronic pain (pain lasting longer than 3 months) differently.

Our understanding of how we manage chronic pain has changed over the last 15 years with less of a focus on medicines and more of a focus on supported self-management to improve function and quality of life.

Pain Medicines are extremely helpful in managing acute pain but can be less helpful and may actually cause problems when managing chronic pain. When we use the term *painkillers* it builds an expectation of complete relief from pain which is very hard to achieve - it is better to refer to them as *pain medicines*.

All medicines have the potential to cause side effects. This is particularly the case with pain medicines and when we use them, we need to make sure they are working well (effective) and not causing harm (safe).

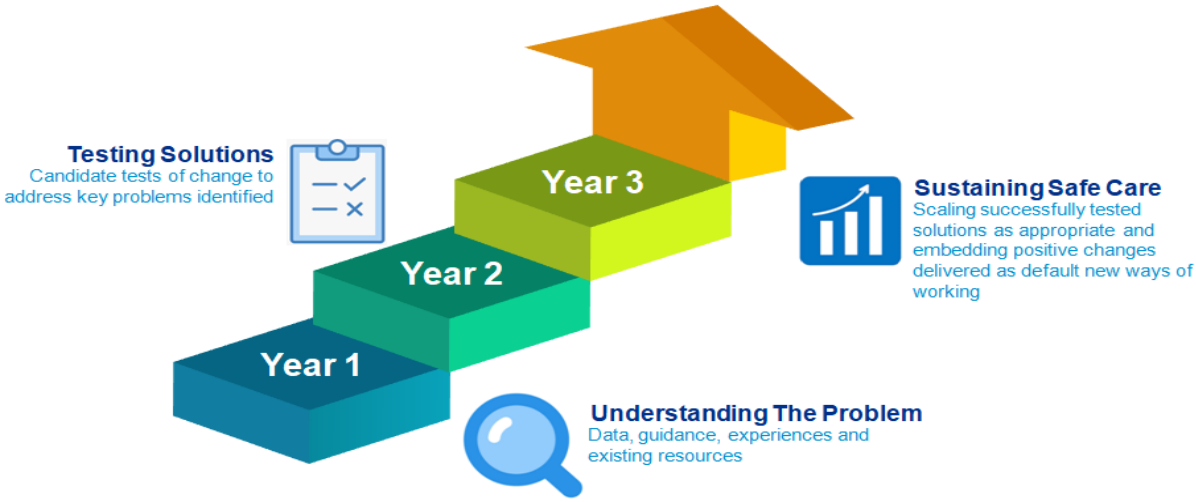
NHS Fife are high prescribers of pain medicines in comparison to other Scottish Health Boards and we have a higher involvement of prescribable pain medicines in nationally reported drug related deaths, as well as pain medicines being consistently involved in local Datix reporting incidents. The programme aims to understand why and ensure that when we are using them, it is part of a shared decision-making process and monitored regularly. By ensuring patients and prescribers have accessible alternatives to prescribing we also hope to change the narrative around managing long term pain to a more supported self-management focus.

The HRPM programme to date

The HRPM programme is running over 3 years, described in diagram 2.

We have just completed Year 1 – *Understanding the Problem.*

Diagram 2 – HRPM program



During Year 1 we have explored and scoped understanding in several different areas:

- Patient Experience
- Staff Experience
- Data, Prescribing & Guidance
- Supported Self-Management Resources
- HRPM & Substance use population
- National and international scoping

Patient Experience

We reached out to people living with pain via various routes including NHS Fife service users, third sector agencies such as Pain Association Scotland, Fife Carers and Fife Voluntary Action and via social media. People came forward and either completed our patient and carer surveys or shared their experience directly with us. We have a participation and engagement officer to support this piece of

work. We had a fantastic response with 190 patient responses, 32 carer responses and collation of over 15 comprehensive patient experiences. It gave us real insight into their experience of managing pain and their experience of pain medicines.

In relation to medicines key findings are included in the following table:

Themes
Lack of information provided about medicines
Lack of medication reviews
Adverse interactions between medicines
Lack of communication across services/ healthcare professionals
Lack of knowledge of non-pharmacological solutions (other ways of managing pain)

Staff Experience

Multiple awareness sessions and focussed discussions took place to gauge key areas. A suite of surveys was used to gain knowledge and understanding from across Primary and Secondary care and different professional groups. All clinicians welcomed the programme and recognised it was an important, but challenging area.

Findings
High clinician confidence in delivering pain management in both sectors contrasted with very limited accessing of guidance and lower confidence in advising on non-pharmacological strategies suggesting a risk that current pain management work is not aligned to the most up to date guidance
Pain teaching across professions usually focussed on acute pain management
Challenge of managing patient expectations around medicines and surgery as a “cure”
Perceived lack of alternatives to prescribing or difficulty in accessing to refer
Lack of capacity and time to support patients- requesting easy to use accessible resources including Community Education

Data, Prescribing and Guidance

Extensive analysis of electronic prescribing systems in primary care allowed us to see variations in prescribing and supported by data analysts, created a MicroStrategy dashboard to facilitate

understanding. Use of Scottish Therapeutic Utility search allowed us to quantify cohorts of higher risk prescribing. Both streams of data are being combined to create quarterly practice data packs which will support practice level review and identify areas or practices to support.

Secondary care analysis is more challenging the absence of electronic prescribing systems. This will be rectified in the near future with the arrival of an electronic system called HEPMA. Manual audits and projects as ward /service level and analysis of supply routes allowed comparison against national guidance and identified areas of good practice and areas for improvement.

Local guidance was reviewed against best practice and national guidance and found to be comparable but with limited evidence of local implementation. Staff surveys identified that clinicians found the guidance difficult to find, inaccessible and unwieldy.
Datix incidents involving HRPM were scrutinised for the year and flagged areas needing addressed through training and development across the organisation.

Supported Self Management Resources

A mapping exercise was undertaken of all resources, services (Health and Partnership) and third sector agencies that provide support for people living with pain. Working with partners and from staff and patient carer/surveys we identified limited awareness and utilisation of available resources. Having easily accessible, meaningful alternatives to prescribing is key to addressing the over-reliance on medicines to address pain and in improving access , will reduce overall population risk from medicines.

HRPM and Substance Use population

In recognition of greater involvement of prescribed medicines in local drug related deaths it is important to understand the impact of the HRPM medicines in this patient population. This will include people who use substances and are managing a long term pain condition, which needs addressed, as well as the population who use HRPM as part of their polysubstance use for non pain reasons. A short life working group was established and are currently summarising findings from an audit of medicines in the drug related deaths, a multi-professional focus group and literature search. There are plans to undertake a survey with people with lived experience to help understand routes of access to HRPM and the pain support needs of this cohort.

National and International Scoping

Literature searches were undertaken, and national and international programmes of work related to HRPM were investigated. The programme engaged directly with key stakeholders to understand successes, challenges and quick wins. All the learning will inform the Year 2 and 3 direction of the programme. What was clear is that most analgesic stewardship programmes elsewhere focussed on one drug group at a time, predominantly opioids and often in one sectoral area e.g. primary care.

Summary

All the findings for Year 1 "Understanding the Problem" have been scrutinised as part of several workshops and a major event with over 50 key stakeholders to identify opportunities for improvement and potential tests of change. To help deliver on the main initiatives key work streams have been established:

- Engagement & Experience – will take forward establishing lived experience group and peer support network
- Evidence & Education- will develop and deliver the training response to address knowledge and understanding gaps in workforce. It will also create easily accessible guidance with prescribing toolkits and regular data updates to help clinicians review own local practice and undertake quality improvement initiatives
- Incremental Improvement – will address process quality improvement packages to increase safe and effective prescribing of HRPM

The programme will be underpinned by a development of a patient and clinician accessible web based resource hub and a strategic internal and external communications plan based on a clear public health message in relation to managing pain and safe use of pain medicines.

NHS Fife is uniquely addressing a complex area with a whole system approach to addressing analgesic stewardship which will ultimately improve the management and support of people living with pain and reduce risk of harm from high risk pain medicines.

6. MEDICINE SAFETY PROGRAMME

The programme around medicines safety contains four key areas of focus for the coming year. It should be noted, that this programme and indeed wider medicines safety improvement, will be supported and enhanced by delivery of improved digital systems, including HEPMA (Hospital Electronic Prescribing and Medicines Administration) over the coming months and years.

Anticoagulants

Medicines Safety Programme
Objective 1 - Focus on Anticoagulant Prescribing and Administration

Anticoagulant medicines are very effective at preventing and treating clots, but they can also be harmful if they are prescribed or administered incorrectly. Reducing errors associated with anticoagulants is important, because oral warfarin, Directly Acting Anticoagulants, injected heparin and low molecular weight heparin have all been reported in prescribing error incidents that have caused death and serious harm. The National Patient Safety Agency (NPSA) has identified these medicines as major causes of adverse events and hospital admissions.

Patients who are admitted to hospital may be at risk of developing, or admitted with, a deep vein thrombois (DVT) or pulmonary embolism (PE). The Venous Thromboembolism (VTE) risk assessment within the patient admission document is completed and anticoagulants may be prescribed for the prevention and management of DVT and PE as per the NHS Fife *policy and management of deep venous thrombosis and pulmonary embolism* guideline. This guideline is accessible on the NHS Fife formulary website.

As part of that risk assessment, care should be taken to assess whether the patient is already prescribed an anticoagulant, to avoid the duplication of anticoagulant prescribing. The most common conditions that patients may be prescribed anticoagulation before hospital admission are ongoing management of clotting disorders, AF and replacement heart valves.

The main medicines prescribed for these indications are blood clotting treatments such as low molecular weight heparin (NHS Fife first line LMWH is dalteparin), warfarin and direct acting oral

anticoagulants (DOACs) such as edoxaban, apixaban and rivaroxaban. During a patient's stay in hospital, a decision may be made to commence anticoagulation and care should be taken at this point to ensure that co-prescription of anticoagulants does not occur (except when patients are prescribed 'bridging anticoagulation' and are being appropriately monitored.

An initial review of Datix incidents has been undertaken with a medicine safety bulletin focusing on anticoagulant therapy produced as an initial response. The audit between September 2021 and September 2022 showed a total of 68 incidents across NHS Fife. Notably, while the majority occurred in the VHK, there were errors reported in every hospital.

A detailed programme of improvement will be developed. Importantly, this will span clinical professions and care settings across Fife. A core component will be a focus on the education and training of staff, ensuring all clinicians understand the risks and appropriate preventative actions. There will be a need to alter dosages in the primary care setting, reflecting up to date information on patients' renal function, in conjunction with regular review at a patient level.

In the longer term, the introduction of the HEPMA system will have a positive impact on safety in this area through implementation of a safety alert. For the coming year, a cross profession and cross sector approach is critical to ensuring safe care.

Lithium

Medicines Safety Programme
Objective 2 - Focus on Lithium Prescribing and management

Lithium is an effective medicine, particularly in the maintenance treatment for bipolar disorder, recurrent depression, and with growing evidence of suicide-protective effects. Research informs us that in Scotland the use of lithium has declined in recent years, despite lithium being recognised as the gold standard treatment for bipolar disorder.

A multidisciplinary team, with contributors from primary and secondary care, Mental Health and the Medicines Management Team, was established in May 23. Their role was to determine the quickest and most effective way to audit and review all patients currently prescribed lithium (currently 339 patients in NHS Fife), to ensure they meet the requirements outlined in the CMO's National Guidance for Lithium Monitoring.

This is a complex picture including management by both primary and secondary care clinicians. In many cases, patients may have shared care agreements (which clarifies responsibility for facets of care between general practice and specialists) in place to ensure highest quality support and cooperation between clinicians.

Lithium has a narrow therapeutic index and requires tight control of prescribing and adherence to prevent toxicity, whilst also ensuring that the dose is therapeutic. Even at the optimal dose, it can have side effects, and long-term use can be associated with thyroid disorders and cognitive impairment. As a teratogenic medicine, it can also have a particularly negative impact during pregnancy, and therefore requires special considerations for some patients.

Audit and improvement work for patients taking Lithium will be undertaken, this will:

- Ensure appropriate monitoring plans are in place, and facilitate alterations to the prescribed Lithium levels through an MDT approach, if required
- Ensure monitoring of patient parameters, including kidney and thyroid function, is in place
- Ensure that clinical review is ongoing at appropriate intervals for the individual patient
- Ensure that prescribing is done on a branded basis - due to differences in bioavailability, patients react differently to various brands, and with a narrow therapeutic window, switching brands can have undesired effects
- Ensure effective contraception is in place, if required.

The reviews will be led by Pharmacists, with patients referred to their GP or consultant for review as required. This will include consideration and recommendations on patient management systems and process, such as recall. Ultimately, the Board will be assured that patient care is at the appropriate standard for this vulnerable group.

Insulin

Medicines Safety Programme

Objective 3 - Focus on Insulin Prescribing and Administration

Type 1 diabetes is an autoimmune disease that causes the insulin producing beta cells in the pancreas to be destroyed, preventing the body from being able to produce enough insulin to adequately regulate blood glucose levels. Type 2 diabetes is a disorder in response to environmental stimuli that results in patients experiencing insulin resistance. Diabetes symptoms should be acted upon immediately, as without treatment certain type of diabetes can be deadly. Diabetes is a serious condition which can carry a significant risk of both short term and long-term complications. Both diabetes types may require treatment with insulin. Most people will take insulin by injection with insulin pens: some people require district nurses to attend and administer insulin.

Insulin doses are very individualised: the patient's record of repeat medications will not document the exact number of units of insulin they take as this may vary depending on meals and activity levels. Confirming the current dose of insulin when the patient is admitted to hospital is a critical component of medicines reconciliation. This can be challenging, for example if the patient is usually independent but cannot confirm their usual dose due to issues such as new confusion or difficulty communicating. If the insulin is administered by district nurses, it is necessary to contact the district nurse team via phone to confirm the usual dose. If the insulin dose is not accurately confirmed on admission this can lead to errors in prescribing.

If the patient receives too much insulin in error this will result in hypoglycaemia which can be life threatening if not corrected urgently. If the patient receives too little insulin or misses a dose, there are a number of potential risks from the resulting hyperglycaemia. Patients requiring insulin are at risk of diabetic ketoacidosis (DKA), a serious condition with rapid onset resulting from too little insulin. Complications include low glucose and potassium levels in the blood, fluid build-up in the lungs and acute respiratory distress syndrome. A rare complication is cerebral oedema where fluid builds on the brain; this is more common in children. DKA is a life-threatening condition and requires admission to critical care of medical high dependency for safe management.

Locally, the number of injections performed properly in hospitals far outweighs the number of incidents: 25% of inpatients are prescribed insulin with 64 insulin incidents reported in Datix in 2022. NHS Improvement (an NHS England body) lists overdose of insulin as a 'never event'. The National Patient Safety Agency (NPSA) notes insulin as one of the medication categories, where missed or delayed doses may cause the highest impact with regards to severe patient harm or death.

NHS Scotland published 'Diabetes care - Diabetes improvement plan: commitments - 2021 to 2026' in February 2021 to improve prevention, treatment and care for all people in Scotland affected by diabetes. The 'Think, Check, Act' campaign focuses on a minimising of insulin related errors for persons within inpatients settings and makes the following commitments:

- Improved patient safety through the further roll out of Diabetes Think, Check, Act focusing on reducing insulin prescription errors and DKA
- Optimising diabetes inpatient care in hospitals across Scotland and reduction of avoidable adverse events

The programme will be broken down into the following components:

- Phase 1: Understanding the problem.
    - Undertake audit and analysis of prescribing/ administration of Insulin, incorporating a six-month review of Datix Incidents.

- Phase 2: Prevention
    - Explore options for regular and ongoing (mandatory) training.
    - Develop an Insulin Safety Improvement Plan.
    - Introduce and develop champions at service, ward and cluster level.
    - Establish Insulin safety bundle.
    - Deliver Insulin Safety Sessions as part of rolling programme of Safety Huddles.

- Phase 3: Develop Guidance for use
    - Update appropriate sections of SSUMPP
    - Rapid dissemination of improvement actions & learning via Medicines Safety Bulletin
    - Establish regular review of Datix Incidents.

There is an established MDT group including clinical and primary care pharmacy, hospital and HSCP nursing, diabetes specialist nursing, community diabetes nursing, district nursing, managed clinical network (MCN) management and care home representation. This program is led by Head of Pharmacy for governance and therapeutics and will report to Safe and Secure use of Medicine

group. Reporting of progress and outcomes will be provided to the Area Drug and Therapeutic committee.

Sodium Valproate

Medicines Safety Programme

Objective 4 - To continue to develop and enhance our approach to prescribing of Sodium Valproate

In 2018, the Medicines and Healthcare products Regulatory Agency (MHRA) introduced a requirement that valproate medicines must no longer be used in women or girls of childbearing potential unless a Pregnancy Prevention Programme (Prevent) is in place. All women and girls (and their parent, caregiver, or responsible person, if necessary) must be fully informed of the risks and the need to avoid exposure to valproate medicines in pregnancy. If valproate is taken during pregnancy, up to 4 in 10 babies are at risk of developmental disorders, and approximately 1 in 10 are at risk of birth defects.

In 2019 a Short Life Working Group of relevant clinical experts was set up to respond to the MHRA guidance. This group produced an annual audit to review all women and girls of childbearing potential to ensure they met the audit standards. This audit has been completed in 2019, 2020, 2021 and 2022.

In 2022 a thorough review has been carried out into the audit process and as a result the audit has been amended to include a follow up process to ensure delivery of more detailed outcomes ensuring the safety of the childbearing population of NHS Fife.

In the most recent audit, locally there are 135 women and girls of childbearing potential taking Valproate medicines and of these 46 already met all four standards at the time of the audit. Of the 89 who did not meet at least one standard, plans were urgently put in place and actions will be delivered as a priority for their respective MDTs.

There will be a follow up data collection at the end of June 2023 to ensure that the plans in place have been followed through and we are assured of the safety of our women and girls of childbearing potential on valproate medicines.

The future is to move from an annual audit to an ongoing annual review process so that referrals are made each year to either Neurology, Learning Disability or Psychiatry for the Specialists (Either consultants or Nurse Specialists) to complete the appropriate paperwork. To assist with this, we are in liaison with the Business Managers for these areas to ensure we have enough referral slots available to review the forms that require to be completed.

A permanent MDT group is being developed to oversee the management and improvement of this area, including representation from neurology, psychiatry, general practice, nursing and Pharmacy. Reporting of progress and outcomes will be provided to the Area Drug and Therapeutic committee.

7. AUDIT AND ASSURANCE

Medicines continue to be the most common therapeutic intervention in healthcare, and the Safe and Secure Use of Medicines Policy and Procedures (SSUMPP) is the main document that details the systems and processes in place to ensure the safe and secure prescribing, administration, supply, storage and destruction of medicines - including controlled drugs.

Following a number of serious medication incidents in late 2016/ early 2017 a wholesale review of the Policy was undertaken, and an audit programme developed to provide assurance that the requirements of the policy were being implemented and met.

The Safe and Secure Use of Medicines Group agreed to review the audit programme to create a sustainable Medicines Audit and Assurance Programme going forward.

In 2018 sixteen audits were agreed and prioritised by identifying the risk, reviewing the assurance against the three lines of defence model and agreeing the areas of the SSUMPP being audited.

All audit reports and action plans as a result are reviewed and monitored by The Safe and Secure Use of Medicines Group (SSUOMG), with assurance provided to Area Drug and Therapeutic Committee. Table 3 below details the audits completed in 2022 and planned for 2023.

Table 3- Audit and Assurance Programme

Audit	How often/Areas covered	Status	Current update
Clinical Management Guidelines, for Systemic anti cancer Therapy (SACT) protocols	Annually- areas that use SACT protocols	Received by ADTC April 23 Plan in place for 23/24	Actions from audit are monitored by SSUOMG with 6 monthly updates to ADTC
Controlled drug audit	Annually- all wards/depts that hold schedule 2 or 3 controlled drugs that require safe storage	Received by ADTC April 23 Plan in place for July-Dec 2023	Actions from audit are monitored by SSUOMG with 6 monthly updates to ADTC
Provision of Discharge Medicines and Medicines to Take Home	Twice in 5 Years- Sample of wards/depts across ASD and HSCP	SSUOMG in May 23. ADTC September 23	Actions from audit are monitored by SSUOMG with 6 monthly updates to ADTC
Controlled Drugs Observational Audit – Wards	Twice in 5 Years all wards/depts that hold schedule 2 or 3 controlled drugs that require safe storage	Planned September 23	Actions from audit will be monitored by SSUOMG with 6 monthly updates to ADTC
Controlled Drugs Observational Audit – Theatres	Twice in 5 Years- All theatres	Planned September 23	Actions from audit will be monitored by SSUOMG with 6 monthly updates to ADTC
Medicines Administration Observational Audit - Wards	Twice in 5 Years- all inpatient wards/depts	Planned September 23	Actions from audit will be monitored by SSUOMG with 6 monthly updates to ADTC

Return and Destruction of Medicines	Twice in 5 Years- Sample of wards across HSCP and ASD and pharmacy stores	Received by ADTC April 23	Actions from audit are monitored by SSUOMG with 6 monthly updates to ADTC
Transportation of medicine	Once in 5 years – Sample of wards across HSCP and ASD ,pharmacy stores , hospital dispensaries and portering services	Planned for 2023/24	Conducted by internal audit and actions monitored by Audit and Risk Committee, assurance given to SSUOMG and ADTC
Medicines Requiring Refrigeration – Hospital wards/ departments	Every 2 years ASD 2022 HSCP 2023 All wards/departments that have a refrigerator	Received by ADTC Oct 23 Planned- August-Sept 23	Actions from audit are monitored by SSUOMG with 6 monthly updates to ADTC
Medical Gases – Wards/ departments	Annually - all wards and departments that hold medical gases	2022 audit Reviewed by Medical Gas Committee June 23 2023 audit planned Oct-Nov	Actions from audit are monitored by Medical Gas Committee with 6 monthly updates to ADTC
Medical Gases – Stores	Annually - all medical gas stores	2022 audit Reviewed by Medical Gas Committee June 23 2023 audit planned Oct-Nov	Actions from audit are monitored by Medical Gas Committee with 6 monthly updates to ADTC
Security and storage of medicines	Once in 5 year cycle – all areas that store medicines	Planned July- Dec 23	Actions from audit will be monitored by SSUOMG with 6 monthly updates to ADTC

PGD	Annually – formic form sent to all areas that use PGD	Received by ADTC April 23 Planned for 2023/24	Actions from audit are monitored by PGD review group and updates to ADTC
Security of prescription stationery	Once in 5 years- sample of wards and departments across HSCP and ASD	Previous year work completed	Conducted by internal audit and monitored by Audit and Risk Committee. Assurance given to SSUOMG and ADTC

8. SUMMARY OF ACTIONS

Reference	Summary
Action 1	Review and improve use of the attractive stock dashboard. Monthly reviews are now in place
Action 2	Development and implementation of and improvement plan for insulin safety is underway
Action 3	Review the Just in Case policy, and development of enhanced support to clinicians is underway
Action 4	A revised approach to analysis of supply incidents will be undertaken this year incorporating historic incidents and common learning/ themes, as part of the action plan for the Controlled Drugs Governance Group.
Action 5	Education and training resources approaches will continue to be developed to support staff with administration errors and will be overseen by the Safe and Secure use of Medicines Policy and procedures
Action 6	A discharge audit tool was developed as part of the SSUMPP audit and assurance programme. An action plan is available and being implemented
Action 7	A working group has been established to review anticoagulant use to address any safety issues and support staff with education and training. This will be a core component of the medicines safety programme.
Action 8	Development and delivery of a package of improvement tools around controlled drugs to support the MDT is underway.
Action 9	A detailed analysis and action plan around extravasation incidents is underway with learning and actions to be shared.
Action 10	Transformation of the function of the Safe and Secure use of Medicines Group to establish a learning system approach is underway, with a key role in the medicines safety programme.
Action 11	Progress has been made on a detailed review of CD incidents within the CD governance group and refresh of the communications approach
Action 12	Develop a short life working group to look at the whole system approach to ordering and supply of medication
MSP Objective 1	Focus on Anticoagulant Prescribing & Administration.
MSP Objective 2	Focus on Lithium Prescribing & Management.
MSP Objective 3	Focus on Insulin Prescribing & Administration.
MSP Objective 4	Continue to develop and enhance our approach to prescribing of Sodium Valproate

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**3 November 2023**
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 Committee, to provide assurance that all IP&C priorities are being and will be delivered.

This is presented for:

- Assurance

This report relates to a:

- National Health & Well-Being Outcomes

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

Update for Infection Prevention and Control for October 2023 committee to provide assurance that all IP&C priorities are being and will be delivered. This report is for information for the Committee update based on the most recent HAIRT circulated to the Infection Control Committee October 2023.

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:
DL (2023) 06 on 28th February 2023 given the continued service pressures it has been agreed by Scottish Government that the previous HCAI targets will be further extended by one year to 2024. 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 2024, utilising 2018/19 as baseline data.
- Outcome measure - achieve 10% reduction by 2023/24 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 2024, 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 2023/234 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 2024, 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 2023/24 is 33.0 per 100,000 total bed days.

2.3 Assessment

SAB

- During Q1 2023 (Jan- March), NHS Fife was below the national rate for healthcare associated infection (HCAI).
- Q2 2023 (Apr-Jun), has seen the same number of cases as in Q1 2023; 26 cases. However, there was a reduction in the number of HCAI cases, when comparing the two time periods. Awaiting national comparison.
- There have been 8 dialysis line related SABs since the start of 2023.
- There have been 6 PWID related SAB cases in 2023.
- **320 days** had been achieved since the last PVC related SAB in Acute Services.

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.

CDI

- During Q1 2023 (Jan- March), NHS Fife was equal to the national rate for HCAI and below for CAI.
- The cumulative total of CDIs for the period Jan- end of August 2023 (n=38) is significantly higher than the number of cases during the same time-period the previous year (n=28). There was also an increase in the number of HCAI (HAI+HCAI+Unknown) cases.

Current CDI initiatives

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

ECB

- During Q1 2023 (Jan- March), NHS Fife was below the national rate for HCAI & CAI.
- Q2 2023 (Apr-Jun), has seen the same number of cases number as in Q1 2023; 49 cases. Awaiting national comparison.
- Considering the time period Sep 2022 to Aug 2023, the number of CAUTI related ECBs (n=29) was slightly lower than during the same time-frame the previous year (n=30).

Current ECB Initiatives

- The Infection Prevention and Control team continue to work with the Urinary Catheter Improvement Group (UCIG).
- 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
- CAUTI bundles have now been installed onto Patientrack and have been trailed on V54 ward. Amendments to the tool are awaited by Patientrack, prior to this being rolled out across the board.

Surgical Site Infection (SSI) Surveillance Programme

National surveillance programme for SSI has been paused due to the COVID-19 pandemic. DL (2023) 06 published February 2023 advises surgical site infection (SSI) and enhanced surveillance reporting remains paused for the time being.

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 (May - June 2023)

Norovirus

- There has been no new ward closure due to a Norovirus outbreak

Seasonal Influenza

- There has been no new closures due to confirmed Influenza

COVID-19

- 10 new ARHAI Scotland reportable outbreaks/incidents of COVID-19 which are detailed in the HAIRT

Hospital Inspection Team
1 new inspection during the last reporting period.

Healthcare Improvement Scotland (HIS): Safe delivery of care inspection - Unannounced inspection to Victoria Hospital, NHS Fife, 31st of July- 2nd of August. Factual accuracy report expected week commencing 2 October.

The publication timelines are as follows:

- Embargoed publication: Thursday 19th October.
- Full publication: Thursday 26th October.

Hand Hygiene

- There is currently no robust electronic recording system for reporting hand hygiene (HH) compliance from clinical areas across Fife. LanQIP had previously been the IT platform utilized by staff to submit their 20 HH opportunities per month. NHS Fife eHealth, they have confirmed that LanQIP continues to be a working platform and they have advised that clinical areas can continue to use, as no patient identifiable data held. However, eHealth have stated there is no assurance that LanQIP will not suddenly fail and if this occurs, there will be no digital support to repair this platform. eHealth have therefore recommended that LanQIP can be utilized as an interim tool to centralize HH data, until a further robust system can be put in place.

Cleaning and the Healthcare Environment

- Keeping the healthcare environment clean is essential to prevent the spread of infections.
- NHS Boards monitor the cleanliness of hospitals and there is a national target to maintain compliance with standards above 90%.
- The Overall Cleaning Compliance for NHS Fife for Quarter 1 (April- June 2023) was **95.9%**.

National Cleaning Services Specification

The National Cleaning Services Specification – quarterly compliance report result for Quarter 1 (April- June 2023) shows NHS Fife achieving **Green** status.

Estates Monitoring

The National Cleaning Services Specification – quarterly compliance report result for shows Quarter 1 (April- June 2023) NHS Fife achieving **Green** status.

2.3.1 Quality/ Patient and Value-Based Health & 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

A potential cost pressure to implement a new HH audit platform for governance and assurance.

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 and Anchor Institution ambitions

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

2.3.6 Climate Emergency & Sustainability Impact

N/A

2.3.7 Communication, involvement, engagement and consultation

This paper has been considered by the Infection Control Manager

2.3.8 Route to the Meeting

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

This is a summary of the HAIRT submitted to the Infection Control Committee October 2023

2.4 Recommendation

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

3 List of appendices

The following appendices are included with this report:

- Appendix 1 - HAIRT Report

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

Infection Prevention
and Control Team

Fife Health & Social Care Partnership

NHS Fife

HAIRT Report

HAIRT Report for Infection Control Committee on 4th October 2023

(Validated Data up to August 2023)

October 2023

Published Month Year

www.nhsfife.org

Contents

Board Wide Issues

Key Healthcare Associated Infection Headlines

1.1 Achievements:

***Staphylococcus aureus* Bacteraemia Prevention (SAB)**

During Q1 2023 (Jan- March), NHS Fife was below the national rate for healthcare associated infection (HCAI).

Q2 2023 (Apr-Jun), has seen the same number of cases as in Q1 2023; 26 cases. However, there was a reduction in the number of HCAI cases, when comparing the two time-periods (from 16 cases in Q1 2023 to 13 cases in Q2 2023). Awaiting national comparison.

At the time of the most recent update (01/09/23), **320 days** had been achieved since the last PVC related SAB in Acute Services.

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

During Q1 2023 (Jan- March), NHS Fife was equal to the national rate for HCAI & below for CAI.

***Escherichia coli* bacteraemia (ECB)**

During Q1 2023 (Jan- March), NHS Fife was below the national rate for HCAI & CAI.

Q2 2023 (Apr-Jun), has seen the same number of cases number as in Q1/2023; 49 cases. This similarity is also reflected in the number of HCAI cases (25 cases in Q1 2023 and 26 cases in Q2 2023). Awaiting national comparison.

Considering the time-period September 2022 to August 2023, the number of ECBs (n=243) was lower than during the same timeframe the previous year (n=277). This reduction was also reflected in the number of HCAI cases (Sep 22-Aug 23, n= 112 versus Sep 21-Aug 22, n=135) and CAUTI related ECBs (Sep 22-Aug 23, n=29, versus Sep 21-Aug 22, n=30).

COVID-19

The weekly ARHAI Scotland nosocomial report has now ceased.

1.2 Challenges:

DL (2023) 06 published on 28th February 2023 advised given the continued service pressures it has been agreed by Scottish Government that the previous HCAI targets will be further extended by one year to 2024.

SABs

Vascular access devices (VAD) remain the greatest challenge for hospital acquired SABs, ongoing improvement work continues.

There was a rise in the number of PWID related SAB cases during 2022 (n=11), when compared to the previous year (n=4). So far, during 2023 (up to end August 23), there have been 6 PWID related SAB cases.

There has been a further dialysis line related SAB since the last report, taking the total number of cases (Jan-Aug 2023) to 8. This is a high number, considering there were only 2 cases for the whole of 2022. Previously, renal services carried out Complex Care Reviews (CCRs) of each patient, and a `Super SAER` meeting took place on 26th June, to discuss all of the findings. The most recent case has been Datix`d by the Microbiology Consultant.

CDI

The cumulative total of CDIs for the period Jan-end Aug 2023 (n=38) is significantly higher than the number of cases during the same time-period the previous year (n=28). There is also an increase in the number of HCAI (HAI+HCAI+Unknown) cases (Jan-Aug 23 n=29, Jan-Aug 22 n=20). IPCT will continue to monitor cases to assess if there is a sustained rise.

Caesarean Section SSI/ Large Bowel Surgery SSI/ Orthopaedic Surgery SSI

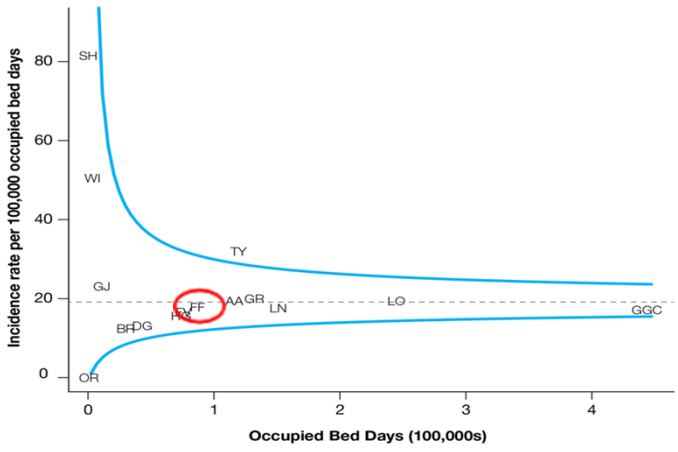
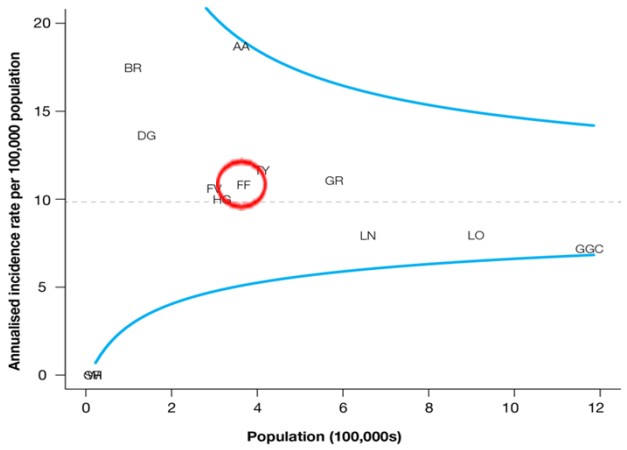
National surveillance programme for SSI has been paused due to the COVID-19 pandemic. DL (2023) 06 published February 2023 advises surgical site infection (SSI) and enhanced surveillance reporting remains paused for the time being.

Surveillance

2. Staphylococcus aureus incorporating MRSA/CPE screening compliance

2.1 Trends – Quarterly

Staphylococcus aureus Bacteraemias (SABs)				
Local Data: Q1 2023 (Jan-Mar) **(Q1 2023 National comparison awaited)**				
In Q2 2023 NHS Fife had:	26 SABs	13 HCAI/HAI 13 CAI	This is EQUAL TO:	26 Cases in Q1 2023

Q1 2023 (Jan-Mar) - ARHAI Validated data with commentary			
Healthcare associated SABs		**Community associated SABs infection**	
HCAI SAB rate: 17.9	Per 100,000 bed days	CAI SABs rate: 10.8	Per 100,000 Pop
No of HCAI SABs: 16		No of CAI SABs: 10	
This is BELOW National rate of 19.1		This is ABOVE National rate of 9.8	
			
NHS Fife was WITHIN the 95% confidence interval in the funnel plot analysis for CAI & below for HCAI.			

New standards for reducing all Healthcare Associated SAB by 10% by 2022 (from 2018/2019 baseline). This standard was extended to 2023 and will be extended for a further year to 2024		
Standards application for Fife:	**SAB Rate Baseline 2018/2019**	**SAB 10% reduction target by 2024**
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 Mar 2023 (HPS)		
SAB by rate 100,000 Total bed days	**14.8** per 100,000 TBDs	
SAB by Number of HCAI cases	**53**	

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 8 dialysis line related SABs during Jan-Aug 2023. Renal services carried out a CCR of each case (Jan-Apr 2023 cases) and the findings were discussed at a `Super SAER` meeting on 26th June 2023. The most recent case (August 2023) has been Datix`d by the Consultant Microbiologist.

As of **01/09/2023** the number of days since the last confirmed SAB is as follows:	
CVC SABs	403 Days
PWID (IVDU)	51 Days
Renal Services Dialysis Line SABs	11 Days
Acute services PVC (Peripheral venous cannula) SABs	320 Days

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

2.2 Current Risk Register Rating

Corporate Directorate – Nursing Directorate Infection Control Team Risk Register		
ID: 637 SAB LDP Standard		
Initial Risk Level	**Current Risk Level**	Target Risk Level
Moderate 12	**Moderate Risk 9**	Low Risk 6

2.3 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.

2.4 National MRSA & CPE screening programme

MRSA

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

NHS Fife achieved **98%** compliance with the **MRSA** CRA in Q2 2023 (Apr-Jun)

This was **BELOW** Q1 2023 (100%), but **ABOVE** the compliance target of 90%.

This was **ABOVE** the national rate for Q2 2023.

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

Quarter	Q1 2021 Jan-Mar	Q2 2021 Apr-Jun	Q3 2021 Jul-Sep	Q4 2021 Oct-Dec	Q1 2022 Jan-Mar	Q2 2022 Apr- Jun	Q3 2022 Jul-Sep	Q4 2022 Oct-Dec	Q1 2023 Jan-Mar	Q2 2023 Apr- Jun
Fife	95%	98%	88%	93%	98%	98%	98%	100%	100%	98%
Scotland	83%	84%	81%	82%	81%	80%	78%	74%	78%	81%

CPE (Carbapenemase Producing Enterobacteriaceae)
From April 2018, CRA has also included screening for CPE.
NHS Fife achieved **100%** compliance with the **CPE** CRA for Q2 2023 (Apr-Jun)
This was **EQUAL** to the compliance rate in Q1 2023
This was **ABOVE** the national rate for Q2 2023.
CPE Critical risk assessment (CRA) screening KPI compliance summary:

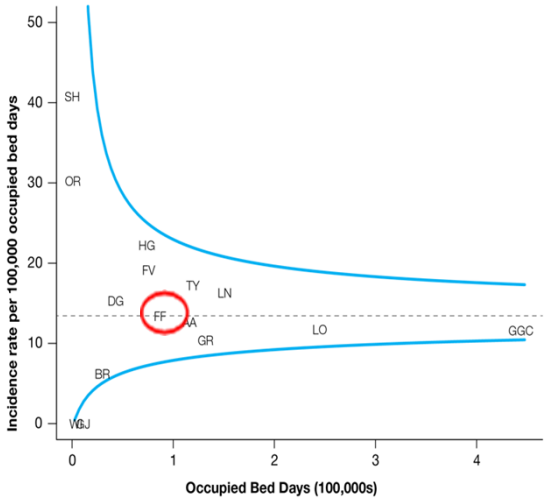
Quarter	Q1 2021 Jan-Mar	Q2 2021 Apr-Jun	Q3 2021 Jul-Sep	Q4 2021 Oct-Dec	Q1 2022 Jan-Mar	Q2 2022 Apr- Jun	Q3 2022 Jul-Sep	Q4 2022 Oct-Dec	Q1 2023 Jan-Mar	Q2 2023 Apr-Jun
Fife	88%	90%	100%	98%	100%	98%	100%	100%	100%	100%
Scotland	82%	83%	82%	80%	80%	79%	78%	76%	77%	80%

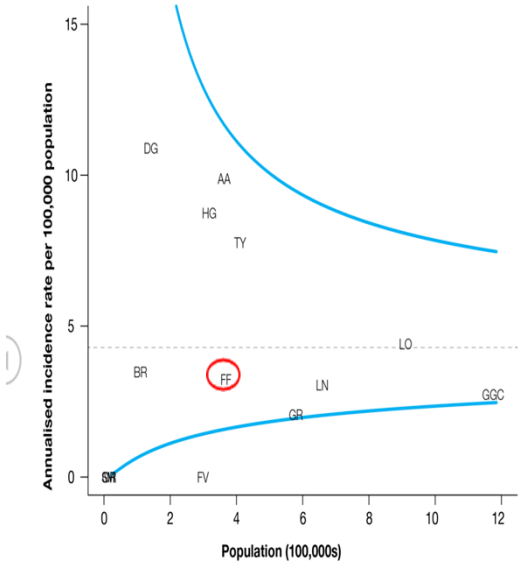
3 Clostridioides difficile Infection (CDI)

3.1 Trends

Clostridioides difficile Infection (CDI)				
Local Data: Q2 Apr-Jun 2023 **(Q2 2023 HPS National comparison awaited)**				
In Q2 2023 NHS Fife had:	18 CDIs	16 HCAI/HAI/Unknown 2 CAI	This is **UP** from	15 Cases in Q1 2023
Q1 (Jan-Mar) 2023 ARHAI validated data with commentary				
With ARHAI Quarterly epidemiological data Commentary *Please note for ARHAI reporting- the CDI denominator may vary from locally reported denominators. This is due to some Fife resident Community onset CDIs allocated back to NHS Fife, even though they were treated at other Health boards.				

Healthcare associated CDIs		Community associated CDIs infection	
HCAI CDI rate: **13.4**	Per 100,000 bed days	CAI CDIs rate: **3.2**	Per 100,000 Pop
No of HCAI CDIs: 12		No of CAI CDIs: 3	
This is **EQUAL** to National rate of 13.4		This is **BELOW** National rate of 4.3	





NHS Fife was **WITHIN** the 95% confidence interval in the funnel plot analysis for HCAI & CAI.

New standards for reducing all Healthcare Associated CDI by 10% by 2022 (from 2018/2019 baseline). This standard was extended to 2023 and will be extended for a further year to 2024		
Standards application for Fife:	**CDI Rate Baseline 2018/2019**	**CDI 10% reduction target by 2024**
CDI by rate 100,000 Total bed days	**7.2** per 100,000 TBDs	**6.5** 100,000 TBDs
CDI by Number of HCAI cases	**26**	**23**
Current 12 Monthly HCAI CDI rates for Year ending March 2023 (HPS)		
CDI by rate 100,000 Total bed days	**10.3** per 100,000 TBDs	
CDI by Number of HCAI cases	**37**	

3.2 Current Risk Register Rating

Corporate Directorate – Nursing Directorate Infection Control Team Risk Register		
ID: 646 CDI Local Delivery Standard Target		
Initial Risk Level	**Current Risk Level**	Target Risk Level
Moderate 8	**Moderate Risk 9**	Low Risk 6

3.3 Current CDI initiatives

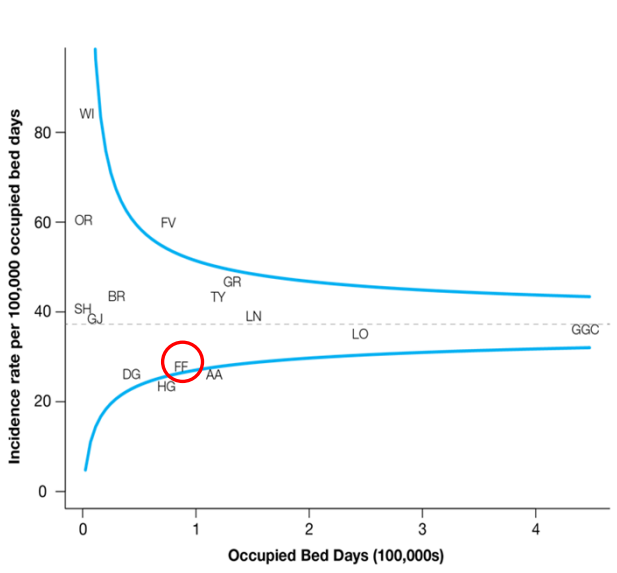
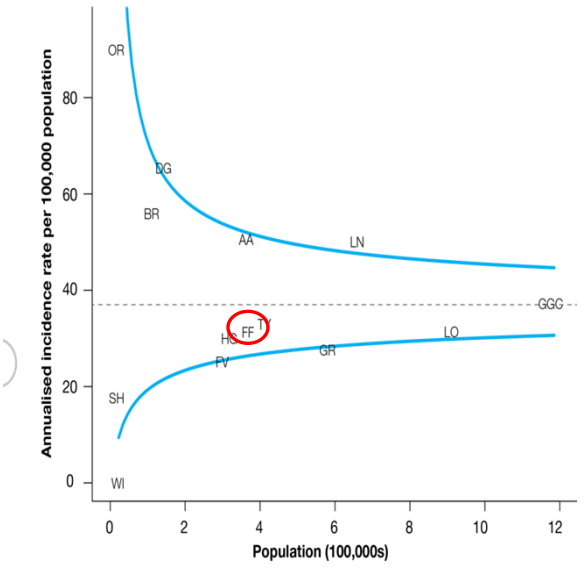
Follow up of all hospital and community cases continues to establish risk factors for CDI

- Monthly CDI reporting to Acute Services & HSCP with summary of all CDI cases
- Enhanced surveillance & HPS trigger tool completion for any triggers/ areas of concerns.
- Dr Venkatesh establishing optimum antimicrobial therapy for multiple recurrence CDI case.
- From October 2019 each CDI case is assessed for suitability of extended pulsed Fidaxomicin (EPFX) regime aiming to prevent recurrent disease in high risk patients.
- Commercial faecal transplant (FMT) is now available and NHS Fife will use this for recurrences that have failed first and second line treatments
- Bezlotoxumab is available, only when FMT is contra-indicated, or if the patient is unable to tolerate the procedure.

4.0 Escherichia coli Bacteraemias (ECB)

4.1 Trends:

Escherichia coli Bacteraemias (ECB)				
Local Data: Q2 (Apr-Jun) 2023 **(Q2 2023 HPS National comparison awaited)**				
In Q2 2023 NHS Fife had:	49 ECBs	26 HAI/HCAIs 23 CAIs	This is EQUAL to from	49 Cases in Q1 2023
Q2 2023 There were **5** Urinary catheter associated (1 of which was from a Suprapubic catheter) ECBs, which was slightly higher than during Q1 2023, when there were 4 CAUTIs.				

Q1 (Jan-Mar) 2023			
HPS Validated data ECBs with HPS commentary *Please note for HPS reporting- the ECB denominator may vary from locally reported denominators. Due to some Fife resident Community onset ECB allocated back to NHS Fife, even though they were treated at other Health boards.			
Healthcare associated ECBs		Community associated ECBs infection	
HCAI ECB rate: **27.9**	Per 100,000 bed days	CAI ECBs rate: **31.4**	Per 100,000 Pop
No of HCAI ECBs: 25		No of CAI ECBs: 29	
This is **BELOW** National rate of 37.3		This is **BELOW** National rate of 37.0	
			

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:

New standards for reducing all Healthcare Associated ECBs by 25% by 2022 (from 2018/2019 baseline). This standard was extended to 2023 and will be extended for a further year to 2024		
New standards for reducing all Healthcare Associated ECB by 25% by 2024 (from 2018/2019 baseline).		
Standards application for Fife:	**ECB Rate Baseline 2018/2019**	**ECB 25% reduction target by 2024**
ECB by rate 100,000 Total bed days	**44.0** per 100,000 TBDs	**33.0** per 100,000 TBDs
ECB by Number of HCAI cases	**160**	**120**
Current 12 Monthly HCAI ECB rates for Year ending March 2023 (HPS)		
ECB by rate 100,000 Total bed days	**33.8** per 100,000 TBDs	
ECB by Number of HCAI cases	**121**	

2021-2017 NHS Fife's Urinary catheter Associated ECBs –

HPS data Q1 2023 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
2023 Q2	TBC	***12.5%**	
2023 Q1	18.9%	**22.2%**	
2022 TOTAL	17.0%	**21.4%**	
2021 TOTAL	16.0%	**15.4%**	* Locally calculated data- TBC by HPS when Q2 2023 data published on Discovery
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
2023 Q2	TBC	***22.2%**	
2023 Q1	26.5%	**12.5%**	
2022 TOTAL	22.7%	**30.9 %**	* Locally calculated data- TBC by HPS when Q2 2023 data published on Discovery
2021 TOTAL	27.0%	**36%**	
2020 TOTAL	24.1 %	**23.0 %**	
2019 TOTAL	22.8 %	**28.0 %**	
2018 TOTAL	22.1%	**36.6 %**	
2017 TOTAL	18.7 %	**35.3 %**	
Data from NSS Discovery ARHAI Indicators			

4.2 Current Risk Register Rating

Corporate Directorate – Nursing Directorate Infection Control Team Risk Register		
ID: 1728 ECB LDP Standard		
Initial Risk Level	**Current Risk Level**	Target Risk Level
Moderate Risk 12	**Moderate Risk 12**	Low Risk 6

4.3 Current ECB Initiatives

The Urinary Catheter Improvement Group (UCIG) work was commissioned in 2018 to address the issues associated with ECB CAUTI incidence and reduce the CAUI incidence. This group developed from a previous Traumatic Catheter group in 2017 which aimed to reduce the incidence of Catheters associated with trauma. The IPC Surveillance team continue to liaise with the UCIG last held on 23rd June 2023. This group aims to minimise urinary catheters to prevent catheter associated healthcare infections and trauma associated with urinary catheter insertion/maintenance/removal and self-removal, furthermore, to establish catheter improvement work in Fife.

Monthly ECB reports and graphs are distributed within HSCP and Acute services to update on the incidence of ECBs, ECB -CAUTIS (Urinary Catheters & Supra-pubic catheters) & associated trauma. Up to August 2023, there have been 17 CAUTI ECBs (14 from urinary & 3 from a supra-pubic catheter). 4 of these have been associated with trauma.

Infection control surveillance alert the patients care team Manager by Datix when an ECB is a urinary catheter associated infection, to then undergo a CCR, to provide further learning from all ECB CAUTIs.

CAUTI insertion & maintenance bundles have now been installed onto Patientrack in February 2022 and were trailed on V54 ward. Amendments to the tool are now awaited by Patientrack before this can then be rolled out across the board.

5. Hand Hygiene

- Good hand hygiene by staff, patients and visitors is a key way to prevent the spread of infections and to minimize risk.
- NHS Boards should monitor hand hygiene (HH) and ensure a zero tolerance approach to non-compliance, to provide assurance of optimum practice.
- A minimum of 20 observations are required to be audited, per month, per ward/unit.
- Reporting of Hand Hygiene performance was based on data submitted by each ward via LanQIP, which displayed the results on it's dashboard.
- There is currently no robust electronic recording system for reporting HH compliance from clinical areas across Fife. LanQIP had previously been the IT platform utilised by staff to submit their 20 HH opportunities per month. However LanQIP had been deemed to be an outdated platform, as it is no longer digitally supported and staff had been advised to no longer input their HH data. Following discussions with NHS Fife eHealth in May 2023 however, they have confirmed that LanQIP continues to be a working platform and they have advised that clinical areas can continue to use without concern, as no patient identifiable data held. However, eHealth have stated there is no assurance that LanQIP will not suddenly fail and if this occurs, there will be no digital support to repair this platform. Ehealth have therefore recommended that LanQIP can be utilised as an interim tool to centralize HH data, until a further robust system can be put in place.

5.1 Trends

- Unable to report
- ICM raising with Senior Management and D&I Teams

6. Cleaning and the Healthcare Environment

- Keeping the healthcare environment clean is essential to prevent the spread of infections.
- NHS Boards monitor the cleanliness of hospitals and there is a national target to maintain compliance with standards above 90%.
- The Overall Cleaning Compliance for NHS Fife for Quarter 1 (Apr-Jun 2023) was **95.9%**.
- The cleaning compliance score for NHS Fife & each acute hospital can be found in Section 11

6.1 Trends

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

- **National Cleaning Services Specification**

Domestic Location	Q1 Apr-Jun 23	Q4 Jan-Mar 23
Fife	95.9↓	96.1%
Scotland	TBC	95.3%

- The National Cleaning Services Specification – quarterly compliance report result for Quarter 1 (Apr-Jun) 23 shows NHS Fife achieving **GREEN** status.

- **Estates Monitoring**

Estates Location	Q1 Apr-Jun 23	Q4 Jan-Mar 23
Fife	96.3↓	96.4%
Scotland	TBC	96.4%

- The Estates Monitoring – quarterly compliance report result for Quarter 1 (Apr-Jun) 23 shows NHS Fife achieving **GREEN** status.

6.2 Current Initiatives

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

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7.1 Outbreaks

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

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

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

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

July – end of August 2023

Norovirus

There have been no new ward closures due to Norovirus or suspected outbreak since last ICC report

Seasonal Influenza

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

7.2 COVID-19 pandemic

COVID-19 incidents/clusters/outbreaks July – August 2023, there has been 10 new COVID-19 outbreaks/incidents reportable to ARHAI Scotland during this reporting period.

3_Hospital	5_Ward	Date of reporting	Total no. deaths	Total no. patients	Total no. staff
WMBH	Ravenscraig Ward	23/08/2023	0	7	4
QMH	QMH 6 Bay B	18/08/2023	0	5	0
SACH	Ward 2 Bay 27	18/08/2023	0	2	2
Cameron Hospital	Balcurvie Ward	11/08/2023	1	11	2
Glenrothes Hospital	Ward 3 Bay 6	11/08/2023	0	3	5
VHK	V31 Bay 3	11/08/2023	0	4	2
VHK	V53 Bay 1	11/08/2023	0	3	1
SACH	Ward 1	02/08/2023	0	2	0
QMH	Ward 4	21/07/2023	0	5	4
QMH	Ward 8	21/07/2023	0	2	3

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

However, a further DL (2022) 13 was issued in May 2022, stating the planned resumption of SSI surveillance in Q4 2022. This has since been postponed, DL (2023) 06 published February 2023 advises surgical site infection (SSI) and enhanced surveillance reporting remains paused for the time being.

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 1 new inspection during this reporting period (July – end of August 2023)

Healthcare Improvement Scotland (HIS): Safe delivery of care inspection - Unannounced inspection to Victoria Hospital, NHS Fife, 31st of July- 2nd of August. Factual accuracy report expected week commencing 2 October.

The publication timelines are as follows:

- Embargoed publication: Thursday 19th October.
- Full publication: Thursday 26th October.

Previous inspections:

Healthcare Improvement Scotland (HIS): Unannounced Infection Prevention and Control Inspections of Mental Health Units Queen Margaret Hospital, NHS Fife. QMH wards 1,2 and 4 and WMBH Ravenscraig ward on Wednesday 8th of February.

Report published 11/05/2023 highlighting:

- 3 areas of good practice
- 7 requirements
- 2 recommendations

10. Assessment

- **CDIs**: The number of *Clostridioides difficile* cases has increased, so far, in 2023. This is rise is also reflected in the number of HCAI cases. Continuous monitoring will highlight if this is an ongoing problem, which requires addressing.
- Reducing incidence of recurrence of infections is key to reducing healthcare CDIs
- **SABs**: The Acute Services Division continues to see intermittent blood stream infections related to vascular access device infections
- Interventions to reduce peripheral vascular device infections have been effective but remains a challenge, with local surveillance continuing
- Ongoing monitoring of dialysis line related SABs. IPCT will support Renal service in investigating cases and any subsequent improvement strategies.
- IPCT will continue to support the Addictions Service in addressing the reduction of SABs in PWIDs
- **ECBs**: Healthcare associated (HAI/HCAI) ECBs remain a challenge
- Addressing CAUTI related ECBs through the Urinary Catheter Improvement Group
- **SSIs surveillance** currently suspended during COVID pandemic for C-sections, Large bowel surgery and Orthopaedic procedure surgeries (Total hip replacements, Knee replacements & Repair fractured neck of femurs). Awaiting further instruction regarding resumption of surveillance. Increased resources and months of preparing will be required prior to recommencing.

Summary

Healthcare Associated Infection Reporting Template (HAIRT)

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

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

ECBs, CDIs & SABs are categorised 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.

Cleaning and Estates compliances are shown by Total Fife, VHK & QMH.

There is currently no Hand Hygiene data to submit, in the absence of a robust Hand Hygiene compliance dashboard.

Report Cards

	NHS Fife								
	SAB			C Diff			ECB		
Month	HAI & HCAI	Community / Not Known	SAB Total	HAI/HCAI /	Community	CD Total	HAI & HCAI	Community / Not Known	ECB Total
Apr-23	4	3	7	6	1	7	9	5	14
May-23	5	4	9	5	0	5	12	9	21
Jun-23	4	6	10	5	1	6	5	9	14
Jul-23	3	4	7	1	2	3	12	15	27
Aug-23	4	1	5	1	1	2	11	18	29

Cleaning Compliance (%) TOTAL FIFE												
	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23
Overall	96.1	95.6	96.2	96.2	96.0	96.4	95.9	95.9	95.9	95.9	95.6	95.6

Estates Monitoring Compliance (%) TOTAL FIFE												
	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23
Overall	96.2	96.3	96.6	96.6	96.6	96.3	96.3	96.5	96.5	96.0	96.1	95.7

Victoria Hospital

	VHK		
	SAB >48hrs admx	CDI >48hrs admx	ECB >48hrs admx
Month	HAI	**HAI**	HAI
Apr-23	4	4	2
May-23	2	3	3
Jun-23	1	3	1
Jul-23	1	0	2
Aug-23	3	0	6

Cleaning Compliance (%) Victoria Hospital												
	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23
Overall	95.9	95.6	95.6	96.3	95.9	96.6	95.8	96.1	95.6	96.1	95.4	95.4

Estates Monitoring Compliance (%) Victoria Hospital												
	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23
Overall	97.1	97.1	97.6	97.2	97.1	96.5	97.5	97.5	97.3	97.0	97.3	96.2

Queen Margaret Hospital

	QMH		
	SAB >48hrs admx	CDI >48hrs admx	ECB >48hrs admx
	HAI	**HAI**	**HAI**
Month			
Apr-23	0	1	1
May-23	1	1	0
Jun-23	0	0	0
Jul-23	0	0	0
Aug-23	1	0	0

Cleaning Compliance (%) Queen Margaret's hospital												
	Sep 22	**Oct 22**	**Nov 22**	**Dec 22**	**Jan 23**	**Feb 23**	**Mar 23**	**Apr 23**	**May 23**	**Jun 23**	**Jul 23**	**Aug 23**
Overall	96.3	95.8	96.4	96.3	96.9	96.5	95.9	96.5	96.7	96.6	95.8	96.6

Estates Monitoring Compliance (%)Queen Margaret's hospital												
	Sep 22	**Oct 22**	**Nov 22**	**Dec 22**	**Jan 23**	**Feb 23**	**Mar 23**	**Apr 23**	**May 23**	**Jun 23**	**Jul 23**	**Aug 23**
Overall	95.4	96.6	95.9	96.6	96.1	95.5	94.8	94.9	95.5	94.1	94.6	95.0

Community Hospitals

	COMMUNITY HOSPITALS		
	SAB >48hrs admx	CDI >48hrs admx	ECB >48hrs admx
Month	HAI	HAI	HAI
Apr-23	0	1	1
May-23	0	0	0
Jun-23	0	0	0
Jul-23	0	0	0
Aug-23	0	0	0

Out of Hospital

	OUT OF HOSPITAL					
	SAB <48hrs admx		CDI <48hrs admx		ECB <48hrs admx	
Month	HCAI	Community / Not Known	HCAI / UnKnown	Community	HCAI	Community / Not Known
Apr-23	0	3	0	1	5	5
May-23	2	4	1	0	9	9
Jun-23	3	6	2	1	4	9
Jul-23	2	4	1	2	10	15
Aug-23	0	1	1	1	5	18

Appendix 1 References and Links

References & Links
Understanding the Report Cards – Infection Case Numbers *Clostridioides difficile infections (CDI)* and *Staphylococcus aureus* bacteraemia *(SAB)* cases are presented for each hospital, broken down by month by Healthcare Associated (HCAI & HAI) & Community (Community/Unknown) onset. More information on these organisms can be found on the NHS24 website: *Clostridioides difficile*: https://www.hps.scot.nhs.uk/a-to-z-of-topics/clostridioides-difficile-infection/ *Staphylococcus aureus* : https://www.hps.scot.nhs.uk/a-to-z-of-topics/staphylococcus-aureus-bacteraemia-surveillance/ For each hospital, the total number of cases for each month are those, which have been reported as positive from a laboratory report on samples taken more than 48 hours after admission. For the purposes of these reports, positive samples taken from patients within 48 hours of admission will be considered confirmation that the infection was contracted prior to hospital admission and will be shown in the "out of hospital" report card. **Targets** There are national targets associated with reductions in C.diff and SABs and from 2019 for e.coli bacteraemias (ECBs). More information on these can be found on the Scotland Performs website: http://www.scotland.gov.uk/About/Performance/scotPerforms/partnerstories/NHSScotlandperformance **Understanding the Report Cards – Hand Hygiene Compliance** Hospitals carry out regular audits of how well their staff are complying with hand hygiene. Each hospital report card presents the combined percentage of hand hygiene compliance with both opportunity taken and technique used. **Understanding the Report Cards – Cleaning Compliance** Hospitals strive to keep the care environment as clean as possible. This is monitored through cleaning and estates compliance audits. More information on how hospitals carry out these audits can be found on the Health Facilities Scotland website: http://www.hfs.scot.nhs.uk/online-services/publications/hai/ **Understanding the Report Cards – *'Out of Hospital Infections'*** *Clostridium difficile infections* and *Staphylococcus aureus bacteraemia* cases can be associated with being treated in hospitals. However, this is not the only place a patient may contract an infection. This total will also include infections from community sources. The final Report Card report in this section covers '*Out of Hospital Infections*' and reports on SAB and CDI cases reported to NHS Fife which are not attributable to a hospital.
For HPS categories for Healthcare Associated Infections: **https://www.hps.scot.nhs.uk/web-resources-container/quarterly-epidemiological-commentary-for-the-surveillance-of-healthcare-associated-infections-in-scotland-methods-caveats/**

Appendix 2 Categories of Healthcare & Community Infections

Categories of Healthcare & community Infections

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

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

Hospital Acquired Infection (HAI):
Positive Blood culture obtained from patient who has been
-Hospitalised for >48 hours
If the patient was transferred from another hospital the duration of the in-patient stay is calculated from the date of the first hospital admission
OR
-The patient was discharged from hospital in the 48 hours prior to the positive blood culture being obtained
OR
-A patient receives regular haemodialysis as an outpatient

Community Infection
-Positive Blood culture obtained from a patient with 48 hours of admission to hospital who does not fulfil any of the criteria for the healthcare associated blood stream infections

Not known:
-Only to be used if the ECB is not a HAI and unable to determine if community or HCAI

Healthcare Associated Infection (HCAI):-
Positive blood culture obtained within 48 hours of admission to hospital and fulfils one or more of the following criteria:
-Was hospitalised overnight in the 30 days prior to the +ve blood culture being obtained.
OR
-Resides in a Nursing home, long term facility or residential home
OR
-IV,IM, Intra-articular or sub cut medication in the 30 days prior to the positive blood culture,
but EXCLUDING IV illicit drug use.
OR
-Underwent venepuncture in the 30 days before +ve BC
OR
-Underwent medical procedure which broke mucous or skin barrier i.e. biopsies or dental extraction in the 30 days before +ve BC
OR
-Underwent any care for chronic medical condition or manipulation of medical device by a healthcare worker in the community in the 30 days prior to the +ve BC being obtained i.e. podiatry or dressing of chronic ulcers, catheter change or insertion
OR
-Has a long term indwelling device (i.e. catheter, central line, drain (excluding a haemodialysis line)

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

HPS Linkage Origin Definitions

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

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

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

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

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

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NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**3 November 2023**
Title:	**Digital and Information Strategy 2019-24 Update**
Responsible Executive:	**Dr Chris McKenna – Medical Director**
Report Author:	**Alistair Graham, Associate Director of Digital and Information**

1 Purpose

This is presented for:

- Assurance

This report relates to a:

- Annual Delivery Plan
- NHS Board Strategy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

At the July 2023 meeting of the Clinical Governance Committee, the Digital Strategy update included an appendix detailing the five strategic ambitions and associate deliverables. The committee requested that further analysis be carried out on the deliverable items for future presentation to the committee.

This report provides that additional analysis and detail on the progress with each deliverable and is provided to the committee for assurance.

2.2 Background

NHS Fife's Digital and Information Strategy "Digital at the Heart of Delivery" was endorsed by the NHS Fife Board in September 2020. The strategy outlined the challenge which had been presented to NHS Fife from a National, Local and Regional perspective through

various digital and data strategies and delivery plans and noted, at that time, the disruptive drivers which may result in the strategy not being realised.

The strategy outlined the 5 key ambitions for Digital and Information: -

- Modernising Patient Delivery – Ensuring we provide our patient/service users with a modern fit for purpose digital healthcare service.
- Joined Up Care – Joining Up Our Services to ensure all relevant information is available at point of contact.
- Information and Informatics – Exploiting data to improve patient safety and quality outcomes to support developments.
- Technical Infrastructure – Ensuring the infrastructure on which digital is situated is fit for purpose, secure and meets the needs of our service.
- Workforce and Business Systems – Assisting our workforce by ensuring the systems on which they operate are effective, efficient and compliment their working practices.

Associated with these ambitions the strategy identified a total of 49 associated delivery items, aligned as follows:-

Strategic Ambition	**Total Number of Deliverables**
Modernising Patient Delivery	11
Joined Up Care	13
Information and Informatics	7
Technical Infrastructure	11
Workforce and Business Systems	7
Total	**49**

In addition to the stated deliverables included at the time of publication of the strategy an additional 25 “new” deliverables were introduced during the strategy period, the majority of which were completed as part of the pandemic response and support to the commissioning of the National Treatment Centre.

The review undertaken also begins to form the themes and re-alignment of the deliverables to the new Population Health and Wellbeing Strategy and associated programmes. It also considers alignment to other strategic drivers contained within the Strategic Plan for Fife (and associated Digital Strategy for Fife HSCP currently in development), Scottish Government’s Digital Health and Care Strategy, Data Strategy and Artificial Intelligence Strategy. Other items of influence include the principles of Values Based Healthcare, NHS Scotland’s Climate Emergency and Sustainability Strategy and the Innovation considerations associate with our role in Health Innovation South East Scotland (HISES) and the Accelerated National Innovation Adoption Pathway (ANIA).

A progress spectrum outlined in Figure 1 below, was used to assess the level of implementation achieved for each deliverable. Its is aligned to the question “has the deliverable been achieved?”.

Figure 1 - Deliverable Assessment

The committee will note that much of this assessment work has informed the deep dive associated with the corresponding Corporate Risk for Digital and Information.

2.3 Assessment

Many of the deliverables are consistent with an overall maturing of the digital capabilities available to our staff and patients. As a result, they can be extended to be present in multiple strategies as we move through the levels of maturity associated with digital capability. They in effect become ever present in current and future strategies.

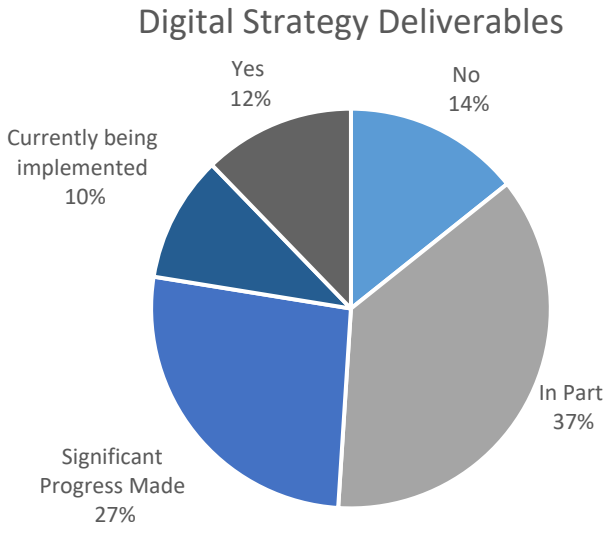
Overall Picture

Having assessed the deliverables identified at the time of publication, Figure 2 outlines the progress that has been made. Nearly half of the deliverables have seen “significant progress” being made, “completed in full” or are “currently being implemented”.

The full list of deliverables, across the 5 ambitions are detailed in Appendix 1.

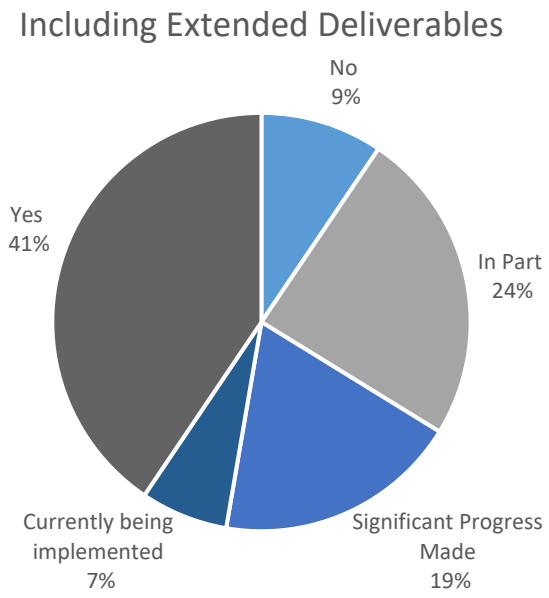
A further 37% have been introduced “in part” and provide an opportunity for further adoption. 7 deliverables of the 49, have made “no progress”. Details of the “in part” and “no progress” are included in Appendix 2. Many of these items (40%) are linked to National items of work and the remainder have had to be deprioritised in support of the new and emerging requirements.

Figure 2 - Progress made



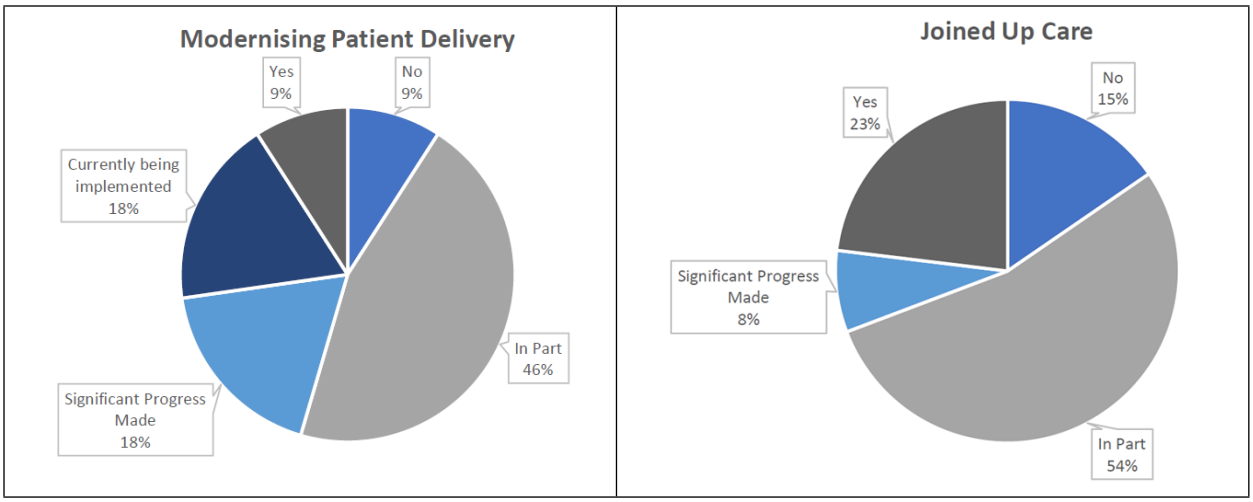
When including the additional 25 deliverables, detailed in Appendix 3, that emerged during the strategic period the summary appears different and is contained in Figure 3.

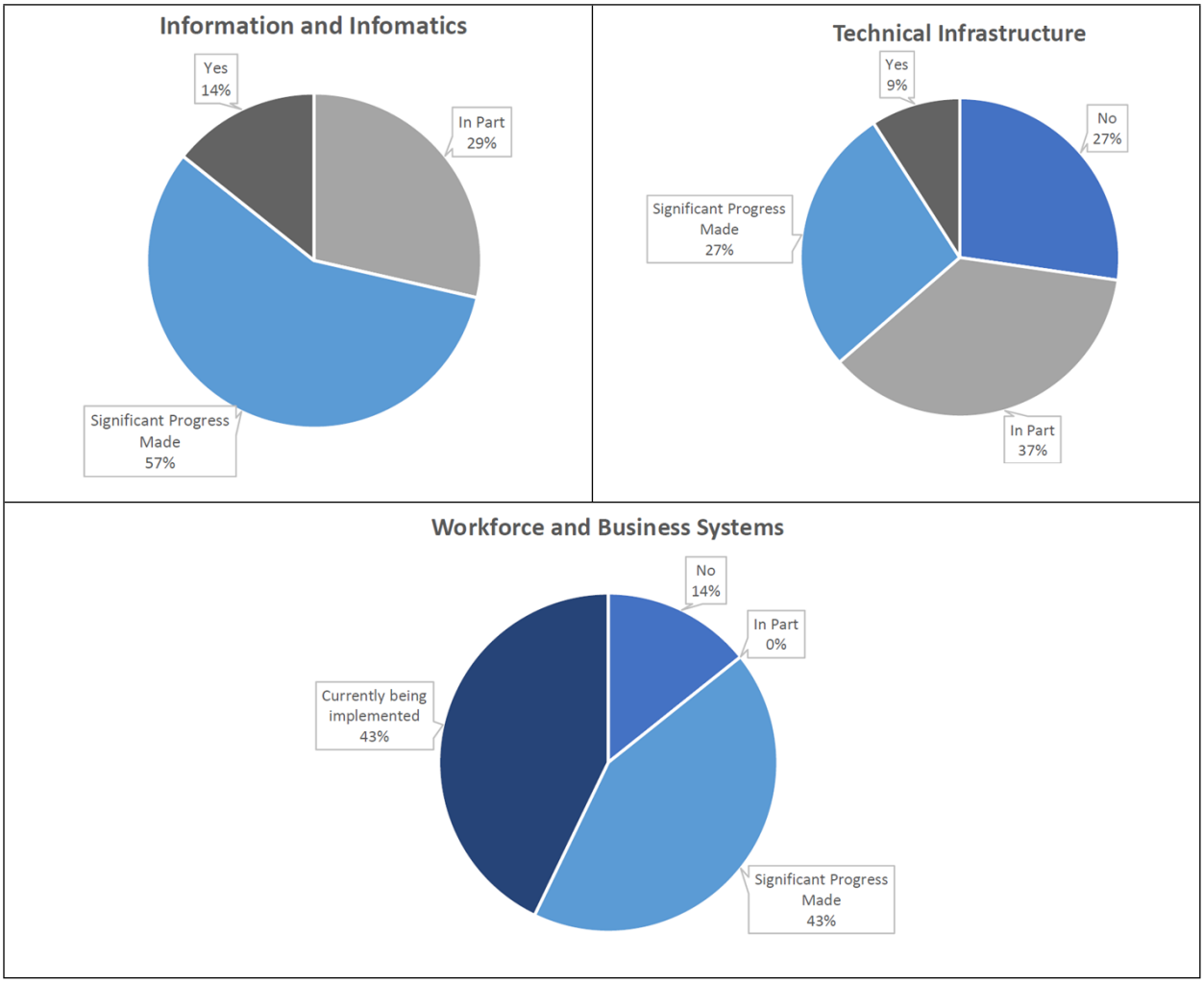
Figure 3 - Progress including additional deliverables.



The breakdown within each of the strategic ambitions is highlighted below within Figure 4 below.

Figure 4 - Strategic Priority Breakdown





As part of the assessment work, consideration was also given to the deliverables that would be candidates for the next digital strategy. It will be no surprise that 80% of the items could be considered for inclusion.

The themes associated are:-

Continued development of the Electronic Health Record and additional data sharing to ensure it becomes part of an Integrated Care Record available to all that provide care to our patients.

Continued development of the digital front door, allowing our patients to have access to and the ability to contribute to their own health record, a function that will further reduce our reliance on paper.

To develop our capability to maximise the capacity for consultation and treatment, including the ability to continually monitor the patients who are waiting.

To support our staff in their work by reducing the number of systems they operate, leveraging integration, improve their available time through automation and be ready for the implementation of artificial intelligence.

Ensure our business systems become an enabler to ensure the correct compliments of staff, with the correct skills are available in the right work setting, while being considered of financial impact and support the wider governance of NHS Fife.

Continue to provide insight through the availability and analysis of data to support operational decision making and strategic planning.

Ensure our infrastructure receives continual investment to guarantee its availability, performance, security, and capacity.

Support our compliance and legislative activities in support of our Privacy Programme and Cyber Resilience Framework.

Deliver an operating model that remains agile to emerging need and innovation yet can sustain large programmes and demand for digital change.

2.3.1 Quality, Patient and Value-Based Health & Care

The aims which were clearly outlined in the Digital Strategy 2019/24 focussed on the ambitions laid out in several key strategies and plans at a local, regional, and national level. The refresh of the digital strategy allows for appropriate realignment to our revised strategies and the ambitions contained within them.

The work associated with the digital front door with provide the ability for patients, their families, and carers to contribute to their health record is a fundamental requirement to support the necessary conversations at the heart of Value-Base Health Care.

A further assessment on outcomes continues to be evaluated as part of the review.

2.3.2 Workforce

As we prepare for a revised Digital Strategy, we also consider the work necessary to ensure our wider workforce can feel supported in their digital adoption. We will work closely with colleagues in Partnership and Workforce to ensure this support is well designed and considered of the support and changes as we progress.

A revised workforce plan has been developed by the Digital and Information SLT with implementation now underway. This will be directly considered as part of the Digital Strategy refresh and outlined in the mitigating actions.

2.3.3 Financial

The scale of the ambition in the strategy and the financial impact associated continues to be a risk that is managed. The scale of demand for digital solutions does not match the available funding or resourcing and so ranking is a key requirement for all initiatives.

Additional risk is also associated with the medium-term cost to digital capability that was introduced as a direct response to the COVID-19 pandemic.

The refreshed strategic approach will be accompanied by a financial framework.

2.3.4 Risk Assessment/Management

The risk management approach continues to be maintained via the Corporate Risk Register, with additional risk reporting and presentation being provided to the Information Governance and Security Steering Group and Digital and Information Board.

A formal risk appetite and tolerance statement has been agreed by the Steering Group and Board allowing a refreshed reporting of Risk controls and mitigations.

2.3.5 Equality and Diversity, including health inequalities and Anchor Institution ambitions

An Equality Impact Assessment will be conducted as part of the strategy refresh work and will be presented in the future.

2.3.6 Climate Emergency & Sustainability Impact

Consideration of the Scottish Public Sector Green ICT Strategy forms part of the revised strategic thinking.

2.3.7 Communication, involvement, engagement, and consultation

- The Digital and Information Strategy was discussed at all relevant Groups and Committees prior to sign off by the NHS Fife Board.
- The challenges outlined have been presented to the Digital & Information Board and form a consistent part of that group's workplan.
- The engagement model has been further developed to include Acute and HSCP SLTs.

2.3.8 Route to the Meeting

This paper has been considered by the following groups as part of its development.

- Digital and Information Board (18 October 2023)
- Executive Directors Group (2 November 2023)

2.4 Recommendation

- **Assurance** – Provided to the committee additional analysis and assurance of progress for the Digital and Information Strategy 2019-2024.

3 List of appendices

- Appendix 1 – Summary of all deliverables
- Appendix 2 - List of deliverables that have had limited or no implementation
- Appendix 3 – Additional Deliverables

Report Contact
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Appendix 1 – Summary of all deliverables

Objective	Key Ambition for 2019-24	Ref	D&I Work in support of Objective	Has this objective been within our control?	Has this objective been achieved?	Candidate for future strategy?
1	**Modernising Patient Delivery** Ensuring we provide our patients/service users with a modern fit for purpose health care service. This incorporates ambitions which were laid out by the Scottish Government in "The Modern Outpatient: A Collaborative Approach 2017-2020", which aimed to provide service users with timely access to advice, treatment and support with minimum disruption when clinically appropriate.	1.1	Clinical Decision/Advice Improve through joining up and improving existing systems.	Yes	In Part	Yes
		1.2	Consultant to Consultant Send and receive information electronically from other Health Boards.	Partially	Significant Progress Made	Yes
		1.3	Digital Maturity Assess the digital maturity of our IT, in order to identify the priority areas for improvement.	National	Yes	Yes
		1.4	Digital Hub Changing the way we communicate with our patients and citizens.	Yes	In Part	Yes
		1.5	GPIT Replacement Modernisation as part of a wider National programme.	Partially	In Part	Yes
		1.6	LIMS replacement Laboratory Information management system (LIMS), support implementation of replacement hardware whilst a new regional system is procured and implemented.	Partially	Currently being implemented	Yes
		1.7	Near Me Video conferencing for our service users to engage with clinicians with minimal disruption.	Yes	Significant Progress Made	No
		1.8	Optimisation of Outpatients Appointments Patient focussed/ self booking, patient initiated follow up appointments and review of clinical letters.	Partially	Currently being implemented	Yes
		1.9	Paperlight Reduce the reliance of paper with the ambition of 85% paperlight by 2022.	Yes	In Part	Yes
		1.10	Technology Enabled Care Support projects which provide care to the patient within their home environment.	National	In Part	Yes
		1.11	Theatres system replacement The system currently in use within Theatres requires replacement.	National	No	Yes
2	**Joined Up Care** NHS Fife continues to work on utilising digital to provide joined up services across primary, community, acute and social care to ensure all relevant information is available to those working with our service users. The new GP Framework Contract (2018) recognised one of the most challenging aspects of being a GP was workload. The contract committed to implement the recommendations of the Improving General Practice Sustainability Advisory Group report (2016), which identified a number of broad themes including effective primary and secondary care interface working. In addition, the contract committed to Health and Social Care Partnerships and NHS Boards placing additional primary care staff in GP practices and the community to work alongside GPs and practice staff to reduce GP practice workload. Implementation of digital changes and improvements to systems supports this delivery. The areas identified within this category all support the need for a more integrated care environment.	2.1	Bedside Risk Assessment Ensuring assessment of clinical risk is conducted at bedside.	Yes	Yes	No
		2.2	CHI Replacement Modernisation of Community Health Index as part of a National programme	National	Significant Progress Made	Yes
		2.3	Child Health Replacement Modernisation of the current Scottish Child Public Health and Wellbeing solution as part of a National programme	National	In Part	Yes
		2.4	Community System Replacing an end of life system (MiDIS) with a more integrated solution.	Yes	Yes	No
		2.5	Community Pharmacy Access Connecting Community Pharmacy to other NHS Fife services	Yes	Yes	No
		2.6	Health and Social Care Portal Extending use to include more services and social care services	No	In Part	Yes
		2.7	HEPMA Hospital Electronic Prescribing and Medicines Administration	Partially	No	Yes
		2.8	Mental Health Pathways Ensuring pathways are implemented within our digital environment.	Yes	In Part	Consideration
		2.9	Neurology Electronic Referral implementation of an e-Referral system for Neurology.	No	No	No
		2.10	Palliative Care Plan Improve palliative care provision through digital.	Yes	In Part	Yes
		2.11	Pharmacy Redesign Redesign pharmacy, introduction of robotics and falsified medicines within NHS Fife	Yes	In Part	Yes
		2.12	Trakcare Maximum Utilisation Achieve maximum benefit by implementing changes requested by practitioners.	Yes	In Part	Yes
		2.13	Women and Children's Redesign Site optimisation exercise to which digital delivery of service will be fundamental.	Yes	In Part	Yes

Appendix 1 – Summary of all deliverables

Objective	Key Ambition for 2019-24	Ref	D&I Work in support of Objective	Has this objective been within our control?	Has this objective been achieved?	Candidate for future strategy?
3	Information and Infomatics Effective use of information is a key component of the Digital and Information Strategy. High quality information enables NHS Fife to plan, manage and monitor effectiveness. This ensures services are best-equipped to cater for users within Fife whilst also ensuring maximum benefit in terms of health outcomes, level of care and cost. Management Information must be readily accessible to all those who require information at the point that they need it. We need to provide our staff with reporting tools and reporting solutions that are accessible and intelligible. We are committed to ensuring that our digital ambitions are robustly supported by information at the centre of delivery and ensure that these deliveries are well-planned and appropriately resourced. NHS Fife recently delivered an extremely successful informatics project - Fife Early Warning Score (FEWS) was the culmination of IT, reporting, and clinical rules-based expertise. This was a very successful collaborative approach and points a way forward for NHS Fife, combining clinical rules-based knowledge with information and technology to move services forward. Increased use of dashboard visualisations, a focus on trigger reports, and alerts generated by our Patient Administration Systems will ensure that our collective data assets are more proactive and productive.	3.1	Business and Health Intelligence This is central to business as usual processes across NHS Fife.	Yes	Significant Progress Made	Yes
		3.2	Convergence of Obsolete Systems and Methods of Holding Data convergence of data from applications which are no longer supported or are classed as at risk from cyber security	Partially	In Part	Yes
		3.3	Fife Safe Haven An invaluable resource for researchers to tackle future healthcare provision and disease management.	Yes	Yes	Support to research maybe
		3.4	GDPR / Data Protection Act 2018 Ensuring NHS Fife remains compliant will GDPR, information security and any relevant governance.	Yes	Significant Progress Made	Support to Privacy Programme
		3.5	Improving Data Quality Influence data collection standards and champion data quality as a key organisational asset	Yes	In Part	Possible as part of data assurance and clinical safety links/accreditation
		3.6	Management Information Hub Central, accessible and intelligible resource for the organisations decision makers.	Yes	Significant Progress Made	Possible
		3.7	NIS and Cyber Essentials (Suggest remove CE and use Cyber Security Framework instead) Ensuring NHS Fife complies with Information Security Legislation	Yes	Significant Progress Made	Maybe as wider requirement SPSCRF

Appendix 1 – Summary of all deliverables

Objective	Key Ambition for 2019-24	Ref	D&I Work in support of Objective	Has this objective been within our control?	Has this objective been achieved?	Candidate for future strategy?
4	**Technical Infrastructure** A fuller picture of the technical work that is carried out is detailed within the 'Keeping Us Safe and Secure' section which outlines the Business As Usual (BAU) work that is undertaken. Alongside the transformational change which is outlined within this strategy there is a need to also improve the technical Infrastructure. The infrastructure ensures the changes are sustainable for NHS Fife. Management of systems and ensuring best value for NHS Fife is critically important. Best value allows NHS Fife to maximise return on investment and generate savings which can be reallocated to delivery of patient care	4.1	Adaptation of Revenue Based Business Model Suppliers are offering the best solutions and services using a revenue/ subscription based business model and we need to embrace this change.	Partially	No	Yes
		4.2	Always within Support Lifecycle Maintain all systems and solutions (hardware & software) within a current support lifecycle and manage suppliers / contracts accordingly	Partially	In Part	Yes
		4.3	Balanced use of public, private cloud and on premise solutions and resilience Adopt a balanced and risk and merit based approach to choosing public cloud, private cloud or on premise solutions	Yes	In Part	Yes
		4.4	Cyber Essentials/NIS/GDPR and Information Security Protect against cyber attacks and comply with NIS regulations, ensure network is secure, risks are understood, impact of incidents are minimised and governance is followed	Yes	Significant Progress Made	Yes
		4.5	Exit Plans for Poor Suppliers Maintain a flexible and versatile approach to supplier contracts. Maintain a product lifecycle which is secure and fit for purpose	Partially	In Part	Yes
		4.6	National Digital Platform Relevant real time data and information from health and care records and services is available nationally	No	No	Plays a role?
		4.7	PACS Upgrade Upgrade to Picture Archiving Communications System (PACS).	National	No	Yes
		4.8	Resilient and Secure by Design Adopt best practice systems and application architectural design principles and ensure resilience, Implement solutions which have been designed with cyber security threats and vulnerabilities in mind	Partially	Significant Progress Made	Yes
		4.9	Regional IT Service Management Rollout of system within the Region and ongoing sharing of best practice	Partially	Significant Progress Made	Yes
		4.10	Security Upgrades Undertake all security upgrades	Yes	In Part	Yes, but 'current or latest desktop OS'
		4.11	Windows 10 Ensure most up to date operating system	Yes	Yes	Yes, but 'current or latest desktop OS'
5	**Workforce and Business Systems** We need to ensure that alongside delivery of this strategy we undertake true engagement with our workforce, they are central to all we do. We will balance how we deliver our ambitions with delivery of traditional medical roles. We can support our workforce by providing them with digital systems. This will ensure they receive maximum benefit with minimum systems.	5.1	Consolidating GP Business Systems Provide the most appropriate delivery of service to primary care colleagues.	Yes	Significant Progress Made	Expected to be a candidate
		5.2	e-Rostering Regional / National e-Rostering solution to assist with staff management.	National	Currently being implemented	Yes
		5.3	Framework for Attracting Youth in NHS Digital Invest in more apprenticeships to help address the ageing workforce problems facing the NHS in Scotland	Partially	Significant Progress Made	Yes
		5.4	Maximising Return On Investment Achieve maximum benefit from the systems which are in use	Partially	Currently being implemented	Yes
		5.5	Office 365 National deployment of office 365, all NHS employees in Scotland to communicate and share information from a single platform	National	Significant Progress Made	Yes
		5.6	Printing Capability Review Centralising printing, to minimise costs per specialty.	Yes	Currently being implemented	Yes
		5.7	Virtual Workforce Consider modernising ways of working e.g. the use of robotics for on boarding and off-boarding of staff	Yes	No	Yes

Appendix 2 – List of deliverables that have had limited or no implementation.

In Part		National	Partial	Yes
1.1	Clinical Decision/Advice	1		
1.4	Digital Hub			1
1.5	GPIT Replacement	1		
1.9	Paperlight			1
1.10	Technology Enabled Care	1		
2.3	Child Health Replacement	1		
2.6	Health and Social Care Portal		1	
2.8	Mental Health Pathways			1
2.10	Palliative Care Plan			1
2.12	Trakcare Maximum Utilisation			1
2.13	Women and Children's Redesign			1
3.2	Convergence of Obsolete Systems and Methods of Holding Data			1
3.5	Improving Data Quality			1
4.2	Always within Support Lifecycle		1	
4.3	Balanced use of public, private cloud and on premise solutions and resilience			1
4.5	Exit Plans for Poor Suppliers		1	
4.1	Security Upgrades			1
	Total	**4**	**3**	**10**
		29%	**21%**	**71%**

No		National	Partial	Yes
1.11	Theatres system replacement	1		
2.7	HEPMA		1	
2.9	Neurology Electronic Referral	1		
4.1	Adaptation of Revenue Based Funding			1
4.6	National Digital Platform	1		
4.7	PACS Upgrade	1		
5.7	Virtual Workforce			1
		4	1	2
	Total	**8**	**2**	**4**
		57%	**14%**	**29%**

Appendix 3 – Additional Deliverables

Other Items Delivered in the Period
Pandemic Response- Vaccination and GP Mobilisation
Endoscopy Redesign
NTC
Microsoft 365
Chat Health
AXLR8
Follow Up Appointments
NPEX
Pain
GDPR GP Support
Stafflink
Brandwatch
Chemocare
Covid Telemonitoring
Covid 19 Vaccination
Cytosponge
Digitisation of GP's
FRAME
Docman Occupational Health
Phlebotomy Trak Development
Scanning Tech Refresh
Self Booking (implemented then removed)
Training Unit QMH
V Create

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**3 November 2023**
Title:	**Patient Experience and Feedback Report**
Responsible Executive:	**Janette Owens, Executive Director of Nursing**
Report Author:	**Siobhan McIlroy, Head of Patient Experience (HoPE)**

1 Purpose

The purpose of this paper is to provide an update on patient experience and feedback, and to describe work being taken forward to present a more rounded picture of patient experience, ensuring improvements are made and are featured in future reports.

This report is presented for:

- Assurance
- Discussion

This report relates to:

- Emerging issue
- Government policy / directive
- Local policy

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

- Person Centred

2 Report summary

2.1 Situation

Patient complaints are reported monthly through the Fife Integrated Performance and Quality Report (IPQR). The indicators are identified as:

- Stage 1 Closure rate (target 80%)
- Stage 2 Closure rate (target 33% by 31st March 2024)

Whilst concern has been raised about the level of performance, these indicators do not adequately capture patient experience and a review is underway to ensure that the quality of patient experience is described, and to improve the complaint handling performance in line with national timeframe standards.

2.2 Background

Person centred care is about ensuring the people who use our services are at the centre of everything we do. It is delivered when health and social care professionals work together with people, to tailor services to support what matters to them. It is about:

- respect for patients' values, expressed needs and preferences
- coordination and integration of care
- communication, information, education,
- physical comfort
- emotional support
- involvement of family and friends

How do we know we are getting it right?

DEFINING THE PATIENT EXPERIENCE

Patient experience is based partly on the patients' and family's *expectations* of what is about to happen and the *cumulative evaluation* of their journey through our system.

- We have opportunities to delight or disappoint based on their clinical and emotional interactions with us, and their interactions with our staff, our processes, and the environment

MEASURING THE EXPERIENCE

Currently, 'patient experience and feedback' is captured through:

- Care Opinion
- Compliments and comments
- Complaints
- Initiatives, such as the Care Experience Improvement Model
- MS Forms Questionnaires / Surveys

Moving forward, we will also make use of:

- Surveys e.g. Your Care Experience
- Focus groups
- Post discharge / appointment phone calls
- Warm welcome / fond farewell
- Care Assurance processes, for example:
    - Shadowing / observation
    - Walkarounds
    - 15 step challenge

IMPROVING THE EXPERIENCE

It is important to analyse the data, identifying themes and any issues:

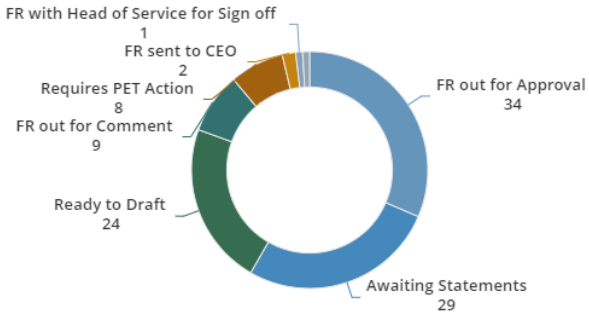
- Develop and share goals and targets based on data
- Assess processes
- Create an enabling infrastructure:
    - Framework
    - Leadership
    - Education and training
- Engage staff, patients, families, and carers in improvement work

2.3 Assessment

The complaint "complexity scoring" tool to triage complaints and categorise them as low, moderate, or high complexity continues to be tested, and all open stage 2 complaints have been re-categorised. The complexity categorisation score will provide insight into the volume of complex complaints that NHS Fife receives and handles. This will also ensure that all major or extreme complaints are appropriately escalated within the organisation and linked to adverse events or incidents.

With the stage 2 complaints, there is now a level of detail which clarifies where each complaint is in the process. Delays in the process remain:

- Awaiting statements – 28% (previous 34% at the end of June 2023)
- Final response, comment or approval – 41% (previously 48%, at the end of June 2023)
- Ready to draft or requires PET action – 30% (increase from the end of June 2023)



In the last week of June (Q1), there were 143 stage 2 complaints in the system, and there are now 108 stage 2 complaints, which is 24% reduction.

NB As of 26 October 2023, there are 108 stage 2 complaints; 18 of these are within the 20-day target, with 5 at the drafting stage, 2 requiring further PET action, and 4 with the final draft out for approval. Seven of these complaints are "awaiting statements". PET are prioritising their workload and focusing on drafting the 5 under 20 days. Of the 18 stage 2 complaints within the 20-day target, 2 are minor, 12 are moderate, and 5 are major. The 5 major stage 2 complaints will likely not be answered within the 20-day standard timeframe target. Therefore, figures over the next quarter for compliance with responding to a complaint within the national 20-day standard timeframe target are predicted to remain low.

Clinical pressures continue to impact performance by obtaining statements and final response approval. The Patient Experience Team are also facing significant absences due to sickness absence, annual leave, and vacancies, which has contributed to the rise in complaints awaiting PET action or drafting. All vacancies are in the recruitment process. Despite these challenges the Patient Experience Team continue to offer support in gathering statements, however this continues to be declined.

The additional 0.26WTE Bank Patient Experience Support Officer that joined the Patient Experience Team to gather patient feedback in the form of Care Opinion, Lived Experiences and Participation and Engagement has temporarily stopped to due to

absence but hopefully this will restart soon. This has had an impact on the number of Care Opinion stories that have been gathered.

Work with services continues reviewing new ways of working and understanding challenges. There will be a focus on reinvigorating the weekly complaint meetings with Acute. New meetings have been established with HSCP (Complex and Critical Care and Community Care). The Patient Experience Team Lead is liaising with Primary and Preventative Care to set up similar meetings.

Initial work has begun with a Senior Project Manager within the Corporate Project Management Office to assist with streamlining and implementing changes in complaint handling processes. Results from an MS Forms questionnaire sent to Senior Medical staff have been collated, and results have provided valuable data highlighting potential improvements regarding further education & training, support, and changes to the complaints handling process. The Patient Experience Team has completed a MS Forms questionnaire to understand their challenges and what works well. The Head of Patient Experience and the Senior Project Manager will work together to create an improvement action plan based on the findings of both these questionnaires. Further work is planned to engage with the services.

A "complaints escalation" standard operating procedure (SOP) is being drafted. This will highlight and support processing complaints within the agreed national timescales, in line with the model handling complaint procedure.

The first version of the Complaint Dashboard has been created and is available on MicroStrategy. A formal launch is planned for early November 2023. The Complaint Dashboard will provide live complaint data across NHS Fife, highlighting delays and stages of complaints within the complaint handling process. The next step is to create a further dashboard specifically for the Patient Experience Team to monitor departmental performance and workload.

A Recovery and Improvement Plan (Appendix 1) has been developed to guide the redesign of the Patient Experience service, focusing on patient experience and feedback.

A quarterly report (Appendix 2) has been developed for the Clinical Governance Committee, which captures information on ‘Measuring the Experience’ and ‘Improving the Experience’. The report provides information on different methods of gathering feedback and, as we emerge from the pandemic, will report on work being taken forward to understand and improve the patient experience.

The report also captures performance data which is required as part of the Model Complaints Handling Procedure.

Importantly, in line with the Organisational Learning Group, emerging themes, lessons learned, and quality improvement initiatives will be highlighted in future reports.

2.3.1 Quality, Patient and Value-Based Health & Care

Analysing data will lay the foundation for quality improvement work. The Organisational Learning Group will review themes, trends and lessons learned from complaints and adverse events which can be triangulated with activity and staffing resource.

2.3.2 Workforce

Workforce planning

The Patient Experience Team establishment continues to be reviewed, examining workload and workforce planning. Understanding the complexity of complaints and the time required to draft a response, for example, will support workforce planning and the model of complaints management.

The team establishment consists of 1.0 WTE Band 7 team leader, 3.6 WTE Band 6 Patient Experience Officers, 1.8 WTE Band 4 Patient Experience Support Officers, 2.07 WTE Band 3 Patient Experience Administrators.

Interviews have taken place for the 1.0 WTE Band 6 Patient Experience Officers post and will be recruited to this post soon. A 0.69WTE Patient Experience Administrator post has been appointed and is awaiting a start date.

All previous additional support via fixed-term posts within the Patient Experience Team has ended. The 1.0 WTE Band 4 Administrator (Navigator) post to support administrative, coordination, and data aspects of the complaints handling process has been extended for 6 months. This role will help to release more time for Officers and help streamline systems and processes.

A retired Band 6 Patient Experience Officer has joined the bank and agreed to support with drafting. The additional 0.26WTE Bank Patient Experience Support Officer that joined the Patient Experience Team to gather patient feedback in the form of Care Opinion, Lived Experiences, and Participation and Engagement has temporarily stopped due to absence, but, hopefully this will restart soon.

2.3.3 Financial

n/a

2.3.4 Risk Assessment / Management

Complaints handling and learning from complaints are vitally important in reducing reputational risk.

2.3.5 Equality and Diversity, including health inequalities and Anchor Institution ambitions

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

- People‘s rights are respected, protected and fulfilled.
- Providers of care clearly inform people of their rights and entitlements.
- People are supported to be fully involved in decisions that affect them.

- Providers of care and support respect, protect and fulfil people's rights and are accountable for doing this.
- People do not experience discrimination in any form.
- People are clear about how they can seek redress if they believe their rights are being infringed or denied.

2.3.6 Climate Emergency & Sustainability Impact

n/a

2.3.7 Communication, involvement, engagement and consultation

NMAHP leadership group has been involved in discussions and improvement action planning.

2.3.8 Route to the Meeting

Update from Patient Experience Team
Executive Directors' Group

2.4 Recommendation

- Assurance
- Discussion

3 List of appendices

The following appendices are included with this report:

- Appendix 1 - Improvement Plan

Report Contact

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Patient Experience and Feedback

Improvement Plan

October 2023

Published Month Year

www.nhsfife.org

CONTENTS

ISSUE: 1	IMPROVE COMPLIANCE
OBJECTIVE	Adherence to the NHS Scotland Complaints Handling Procedures (DH 2017) and compliance with National targets. At least 33% of Stage 2 complaints will be completed within 20 working days by March 2024

No	ACTIONS	LEAD	DATE	PROGRESS	STATUS
1.1	Revamp and commence PET weekly meeting with Services and review membership to include, clinical and managerial teams	HoPE	Dec 23	Meetings to be organised with HSCP to review complaint handling process. Regularly meeting with Acute.	Ongoing
1.2	Implement complexity scoring system to categorise complaints	HoPE	Nov 23	All open Stage 2 complaints have been recategorized with new complexity scoring. Complexity guidelines to be finalized.	Ongoing
1.3	Supportive escalation process to be implemented to highlight delays within the Model Complaint Handling Process	PET Lead	Nov 23	Escalation standard operating procedure to be finalised	Ongoing
1.4	New weekly complaint report to be created and shared with services to provide data and highlight delays within the Model Complaint Handling Process	PET Lead	Nov 23	New weekly report will be finalised once Dashboard is complete.	Ongoing
1.5	Testing of focused Multidisciplinary Team Meeting (MDT) within Acute to respond to complex complaints in a view to negate the requirement for statements and reduce service response time	PET Lead	Jan 24	Further discussions to take place with Acute to test this.	Ongoing

ISSUE: 2	'MEASURING THE EXPERIENCE': ANALYSIS AND REPORTING
OBJECTIVE	Digital Solutions for report Live Patient Experience (Complaint) data

No	ACTIONS	LEAD	DATE	PROGRESS	STATUS
2.1	Meet with Information Services to discuss and develop Dashboard	HoPE	Apr 23	Met with Digital and Information. Several meetings to discuss proposed Dashboard.	Complete
2.2	Liaise with other Health boards regarding their Dashboards	HoPE	May 23	Met with Lothian and Tayside to review and discuss Dashboards. Sharing of information.	Complete
2.3	Discuss and agree data to be displayed with Acute, Corporate and H&SCP	HoPE	Dec 23	Discussions to take place with Acute and H&SCP once first version of the Dashboard has been shared.	Ongoing

2.4	Discuss and agree data to be displayed within Patient Experience Team screen	HoPE PET Lead	Jan 24	Once first version of the Dashboard has been shared to display data, further discussions will take place Digital and Information to design PET Dashboard. Initial discussions have taken place.	Not Started
2.5	Identify test area prior to roll out dashboard	HoPE	Nov 24	Once initial version is finalised, this will be rolled out	Ongoing
2.6	Education and training for dashboard	HoPE	Jan 24		Not Started
2.7	Test implementation of dashboard	HoPE	Jan 24		Not Started
2.8	Communication, promotion and raise awareness of dashboard	HoPE	Jan 24		Not Started
2.9	Roll out Dashboard within NHS Fife	HoPE	Jan 24		Not Started
2.10	Scope potential software to utilise as an automated database for complaint handling	HoPE	Jan 24	Met with AXLR8 team 27/10/23 for demonstration of the system.	Ongoing

ISSUE: 3	AWARENESS, EDUCATION AND TRAINING				
OBJECTIVE	Raise awareness and education of the National Complaint Handling Process				
No	**ACTIONS**	**LEAD**	**DATE**	**PROGRESS**	**STATUS**
3.1	Design and publish intranet “Blink” Patient Experience Team page for NHS Staff	HoPE	Dec 23		
3.2	Devise and implement training and education delivery plan	PET Lead	Dec 23		
3.3	Review training and education materials	PET Lead	Dec 23		
3.4	Re-commence regular training and education to staff	PET Lead	Dec 23		

ISSUE: 4	‘IMPROVING THE EXPERIENCE’: QUALITY IMPROVEMENT				
OBJECTIVE	Ensure that lessons learned from all forms of patient feedback are used to inform quality improvement and promote patient safety				
No	**ACTIONS**	**LEAD**	**DATE**	**PROGRESS**	**STATUS**
4.1	Deliver Patient Experience focused work across NHS Fife, gathering patient feedback and lived experiences	HoPE PET Lead	Dec 23	Bank Patient Support Officer focusing on gathering patient experience from patients who otherwise are unable to provide this.	Ongoing

ISSUE: 5	WORKFORCE				
OBJECTIVE	Ensure that PRT is supported and developed. Ensure that workload and workforce planning is considered in design of team				
No	**ACTIONS**	**LEAD**	**DATE**	**PROGRESS**	**STATUS**
2.1	Complete Workforce analysis tool	HoPE	Dec 23	Gathered data to help with analysis of workload and compare with other National Patient Experience Teams. Comparison between Health boards in relation to number of staff and complaints.	Ongoing
2.2	New Patient Experience Navigators Role within the team	HoPE	Apr 24	Ongoing review of role and responsibilities. Fixed term post appointed to and ongoing review.	Complete

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**3 November 2023**
Title:	**Mid-Year Resilience Assurance Report**
Responsible Executive:	**Joy Tomlinson, Director of Public Health**
Report Author:	**Susan Cameron, Head of Resilience**

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Annual Delivery Plan
- Legal requirement
- Local policy

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

- Safe
- Effective

2 Report summary

2.1 Situation

This report provides the Clinical governance Committee a midyear update relating to the finalised Incident Management Framework and completion of all internal audit recommendations.

2.2 Background

NHS Fife has statutory duties with partners to provide Category 1 response under the Civil Contingencies Act 2004. This places additional duties on our organisation to support the assessment of risks (of different types of emergency and their impacts) including;

- Maintaining emergency plans
- Business continuity plans & promotion of business continuity planning ensuring organisational preparedness.
- Co-operation with other category 1 multiagency responders
- Communicating with the public
- The provision of information, instruction & training support for employees in relation to civil contingencies planning & preparedness
- NHS Fife (as a public service organisation) being able to evidence resilience assurance to its statutory & moral obligations

Recommendations were made by internal audit in 2022/23, highlighting that there was a need to finalise the major incident operational plan. This work is now complete and the major incident operational plan has been incorporated into a wider Incident Management Framework approach.

2.3 Assessment

Despite ongoing pressures, work is progressing well to engage and support service areas with updating their business continuity plans and assure NHS Fife's resilience preparedness.

Emergency Planning:

A. Incident Management Framework

An extensive consultation process took place between March to August 2023. The revised Incident Management Framework describes escalation Levels 1, 2, 3 & 4 and takes a comprehensive approach to Incident Management and escalation.

Development of the new Incident Management Framework has been informed by discussion with Executive Directors alongside Acute and H&SCP leads. It reflects the reporting structure of NHS Fife, and provides a common approach for internal incident escalation with any disruptive events that can evolve into a critical or Major Incident being declared. As part of this, NHS Fife's Operational Pressures Escalation Level (OPEL) triggers have been incorporated into the incident escalation strategy.

NHS Fife's Incident Management Framework was endorsed by Executive Director Group on the 10 August 2023 with a 12-month review timescale (Appendix 1).

The resilience team are now working with key stakeholders to enable associated framework guidance covering;

- Business Continuity Management Systems
- Bomb Threat /Suspicious Packages
- Buildings Lockdown Framework
- Severe Weather Framework
- CBRN/HAZMAT

An update on the roll out of the new Incident Management Framework will be provided in the annual CGC report.

B. Category 1 Response Major Incident Action cards

As part of receiving hospital incident management, 21 role-specific *Major Incident Declared* action cards have been reviewed and agreed for Accident & Emergency.

C. NHS Fife Climate Change Risk Assessment (CCRA)

The Scottish Government have implemented a policy on tackling climate change following the worldwide climate change requirements which are displayed as 17 United Nations

(UN) Sustainable Development Goals. NHS Scotland is aiming to become a net-zero health service by 2040 at the latest. The resilience team are supporting Estates within a review of the associated NHS Fife risk profiling. There are five main themes currently being lead by NHS Scotland:

1. Sustainable Buildings & Land
2. Sustainable Travel
3. Sustainable Goods & Services
4. Sustainable Care
5. Sustainable Communities

D. UCI World Cycling Championships

The resilience team participate in major events Safety Assurance Group planning locally and nationally to provide Category 1 multiagency response preparedness. Across the past 12 months NHS Fife was involved in national planning for the UCI World Cycling Championships for the Men's Elite Race event that crossed Fife on the 6 August 2023. NHS Fife provided a statement of assurance to Health EPRR. Scottish Government following an impact assessment for services and workforce during planned road closures. A briefing note was provided by the resilience team for weekend on-call planning and situational awareness.

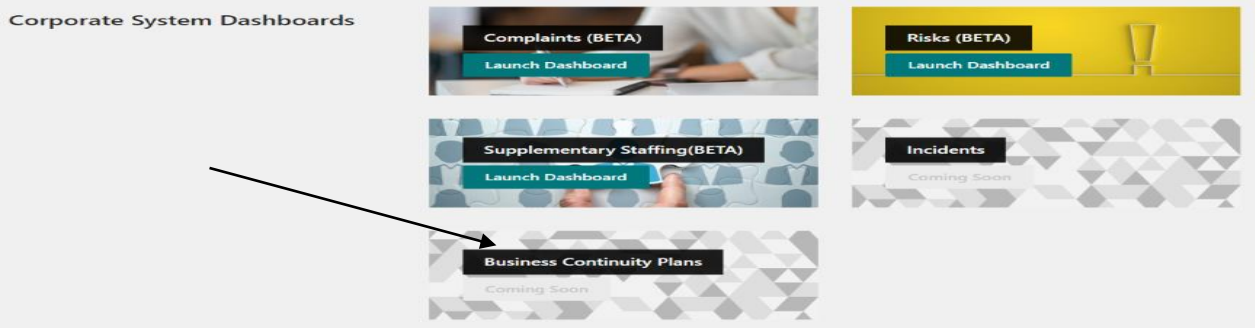
E. Police Incident Officer Training: NHS Fife Support

NHS Fife resilience officers provided a presentation on behalf of NHS Scotland which supports national Police Incident Officer scenario based training & education in multiagency category 1 response.

F. Business Continuity Management Framework Systems (coming soon)

Following consultation with acute services, it has been agreed that a Business Continuity Management System (BCMS) approach to business continuity governance and assurance will be established. A corporate dashboard system using Datix will monitor & hold Business Impact Analysis (BIA) and Business Continuity plans.

This new dashboard will ensure senior managers and responsible Executive Directors are fully informed about the status of Business Continuity plans in their area of responsibility. Summary reports from the Datix systems will also be provided to the Resilience Forum & EDG for assurance. The advantage of this approach is that the checking process is spread over a more manageable time period for all involved.



G. Business Continuity Plan Testing, Training and Exercise

A rolling program of departmental plan testing to support planning quality has commenced. In Quarter 1 April 1st -30 June 2023: 8 electrical outage business continuity scenario based tests and 1 IT/cyber outage business continuity scenario based have been supported by the resilience team.

The resilience team have established regular BC testing & exercise update sessions with BC plan owners' service areas. In Quarter 1 testing sessions have been provided across 19 areas.

Additionally four future dates for bite sized training are planned 2 November, 7 December, 11 January and 8th February.

H. Internal Audit Interim Report

NHS Fife's internal audit team confirmed on the 23/8/2023 receipt of evidence from resilience team that the actions noted within their Interim report B23/22 have been completed. Details in this table:

Requested Actions	Status Evidence
Evidence of Business Continuity (BC) Plans having been reviewed in accordance with relevant guidance	• Master BC Ledger centrally held • Testing and Exercising programme • Quarterly EPRR Whole systems Assurance Reporting to Resilience Forum & EDG • Supportive Site visits • Resilience team huddles • Datix Business impact assessment risk profile status & Dashboard
Finalised Major Incident Operational Plan with scheduled review date	• Major Incident Framework guidance & action cards ratified 10/8/2023 review in 12 months (10/8/2024) • Action Cards implemented for BC planning • 21 Emergency Department action cards reviewed & updated • HAZMAT Scenario Test to planning undertaken 25/8/22
Resilience Assurance Reporting mechanisms	• Quarterly EPRR Whole Systems Assurance Reporting to Resilience

	Forum & EDG • Annual Statement of Assurance • Business Continuity Management Systems datix risk profiling • Stakeholder consultation via SBARs to SLT & H&SCP SLT meeting groups

Assurance evidence is supported & provided in partnership, providing whole systems assurance across Acute, H&SCP and Digital partners.

I.PREVENT
PREVENT Training on TURAS

2023/24 Quarter 1	H&SCP Staff Trained	Acute Staff Trained
	93	54

Advice is available from NHS Fife's resilience team & information about raising concerns is now accessible via the EPRR Stafflink pages. Concerns can be raised in confidence via fife.resilience@nhs.scot.

2.3.1 Quality, Patient and Value-Based Health & Care

The newly established Incident Management Framework will increase situational awareness and strengthen the ability of the organisation to protect patients and workforce from events.

2.3.2 Workforce

Senior Leadership Team within Acute Services agreed a rolling programme of business continuity testing & exercising to commence in March 2023. This is on track.

2.3.3 Financial

Testing and Exercising will improve incident support and promote a quicker, more effective, and less costly recovery response to adverse events.

There may be an additional need for NHS fife to support the resilience team with equipment & educational resources.

2.3.4 Risk Assessment / Management

Emergency planning and preparedness risk assessment is carried out nationally, regionally and locally. NHS Fife is represented and contributes to national, regional and local emergency planning and preparedness working groups.

Risk mitigation actions include;

- Annual work planning with key stakeholders for resilience planning, information, instruction and education.

2.3.5 Equality and Diversity, including health inequalities and Anchor Institution ambitions

Equality and Human Rights lead has been invited to be a member of the NHS Resilience Forum.

Equality and diversity assessment is factored into emergency planning and in-house resilience training.

2.3.6 Climate Emergency & Sustainability Impact

The climate emergency will increase risks to population health. These are considered as part of the planning process and there is representation from the Sustainability Forum within the Resilience Forum. **See item 3**: NHS Fife Climate Change Risk Assessment (CCRA)

2.3.7 Communication, involvement, engagement and consultation

The quarterly resilience workforce briefing newsletter supports awareness to framework documents and provides situational awareness.

Resilience EPRR reporting across 2023/24 will be themed as follows;

Quarter 1: EPRR Risk Profile
Quarter 2: EPRR Education, Training & Exercising
Quarter 3: Emergency Planning
Quarter 4: Business Continuity

Quarter 1 Resilience report was considered by the NHS Fife Resilience Forum on the 10 October 2023. This report is created in partnership with H&SCP and Digital resilience colleagues to provide a whole systems approach.

Meetings:

NHS Resilience Forum (RF) meetings	**Acute SLT Meetings**	**H&SCP Meetings**	**Executive Director Group (EDG) meetings**
Quarter 4 Report (2022-23) 8/6/2023	Draft Incident Management Framework 25/7/23	**H&SCP SLT** Incident Management Framework 18/9/2023	Quarter 4 Report (2022-23) 8/6/23
Quarter 1 Report (1 April -30 June 2023) 10/10/2023	Draft Business Continuity Management Systems S BAR (BCMS) 25/6/23	**H&SCP Resilience Assurance Group** 21/9/23 Draft Suspect Package and Bomb Threat framework document	Final Incident Management Framework 10/8/2023
	Assurance of Resilience Capabilities SBAR 30/5/2023		

Additional Meetings Supported:
28/6/23 Winter Sports Committee Feedback

2.3.8 Route to the Meeting

This paper has been prepared to provide a midyear progress update to CGC in advance of an annual board assurance paper for 2024.

2.4 Recommendation

This paper provides an overview of emergency planning & preparedness progress for assurance for Quarter 1 April 1st -30 June 2023. The Clinical Governance Committee will receive an Annual statement of Assurance in line with that provided by other sub-groups.

3 List of appendices

The following appendices are included with this report:

- **Appendix 1** - NHS Fife's Incident Management Framework

Report Contact

Susan Cameron
Head of Resilience
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Resilience

Incident Management

Escalation Levels 1,2,3,4, Major Incident Declared and Category 1 Response

Framework Document

nhsfife.org

Version 1 - April 2023

Contents

Abbreviations used:

AHP	Allied Health Professional
ALO	Ambulance Liaison Officer
ANP	Advanced Nurse Practitioner
BCP	Business Continuity Plan
CBRNe/HAZMAT	Chemical, Biological, Radiological or Nuclear (explosive) or Hazardous Material
CMHT	Community Mental Health Team (H&SCP)
C3	Command, Control & Communication
DVI	Disaster Victim Identification
ED	Emergency Department
EOSRRP	East of Scotland Regional Resilience Partnership
EPRR	Emergency Preparedness Resilience Response
GP	General Practitioner
H&SCP	Health & Social Care Partnership
HIC	Health Information Cell
HOTO	Handover – Takeover
IBIS	Interagency Bronze Interoperable Solution (Airwave Radios)
ICT	Incident Control Team
IMT	Incident management Team
LRP	Local Resilience Partners
MACA	Military Aid to the Civil Authorities
MACC	Multi Agency Control Centre
MI	Major Incident
MIF	Major Incident Framework document
MI-MC	Major Incident with Mass Casualties
MIO	Medical Incident Officer
NHS	National Health Service
OoH	Out of Hours
OPEL	Operational Pressures Escalation levels
SAS	Scottish Ambulance Service
SHG	Strategic Health Group
SHPIR	Scottish Health Protection Information Resource
SOP	Safe Operating Procedure
STAC	Scientific & Technical Advice Cell
VHK	Victoria Hospital Kirkcaldy
VIP	Very Important Person’s
WRVS	Women’s Royal Voluntary Service

IMPORTANT NOTICE

NHS Fife's Incident Co-ordination Action Cards (Level 4) are hyperlinked forefront to this document for immediate use where required:

Major Incident Action Card – Chief Executive
Major Incident Action Card – Executive (Gold) On-call
Major Incident Action Card – Duty Manager/Silver On-Call
Incident Level 4 (Major Incident) Mortuary Services Action Card
Public Health Incident Consultant in Public Health Medicine/On-call Consultant.

All associated National Guidance, Service area Business Continuity Plans & Official Sensitive restricted guidance will be available electronically to GOLD Command in the Resilience folder in the "T:/ Drive" . Documents will be available from within the Executive Virtual Incident Room folders & are fully backed up on a USB drive held in the Major Incident Store. In the event that IT access is unavailable, physical copies are maintained within the Major Incident Store in the Education Centre at VHK.

1 Introduction

NHS Fife requires an ability to respond effectively to a wide range of events, including critical incidents and emergencies that could adversely affect health or patient care. The Civil Contingencies Act 2004 (the Act) places a duty on NHS Fife to have local planning for preparedness in place to facilitate emergency response & recovery management. Under the Civil Contingencies Act 2004 NHS Fife, as a public organisation, is regarded as a Category 1 multiagency responder with key multiagency responsibilities being to save lives in conjunction with other emergency services. See: Civil Contingencies Act 2004 (legislation.gov.uk) and Civil Contingencies Act 2004 (Contingency Planning) (Scotland) Regulations 2005

NHS Fife's resilience framework aims to establish good practice/s within the escalation & management of incidents, this includes maintaining an operational ability during any disruptive event to ensure continued NHS services for patients. To enact this NHS Fife must ensure;

- Planning for preparedness within response & recovery is in place locally and is aligned to national guidance/s Preparing-Scotland-Responding-to-Emergencies (ready.scot) & Major Incidents with Mass Casualties
- That the workforce has received adequate information, instruction, training & education within incident escalation, management, response & recovery.
- Effective communications can be maintained with partner Health Boards, partner agencies and local/national resilience partnerships within any incidents arising.

The resilience framework escalation Levels 1, 2, 3 & 4 reflect the reporting structure of NHS Fife. Framework incident Levels 1, 2, 3 & 4 provide a common approach for internal incident escalation with any disruptive events that can evolve into critical or major incident situations.

During day-to-day operations NHS Fife deals with a wide range of issues that are typically resolved by enacting local business continuity plans. Certain incidents, however, in response might require a different approach where it is necessary to establish a dedicated command & control incident management team. Operationally NHS Fife adopts Gold (strategic)/ Silver (tactical) & Bronze (operational) command & control.

The command-and-control hierarchy when required provides strategic level authority with the deployment of available NHS resources and equipment. The principles of command and control are operationally scalable where it may also be required as part of a much wider multiagency Category 1 major incident response.

NHS Fife's Major Incident Framework planning is broken down into three sections Prepare, Respond & Recover following the Emergency Management Cycle.

Prepare	Sets out the structure and organisation of NHS Fife's Acute Services Division during a Major Incident. It also outlines the roles and responsibilities of partner agencies in the event of a Major Incident.
Respond	The response focus is on saving lives and protecting public assets such as our NHS hospital buildings & infrastructure. It sets out the management communication links, the patient journey through the system and the key actions when responding to any Major Incident declared.
Recover	Supports a coordinated process of recovery following emergency-affected areas & how NHS Fife will return to normal after a Major Incident.

2 Associated Framework Guidance/s may be required during incident response (dependant on incident situation & support required) these include:

Business Continuity Management Systems	The ability of Category 1 organisations to continue to be able to perform their functions in the event of emergencies.
Bomb Threat /Suspicious Packages	Threats concerning bombs or explosive items, whether genuine or false, are regrettable hazards of modern day living. Hospitals, due to their open nature, are particularly at risk.
Fire Procedures/Building Evacuation	Fire Strategy - including buildings evacuation. Managed via NHS Fife Estates & Security.
Buildings Lockdown Framework	The planning and execution of a lockdown of a healthcare site or building within NHS Fife.
Severe Weather Framework	Procedure for mitigating and limiting the effects of the climate emergency impact to NHS Fife.
Scientific Technical Advice Cell (STAC)	Dependant on the scale and impact of an incident, Health Boards need to be prepared to: • Convene and chair a STAC, providing advice to the local LRP/RRP on human health, risk management strategies, countermeasures, and longer-term health monitoring. • Advise SAS and other first responders, other public bodies, the public and the media about effects of a Hazmat incident on human health, and of countermeasures to those effects.
CBRN/HAZMAT	All Category 1 designated Health Boards have a duty to provide care for people who may be contaminated with chemical, biological, radiological, or nuclear (CBRN) material or hazardous material (Hazmat) and a role in managing the consequences of such incidents.

PREPARE

3 Incident Levels Defined:

NHS Fife manages incident escalation through a series of incident level triggers. The levels are defined as follows:

Incident Level 1 - Locally managed incidents

Incident level 1 describes any incident event that can be responded to and managed within the department (within business-as-usual capabilities) using safe operating procedures (SOPs).

Incident Level 2 - Business Continuity Incident

A Business Continuity Incident (Incident Level 2) is any internal board event that disrupts normal service delivery where special arrangements/mitigating actions are required to be implemented until services can return to an acceptable level.

Within NHS Fife a central repository of service area Business Continuity plans is held in the Board's "T:/ Drive" and access is shared with executive directors on call. "T:/ Drive" data is backed up locally on an encrypted USB memory stick held securely within the Resilience department. Each individual service area should also maintain an electronic and hard copy of their Business Continuity Plan.

In any event where a Business Continuity incident escalates across to two or more service areas or is deemed as may have significant impact on Board-wide services then it must be escalated from Incident Level 2 (Business Continuity Incident) to Critical Incident (Incident Level 3) verbally or in writing using the SBAR format.

Incident Level 3 - Critical Incident

Critical Incident (Incident Level 3) is defined as a localised event where the level of disruption results in NHS Fife as an organisation temporarily or permanently losing its ability to deliver critical services, patients may have been harmed, or the environment is not safe requiring special measures and support from other departments, Health boards & partner agencies support is required to restore normal operating functions.

Examples:

- Bomb Alert
- Explosion
- Failure of electrical/mechanical systems in buildings infrastructure
- Fire

- Flood
- Infant abduction
- Infestation
- Significant IT failure/Cyber Attack
- Telecommunications system failure
- Water Contamination/Loss
- Infectious Diseases
- Operational Pressures Escalation Level (OPEL): Purple (L5) Acute & H&SCP (trigger 90>+)

  ***Note**: Capacity & Flow metric is not directly related to incidents, instead focuses on hospital capacity, however, in instances where both Acute & H&SCP services have escalated to OPEL Purple (L5) with an OPEL scoring of 90>+: Incident Level 3 critical incident framework management must be adopted.*

Critical incidents are managed though control measures identified locally in Business Continuity departmental plans & action cards. In situations where Critical (Incident Level 3) incident is escalating to Level 4 it must be escalated to Gold Command verbally or in writing using the SBAR format. Any SBAR detail shared during incident management handover must be recorded into the decision logs (with the time also being noted) for the incident record.

Public Health Incident

Any of the above examples could lead to a Public Health Incident, which would require an Incident Management Team (IMT) to be enabled or a Scientific Technical Advice Cell (STAC) to support incident management via NHS Fife Public Health Department. An Incident Management Team (IMT) is defined as a multi-disciplinary, multi-agency group with responsibility for investigating and managing the incident. Following a Public Health Incident, 'lessons learned' must be captured in the form of a 'hot debrief'. The storage and dissemination of the completed debrief is covered in Management of Public Health Incidents: Guidance on the Roles and Responsibilities of NHS Led Incident Management Teams (publichealthscotland.scot) and STAC | Ready Scotland and the debrief template is at Annex 2. The Scottish Health Protection Information Resource, listing Public Health alerts and information can be found online at SHPIR - Home (scot.nhs.uk) using the NHS Fife password (held by the on-call Public Health Consultant).

<u>Incident Level 4</u> - Major Incident Declared:

This is defined as any occurrence that presents a serious high-risk threat to the health of the community or causes such numbers or types of casualties as to require specialist arrangements to be implemented. This includes any incident defined as an "emergency" as in Section 1 of the Civil Contingencies Act 2004 and is coordinated by GOLD command.

NHS Fife may determine to follow an Incident Level 4 incident response in any situation where a Major Incident has been declared in a neighbouring Health Board where mutual aid for patient welfare is required.

Examples of incidents which could lead to a major incident occurring are, but not limited to:

Type	Key Characteristics	Example
Big Bang	Happens unexpectedly	A serious transport accident or explosion
Rising Tide	Builds over a period of time and allows some time to prepare.	COVID-19
Cloud on the Horizon	Significant chemical or nuclear release developing elsewhere and needing preparatory action.	Volcanic Ash
Headline News	Public or media alarm about an impending situation, which may be an over-reaction.	Zika Virus
Chemical, Biological, Radiological, Nuclear and explosives (CBRNE)	Actual or threatened dispersal of CBRNE material, with deliberate criminal, malicious or murderous intent.	Salisbury Novichok nerve agent release
Hazardous Materials (HAZMAT)	Accident involving hazardous materials.	Self-presenters at A&E Secondary exposure
Cyber Attacks	Attacks on systems to cause disruption.	'Wannacry' malware attack

4 Incident Escalation

Diagram 1: Internal/External Incident Escalation (Levels 1, 2, 3 & 4 Major Incident/Category 1 response)

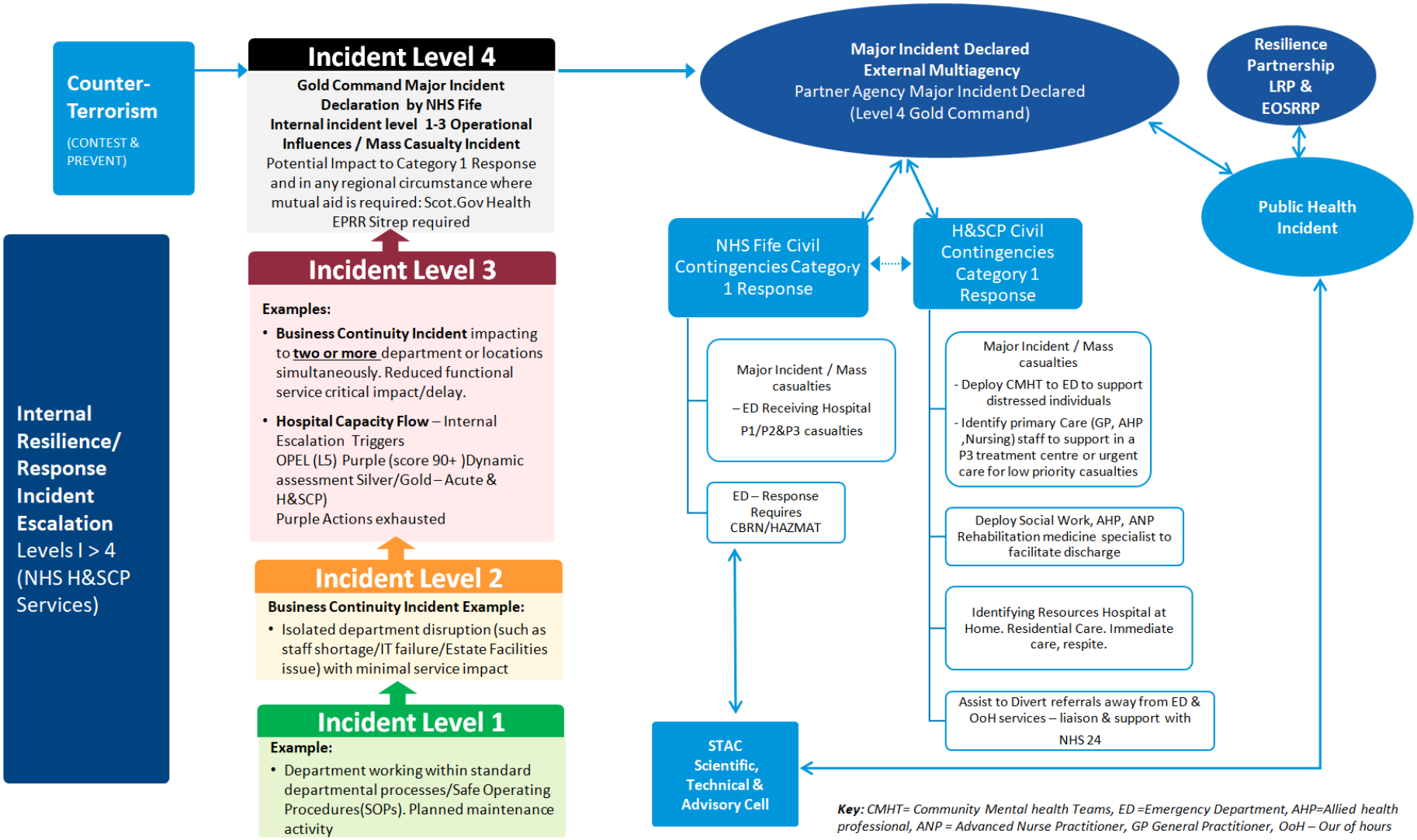


Diagram 2: Internal incident escalation Levels

Situation Background Assessment Report (SBAR) format should be used when escalating incident level

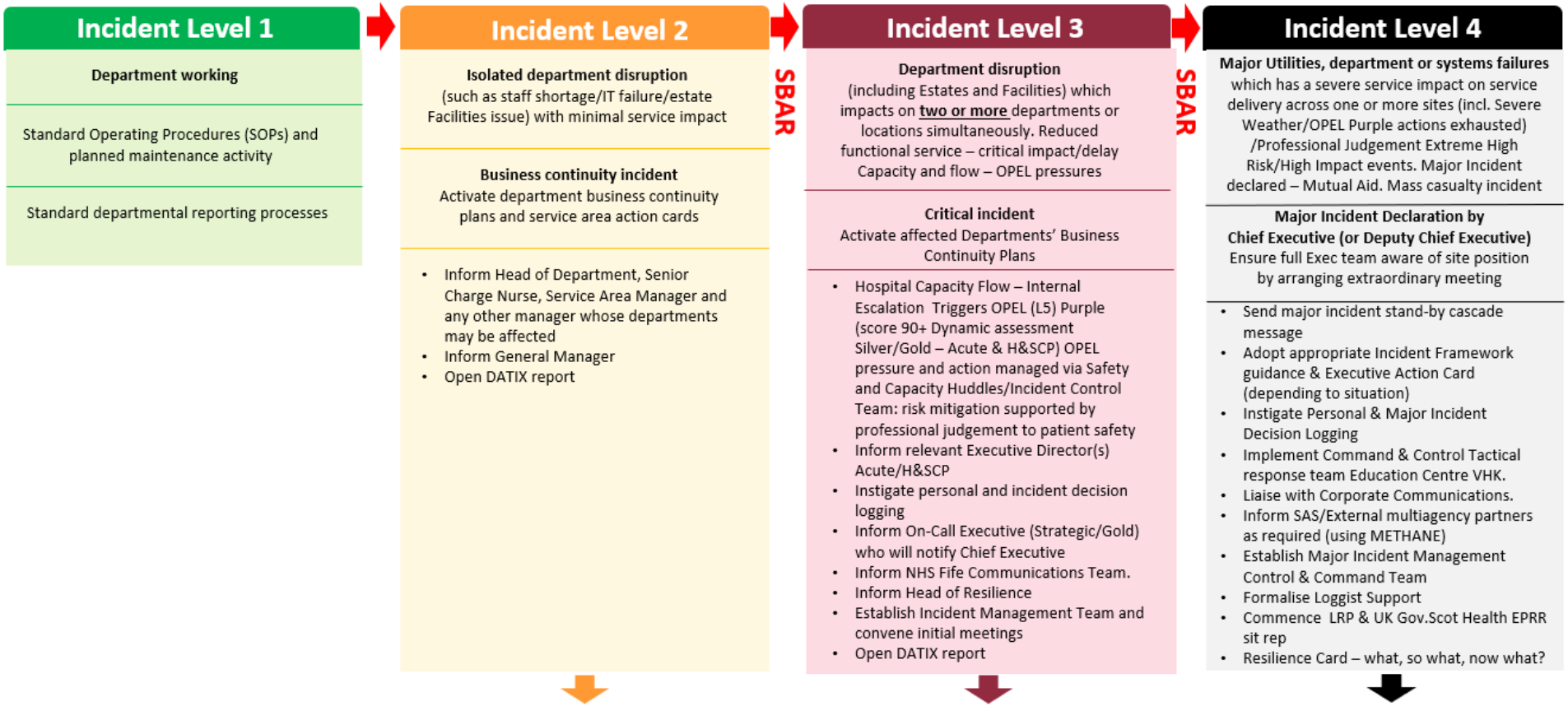


Diagram 3: S BAR

SBAR Format: verbally or written using Appendix 1 template.

Incident Level 2 (Business Continuity Incident) – Level 3 (Critical Incident) – Level 4

SBAR Report	
Situation	Describe situation/incident that has occurred i.e. Exceptional risks arising from weekend or overnight, surges in activity, increases in ED presentations, workforce.
Background	Explain history and impact of incident on services/patient safety – risk/s
Assessment	Confirm your understanding of the issues involved. What measures are in place. What has already been exhausted other than business as usual. Have all organisations confirmed that hey have implemented all relevant actions from their own internal escalation plans. Has any provider declared or is about to declare an internal critical.
Recommendation	Explain what you need, clarify expectations and what support is needed. What benefit / outcome do we need to achieve de-escalation.
Ask receiver to repeat information to ensure understanding	

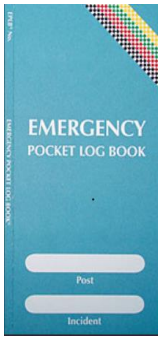
For SBAR template go to Appendix 1 **Note** – SBAR detail shared during incident management & handover must be recorded into the decision logs (with the time being noted) for the incident records. In instances where a written SBAR has been provided it must be uploaded to the DATIX incident record.

4.1 Decision Logging/Meeting Minutes

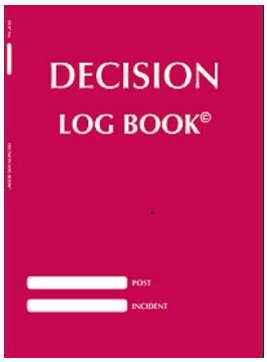
Logging incident information and decisions is an essential part of incident management and is required at all levels within Response and Recovery. Decision logging is a means of providing an auditable trail of defensible decision making. Strategic decisions need to withstand 'hindsight scrutiny' should negative outcomes occur. Decision logs must be used to keep a comprehensive record of all events, information received, decisions, reasoning behind those decisions and actions taken. Personal logs must also be enabled as part of the incident record. NHS Fife has a register of trained Loggists who would be made available to Gold Command (listed in T: / Drive Resilience Folder). Any meetings in relation to the Major Incident must produce a full set of minutes and action points and be separately retained. Decision Logs and Personal Logs have individual identification codes which must be annotated in the DATIX incident report.

Emergency Log Books are available via the Public Health Resilience Team and these **physical logs must be used by default** as this provides resilience in the event of power outage or loss of infrastructure. Log Books fall under 'records retention' legalities and must be forwarded to the Resilience Team to be retained centrally following any Major Incidents.

Picture 1:
Emergency Pocket Log Book



Picture 2:
Loggist Decision Log Book



4.2 Reporting Major Incidents (Gov.Scot Health EPRR)

On declaration of a Major Incident with Mass Casualties (MI-MC), a Strategic Health Group (SHG) will be established by the Chief Executive of the territorial NHS Board in whose area the MI-MC incident first takes place or where the greatest impacts occur, if it is a multi-site incident. There is an option for this Chief Executive to formally pass on the role of SHG Chair to another Chief Executive at the outset, according to their judgement in the circumstances of an actual incident. Their decision for doing so must be recorded at the first meeting of the SHG.

NHS Scotland reporting arrangements require a sitrep proforma to be completed (within 2-3 hours) to Health EPRR in Scottish Government following an Incident Level 3-4 incident including:

- Internal incidents within NHS Fife Health Board
- Incidents declared by a Regional Resilience Partner (RRP) that requires the deployment of healthcare resources; and
- An incident that creates significant service pressures for the Health Board and is likely to impact on business as usual or NHS Fifes agility to undertake category 1 response.

See: NHSScotland Resilience Preparing for Emergencies - Guidance for Health Boards in Scotland (www.gov.scot) (Section 5.17)

- Scottish Government Health EPRR Situation Report:
  The proforma Health EPRR - SITREP Template must be completed and submitted to Health EPRR health.eprr@gov.scot no later than 2 or 3 hours following the occurrence of an incident

UK.Gov.Scot Health EPRR Contact Numbers:	
Weekday 08:30-17:00	0131 244 2429
Out of hours emergency pager 17:00-08:30 weekdays/weekends & Public Holidays	07623 909981
*In any event that the out-of-hours SG Health EPRR contact has not responded **within 1 hour**, follow up with another call to the duty pager and a follow-up email.*	

Scottish Government Health EPRR Situation Report
NHS Boards – Incident Reporting Levels

Level	Scale	Impact	Response	Reporting action and timeframe for notifying SG Health EPRR
1	Minor – local	Low. Business continuity issues - impact is localised.	Can be managed by the Department/Hospital within BAU capabilities and BCP's	No reporting required
2	Medium	Moderate. Larger business continuity issues such as local IT outages, major infrastructure damage, larger Road Traffic Collisions, and other issues impacting on a larger part of the hospital; has led to or likely to lead to suspension or delay to healthcare services; contained to one hospital site.		Submit SitRep to SG Health EPRR within 3 hours.
3	Significant	Impact on the whole Board and service provision / performance, as well as neighbouring NHS Boards. Loss of critical services and functionality. Normal functions interrupted /suspended. No workaround exists.	MI team / C3 set up at Hospital or Board Level. Possible regional and national co-ordination established.	Immediate by phone followed by SitRep within 2 hours
4	Major	The specific functionality is mission critical to the business and the situation is considered an emergency. Severe weather affecting the whole or part of Scotland, terrorist incidents, any incidents/accidents which cause mass casualties, major business continuity issues such as pan-Scotland IT outages.	Requires Board C3 group to be set up. Potentially an SHG would be established. Regional and national co-ordination in place.	Immediate by phone, followed by SitRep within 2 hours

4.3 Incident Health and Safety

For all personnel involved in the response to an incident (including 3rd sector volunteers working under NHS Fife direction) Gold Commanders must ensure that suitably qualified and experienced personnel are brought into the response to ensure the health, safety and welfare of all personnel involved is observed. The focus should be around the availability of appropriate equipment, monitoring of environmental conditions, wearing of appropriate PPE and the recording of actions taken in relation to these. Advice, where appropriate, should be sought from the Health and Safety Manager.

4.4 (M)ETHANE Report

A notification of a Major Incident (either internally via Gold command or externally via any partner Category 1 agency) will be in the form of a (M)ETHANE report. The Joint Emergency Services Interoperability Principles (The Joint Decision Model (JDM) - JESIP Website) identifies (M)ETHANE as the preferred model for sharing information to promote a shared situational awareness for all responders.

Diagram 4: (M)ETHANE

4.5 Major Incident Standby (Emergency Department)

This is used when there has been a report that a Major Incident has occurred but is not confirmed, or where the capabilities/capacities of other hospitals already alerted are filled. The Scottish Ambulance Service (SAS) will issue a Major Incident Standby message. If a Major Incident Standby message is received from another source, it must be confirmed by the SAS before any actions are taken.

4.6 Major Incident Declared (MID)

This is when the call-out procedures and actions are needed to mobilise additional staff & resources to cope. MID can be activated either internally via Chief Executive (or their deputy) or externally via a partner agency such as Scottish Ambulance Service / Police Scotland.

The Major Incidents with Mass Casualties National Plan for NHS Boards and H&SCP 2019 will be enacted where appropriate.

4.7 Stand-Down (Recovery):

This is determined and actioned by the designated incident lead when pressure on services is reduced after a declared incident, or when standby is no longer deemed necessary.

4.8 Incident Exercise:

This is when NHS Fife initiates an exercise which can be tabletop or live play exercise. Exercises are used to identify any planning gaps & to validate planning.

5 The Role of NHS Fife Acute Hospital/s

NHS Fife operates 2 acute sites:

Victoria Hospital Kirkcaldy (VHK): VHK is the designated hospital to receive casualties in the event of an external Major Incident being declared.
Queen Margaret Hospital (QMH) Dunfermline: The QMH will provide support to VHK to enable resources to be used flexibly across both sites in order to respond to any increased activity.

5.1 Incident Control Room Location/s:

PRIMARY VENUE (virtual meeting room) **- Fife Executive Virtual Control room via M/S Teams** by Chair invitation.

In any event where a virtual control room cannot be facilitated physical control rooms will be located at:

Victoria Hospital Kirkcaldy

Physical location PRIMARY	**Physical location SECONDARY**
Lecture Theatre, Education Centre Incident Control Teams locate into Seminar Room 2	Meeting Room 1, Hayfield House
Executive Response Group Chief Executive's Office, Hayfield House	**Executive Response Group** Staff Club

National Teleconference Facilities:

- Lothian/Fife/Borders/D&G sites: bring up **1MCU10** from the **system phonebook** and press Connect.
- NHSS sites who are set up to dial over IP nationally, dial **520469237**
- Joining details for the **Scottish Strategic Health Group - Major Incident Bridge** can be found in the Fife Executive Virtual Control room on Teams.

5.1.1 Multi Agency Control Centre (MACC)

Physical MACC	**Fife Police Headquarters**, Detroit Road, Glenrothes, Fife KY6 2RJ
Virtual MACC	Membership by Teams invitation from MACC Commander/Police Incident Officer

5.2 NHS Fife Incident Control Team (ICT)

In order to ensure a co-ordinated and appropriate response, an Incident Control Team (ICT) will be formed under Executive (GOLD) direction dependant on the nature of incident & management required. (Consider requirement from the following: Director of Acute Services, Director of Public Health, Director of H&SCP, Estates Lead, Finance Lead, Incident-specific Specialists, Resilience Team, Comms Lead, Loggist support.

5.2.1 Control Room

If the virtual (Teams) meeting platform is unavailable, each member of the designated Incident Control Team should report in person to Seminar room 2, Education Centre, VHK where a physical major incident box is located in the major incident store cupboard.

5.2.2 Major Incident Equipment

Major Incident Equipment is held in the following locations:

Location	Site
Seminar Room 4, Education Centre	VHK
Maternity Unit - Main Reception Area	VHK
Major Incident Equipment Store, Emergency Department	VHK
Public Health Department	Cameron Hospital
Minor Injuries Unit(CBRN-specific)	St Andrews Hospital
Minor Injuries Unit(CBRN-specific)	Adamson's Hospital

Major Incident Equipment areas are highlighted with the following signposting:

There are physical folders of all required framework documents in each of the above locations, alongside physical Decision Logs & stationery supplies (pens, paper etc). Emergency Department, VHK hold physical copies of all ED Action Cards in the Major Incident Store.

5.2.3 Communication Equipment (telecommunications failure)

In any local event of telecommunication systems failure 2-way radios are available in the Control Room, VHK for in-house communications use. If these are adopted for internal communication, the person to whom the handset is issued must be noted into the decision log book.

In the event of a regional communication network failure the Interagency Bronze Interoperable Solution (**IBIS)** airwave radio handsets are available from Police Scotland partners for communication between Emergency Services, multiagency partners (GOLD command) and, in the event of mutual incident response, between NHS & Scottish Government Health EPRR. **IBIS** radios are available on request from the Senior Police Incident commander. In any event that **IBIS** messaging is

taking place the person using the handset and its unique radio identifier should be noted into decision logbook detail.

When adopting use of radio handsets the phonetic alphabet is used; see Radio handset guide Annex 1.

5.2.4 Physical Messaging

In any event where digital systems & telecommunications networks are locally unavailable it may be necessary to delegate a physical team of staff to act as messaging runners between various departments. In the event that this is required, numbered tabards are available for use in the major incident equipment store in the Education Centre VHK. The number and name of the person passing on information as part of this role must be noted in the decision logbook detail.

5.3 Command, Control and Coordination (C3)

Command, control & coordination communication strategy is adopted during incident management by Gold/Silver in Incident Level 3/4 management. Gold command will establish Silver/Bronze groups as required by the nature of the incident, for receiving hospital Category 1 incident hosptial control structure (see diagram 5B: Receiving Hospital Category 1 Response)

Gold	Strategic
Silver	Tactical
Bronze	Operational

During incident management, key roles should be rotated (with a full handover) every 6 - 8 hours. An SBAR format handover record (utilising the ongoing decision log) must be annotated each time a role handover takes place; all documents must be retained as part of incident management record.

Diagram 5A: C3 Strategy

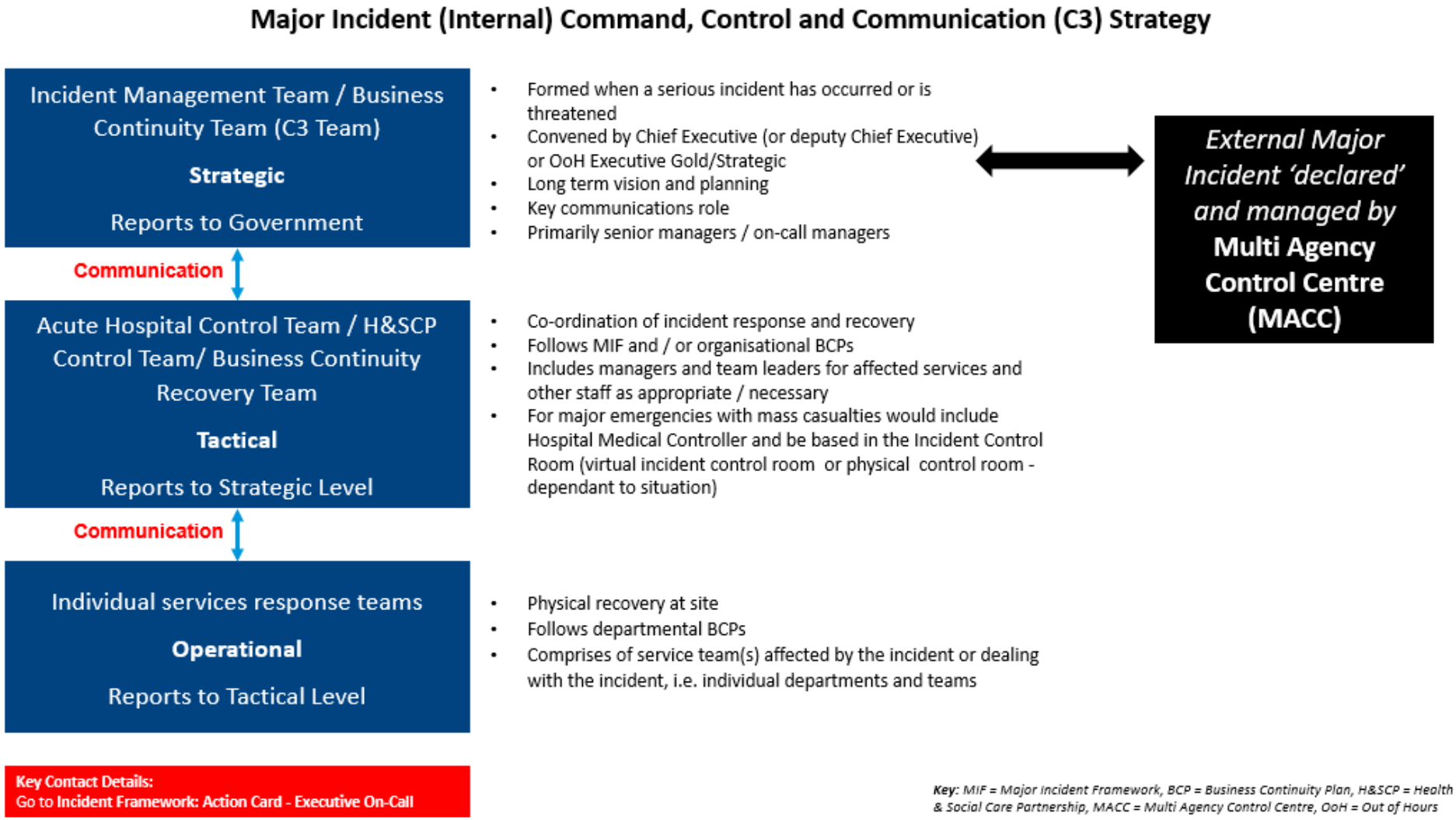
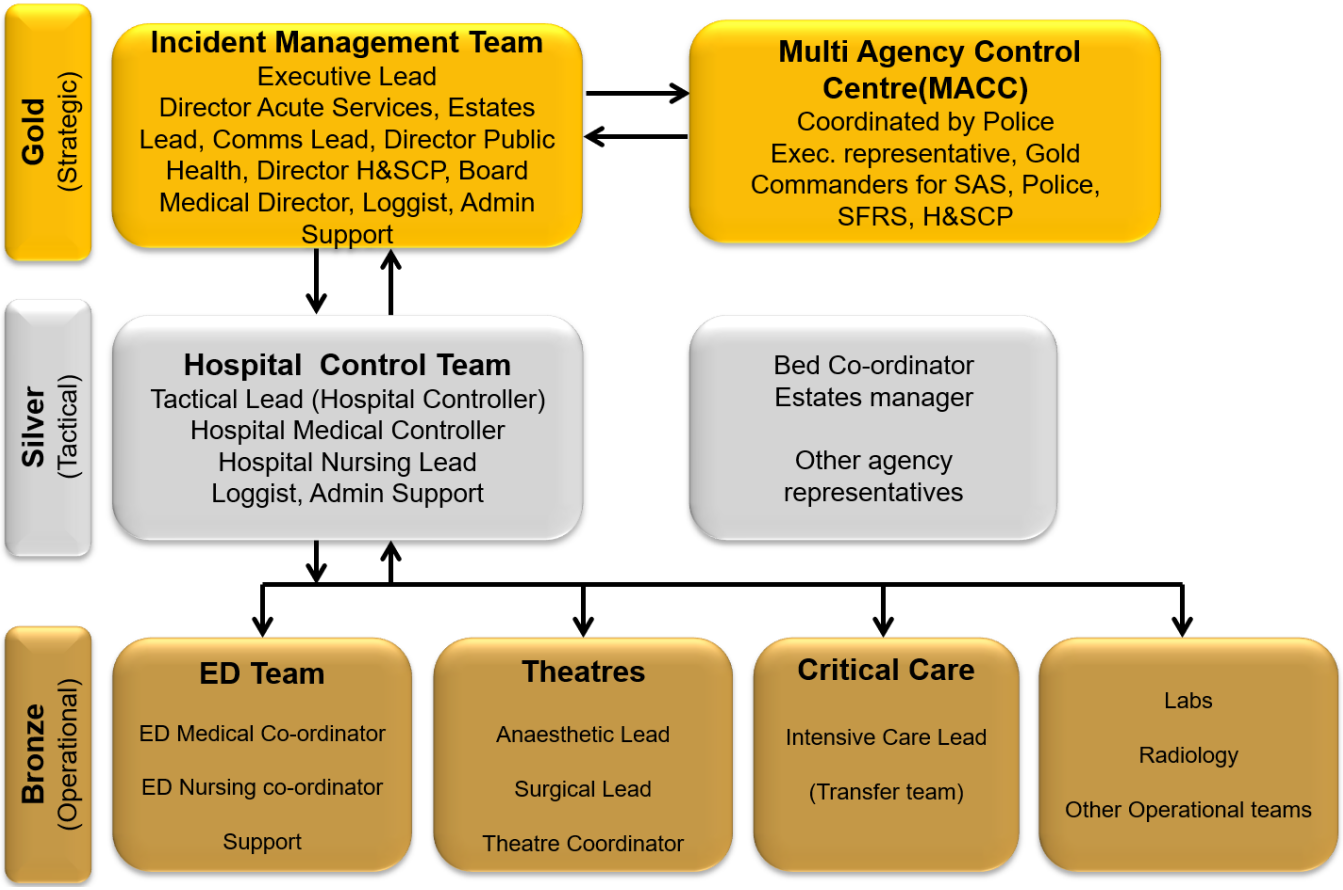


Diagram 5B: Receiving Hospital Category 1 Response



6 Corporate Communications (Incident Management)

The Corporate Communications team at NHS Fife will lead on and coordinate all internal and external communications on behalf of the organisation, in response to a major incident. What and when we can communicate will be agreed in liaison with the agency leading the initial incident response e.g., Police Scotland. This will also include liaison with partner organisation communications leads such as Fife Local Resilience Partnership (LRP), Police Scotland, and Fife Council, as well as local and national press, media outlets and local elected members including Councillors, MSPs and MPs.

NHS Fife's Corporate Communications team will also coordinate all posts and monitor the organisations social media channels as well as issuing regular updates via NHS Fife's internal communications channels including the StaffLink App and all-staff email updates and briefings.

Corporate Communications will also have representation on Gold Command as well as appropriate Silver Commands and the Fife LRP or its communications subgroup to ensure a consistent and timely flow of information to inform and instruct colleagues, service users, partners and the general public as the incident evolves and as the impact on service provision is fully evaluated and any mitigating actions to be taken.

Corporate Communications activity as part of a major incident will fall into four main phases:

1. Alert users that an incident has occurred.
2. Provide users with regular updates throughout the duration of an incident.
3. Notify users once an incident has been resolved.
4. Contribute to post incident review and follow-up.

Corporate Communications will also keep a live log of all communications activity throughout the period of the incident for future incident review and follow-up.

6.1 Minimal Information required by Corporate Communications team to aid communications during an incident.

To aid business continuity communications, particularly when a major incident may be declared, the minimum information the Corporate Communications team will require in the form of a briefing can be best summarised using the acronym -

"METHANE" this information will be used as the basis to coordinate and create consistent communications from NHS Fife.

- Major Incident Declared.
- Exact Location.
- Type of Incident.
- Hazards – present and potential.
- Access – routes safe to use.
- Number, type, severity of causalities.
- Emergency services present / required.

6.2 Press and Media Management

NHS Fife staff are reminded that they must direct any press or media calls, requests, or enquiries to NHS Fife Communications – Ext: 27971 Tel: 01592 647971 (Monday – Friday 9am-5pm), Email: fife.communications@nhs.scot

Out with these hours please call switchboard on Tel: 01592 643 355 and they will forward your message to the on-call service. Staff should not address any media enquiries or requests directly or agree to interviews without discussing first with a member of the NHS Fife Corporate Communications team.

6.3 Social Media

NHS Fife Corporate Accounts:

Social media accounts are NHS Fife's main social media channels and messages and content issued on them represent the official view or comment from NHS Fife. There is only one official-corporate account for each social media platform and these accounts are managed by Corporate Communications on behalf of the Chief Executive and NHS Fife as a corporate entity. These accounts are where the public, stakeholders and the news media can expect to hear the latest news, comment, and campaign messages from NHS Fife. During an incident, these channels are where people will often look to first for real-time updates. Posts, messages, and comments will be coordinated and monitored by Corporate Communications during an incident.

Individual-personal accounts:

Personal social media accounts are private profiles and unregulated by NHS Fife and the responsibilities of the account holder. However, members of NHS Fife staff identifying as such should consider their security settings in the event of a major incident and be mindful that their views or content could be presented as being those of the organisation. This is especially important during an incident as press and media will use social media to solicitate interviews, opinions, or other content. Staff are asked not to post images or film footage of NHS Fife premises during an incident as this could breach confidentiality and negatively impact on any potential police investigation.

6.4 Internal Communications:

NHS Fife Internal Communications during an incident will use a combination of channels. The primary channel for incident communications will be via the Staff Link App (powered by Blink software) – with staff asked to ensure they have downloaded the App to their phone or have access to the desk-top version. StaffLink communications will also be complemented with All Staff Emails as well as Managers' briefings for dissemination via staff huddles, safety briefings and meetings.

6.5 Elected Members Updates and Briefings:

All enquiries from elected members should be directed to the NHS Fife Chief Executive Office for response and co-ordination at: fife.chiefexecutive@nhs.scot. Staff members should also direct any enquires from elected members to this mailbox.

6.6 Corporate Communications Mobile Phones:

The Associate Director of Communications and the three Communications Managers all have work mobile phones. Switchboard, EDG Gold Command and the resilience team also have access to the Corporate Communications on-call rota and mobile numbers for the Corporate Communications team for weekend and out of hour's calls.

6.7 Major Incident Media Centre:

In case of a major incident on the VHK site – any media that arrive on site should be directed to the Staff Club, where the Corporate Communications Team will operate a media hub.

6.8 Casualty Bureau:

Following a Major Incident Police Scotland will establish a Casualty Bureau Team to collate information on those who may or may not be involved in the incident. Once the Casualty Bureau Team have been established; the Police will issue a telephone number to the public via the media. In advance of the Casualty Bureau Telephone number being established, the public will be asked to monitor the news section of the NHS Fife Website and NHS Fife Social Media Channels for latest news and guidance associated with the incident, with the Casualty Bureau number actively promoted via these channels once the numbers have been released by Police Scotland.

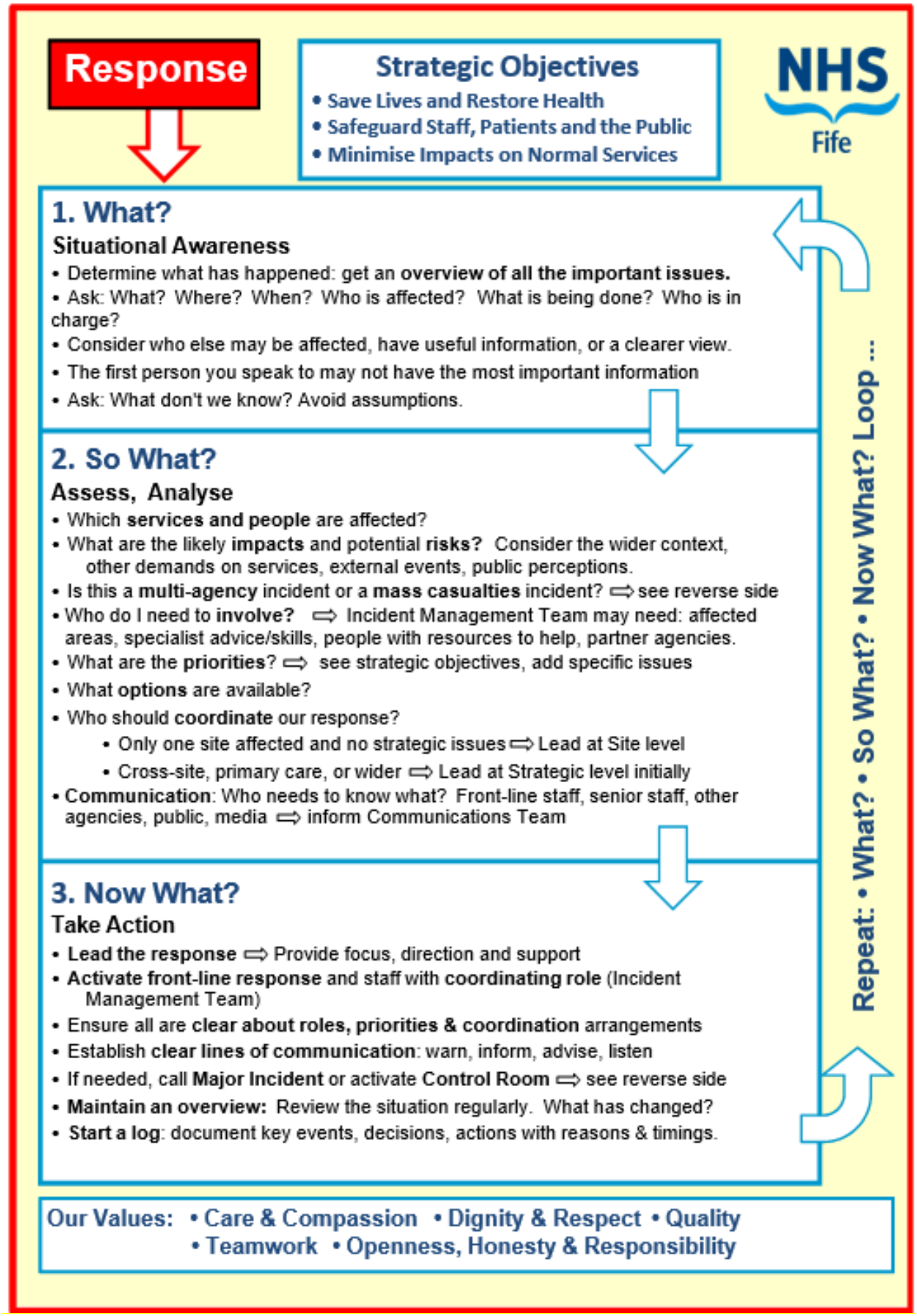
6.9 IT or phone outage:

In the case of an IT or phone outage, media should be directed to submit any initial media enquiries via the NHS Fife Press and Media Enquiry Form on the NHS Fife website: https://www.nhsfife.org/news-updates/press-and-media/press-and-media-enquiry-form/

As the NHS Fife website is hosted separately from any national NHS systems this form should still be accessible in the case of an IT or phone outage.

Alternatively, in the interim any press, media, or general public enquiries should be directed to follow NHS Fife's social media channels for the latest updates and comments from the organisation.

7 Resilience Card (What? - So What? - Now What?)



OFFICIAL

Resilience Card

Information

NHS Fife

See also: Action Cards in designated Incident Control Rooms
NHS Fife Resilience intranet site: Staff Link: NHS Fife EPRR Pages
Scottish Government: www.readyscotland.org/ready-government/

Strategic Incident Management Team

AGENDA

1. **Introduction**
   - Purpose, membership
   - Urgent actions
2. **Situation Update – What?**
   - Actions from previous meeting
   - Reports from internal departments, specialists & external agencies
3. **Assessment and Significance – So What?**
   - Set/Review Strategic Objectives
   - Assess current/future impacts/risks
     - Consider: Strategic Objectives, Service provision, legal, financial, political and reputational aspects
   - Agree Priorities
   - Identify Options available – strengths & weaknesses
   - Review Communications Strategy – Internal & external
4. **Agree Actions – Now What?**
   - To manage incident
   - To manage normal services
   - To manage communications
   - To direct and support staff
5. **AOB**
   - Time of next meeting

Note: To ensure priorities are addressed first, get *concise updates* from all *before* discussing how issues will be managed

Mass Casualty Incidents

Key tactical (site level) tasks:

- Find out how many casualties are expected, how many may need immediate surgery; whether they pose any hazards to staff, any other security risks.
- Ensure theatre lists are halted, space is created in ICU & HDU, both Recovery and Emergency Dept. are cleared and Blood Transfusion Service is aware.
- Ensure the following have met and are clear about their roles (on their Action Cards): Hospital Medical Coordinator, Surgical Lead (coordinating role), Surgical triage, ED Lead consultant

The **National Mass Casualties Plan**

- SAS will assume that Territorial Boards will make available their default trauma capacity levels (28 Adult P1/P2 casualties for NHS Fife)
- The Board where the incident occurs should activate and chair a cross-board **Strategic Health Group** within 2 hours.

Police & Scottish Government

- To contact **Police** in an emergency call **999**.
- To activate the multi-agency **Resilience Partnership** response (MACC) call Police Control Room **0131 203 7904,** request RRP response and say who you need: Council, Police, RRP Coordinator, etc.
- **Who to speak to in a multi-agency incident**: ask for the Police Incident Officer (PIO); identify yourself as NHSL **Tactical** (Site Dir.) or **Strategic Lead** (Exec. Dir.).
- **Scottish Government** should be told about incidents that may seriously affect services or attract media interest. A Director or member of the Resilience Team should do this: call **0131 244 2429** (Out of hours call **07623 909 981** leave a 'call me back' message that includes your contact number)

Coordination & Control Rooms

- The Executive Team provides NHS Fife's **GOLD** (Strategic level) **coordination** of incidents, based at Education Centre Victoria Hospital Kirkcaldy
- VHK is the **Control Hospital**; it provides **SILVER** (Tactical) coordination of the clinical responses for acute hospital, from the VHK Control Room via the management teams on each site.
- **Local Resilience Partnership** is a regional multi-agency group including Police (often including Police (often chair), Fire, Police, Local Authority, SAS & NHS Board.

What?

So What?

Now What?

8 Roles & Responsibilities

8.1 Chief Executive

NHS Fife's Chief Executive (or designated deputy) has overall responsibility for the strategic & operational leadership within crisis & incident management for the board (Operational functions in emergency planning & incident response will be delegated). In MI-MC responsibility to set up Strategic Health Group (for cross-board response) and Health Information Cell.

8.2 Director of Public Health

The Board has delegated the supervision of emergency planning to the Director of Public Health. The Director of Public Health is also one of the Co-Chairs of the Fife Local Resilience Partnership (Fife LRP).

8.2.1 On-call Public Health Consultant would chair the STAC and Public Health Incident Management Team. Also forms part of the East Region Health Protection Team.

8.3 Director of Acute Services

- To establish a tactical-level incident control group to mobilise and coordinate Acute resources in response to incidents.
- Engage and steer resources across multi-disciplinary services involved in the Medical, Nursing, Pharmacy, Allied Health Practitioners, and other Acute & H&SCP rehabilitation services.

8.4 Director of Health and Social Care

- To establish a tactical-level incident control group to mobilise and coordinate the primary and community resources under their control.
- Identify, support, and protect vulnerable adults and children; the latter will be achieved by working with the local authority's Chief Social Work Officer / Head of Children's Services.
- Work in partnership with Acute Sector sites to create capacity by supporting rapid discharges from hospital and commissioning additional social care support if necessary.
- Engage and steer resources from multi-disciplinary partners involved in the HSCP, especially Primary Care Services – GPs, Nursing, Pharmacy and Allied Health Practitioners, and other rehabilitation services.

- Using their knowledge of the local services/area to signpost people to local services or to NHS 24/NHS Inform and/or assisting those who are displaced to access medication or other everyday items.
- Commissioning services from the third sector and independent sector and/or supervising volunteers at Rest Centres/Family and Survivor Centres

8.5 Executive Directors & Directorate Managers

- Ensure that all of their staff are aware of their departmental responsibilities.
- Ensure that all action cards are developed, maintained, and updated for their department.
- Ensure that call-out systems for off duty staff are in place.
- Ensure that their departmental response arrangements are included in local induction programmes for all staff.
- Ensure amendments to the plan are notified to the NHS Fife Resilience Team
- Ensure changes to the Switchboard Major Incident Call-Out List are notified to the switchboard.
- Ensure staff attend on-going training and awareness sessions.

8.6 NHS Fife Communications

- The Corporate Communications team at NHS Fife will lead on and coordinate all internal and external communications on behalf of the organisation, in response to a Major Incident.

8.7 Estates: including Security & Facilities (overseen by the Director of Property & Asset Management)

- Provide annual assurance to NHS Fife board to the resilience of the Estate & Security.
- Take an active role in the development and maintenance of emergency and business continuity plans.
- Take an active role in the annual exercise programme and maintain a separate testing programme of response capabilities (i.e.: generator testing/medical gas supplies maintenance/security).
- Take a lead role in the preparation of Board Estates for winter.
- Take a lead role in maintenance of essential supplies such as Food/Water/ Fuel /Laundry.
- Buildings Security, Lockdown procedures & CCTV.

8.8 Director of Workforce

The Director of Workforce will be responsible for the development and review of plans designed to provide support for staff during the response to an incident and for ensuring arrangements are in place to allow for an appropriate level of de-briefing and the on-going support for staff.

8.9 Pharmacy and Medicines

The Pharmacy & Medicines Directorate is responsible for ensuring access to all medicines during a major incident including medicines for pandemic influenza and counter measures for a chemical, biological, radiological or nuclear (CBRN) incident. This includes ensuring medicines are redistributed from across NHS Fife holding areas, enacting reciprocal medicine supply arrangements with other Boards, arranging access to the centrally held national stockpiles (pandemic influenza/CBRN) and engagement with Community Pharmacy as required. Non-Pharmacy personnel should not move, request or purchase medicines without Pharmacy advice.

During working hours (Monday to Friday), contact the Director of Pharmacy & Medicines (01383 674169) or the Deputy Director of Pharmacy & Medicines (01592 648037). Out with Pharmacy working hours, contact the on-call Pharmacist via Switchboard.

8.10 The Resilience Team

The Resilience Team supports the Executive in the discharge of its duties for emergency preparedness. NHS Fife Resilience Team provides support in Emergency Preparedness, Resilience and Response (EPRR) to Major Incidents by:

- Providing a single point of contact (Head of Resilience) for advice concerning all aspects of EPRR.
- Ensuring that all plans and action cards are available, in all formats, for use in Major Incidents.
- Ensuring all plans and framework documents reflect National guidance and remain current should legislation be updated or changed.
- Testing and exercising plans and action cards on a regular basis in order to ensure they are fit for purpose.

8.11 Scottish Ambulance Service (SAS)

The role of the SAS is to:

- Alert NHS Fife of a Major Incident Standby or Major Incident Declared
- The Ambulance Control Centre (ACC) Duty Manager is the tactical level manager responsible for running the ACC response to the Major Incident.
- Deploy a Medical Incident Officer (MIO) to the scene of the incident.
- Deployment of Hospital Ambulance Liaison Officer (HALO)

8.12 NHS 24

NHS 24 play a central role during Major Incident – Mass Casualties (MI-MC) incidents providing quality assured tele-health and care information for the public at various stages during response. In any event of MI-MC being declared by SAS, NHS 24 is notified at the same time as Territorial Boards, and will:

• Be ready to support the responding Territorial Boards and partner agencies by preparing to activate relevant web pages with pre-agreed content onto their website;

• Fulfil a public messaging function in support of Territorial Boards to keep patients informed of which service to access if they have been injured in the incident, need medical attention for other reasons, or attending for routine appointments.

8.13 External Agencies

Dependant on the nature, location, and scale of any the incident, NHS Fife will liaise with partner agencies (i.e. the Emergency Services, including Scottish Fire and Rescue (SFRS) and the Maritime and Coastguard Agency, as per inter-operability principles, ensuring shared situational awareness and understanding of tasks) and Fife Council through the Fife LRP to ensure that it is delivering an effective response which is co-ordinated with multi-agency partners.

8.13.1 Police Scotland

Police Scotland has overall responsibility for co-ordinating the strategic response to a Major Incident of all emergency services and any other organisation involved. Moreover, they will co-ordinate the provision of information to the public and the media. Police Scotland will instigate a Multi-Agency Control Cell (MACC) either virtually through Teams or physically within

a defined location. All Emergency Services and associated agencies (incident-specific) will be represented in order to form a working strategy for the Incident Leads. NHS Fife may be required to nominate a Medical Incident Officer for the MACC in order to provide updates and liaison between the MACC and NHS.

Police Scotland will, when deemed necessary due to mass fatalities, send a Casualty Bureau Team to the VHK. The role of the Casualty Bureau Team is to collate demographic information of the arrivals at the Emergency Department (ED) for the purposes of identifying the deceased and injured. Upon arrival, the Team will liaise with the ED Senior Charge Nurse and Senior Health Records Manager. The Team will establish an operating centre within the Children's Outpatient Department alongside Medical Records staff.

8.13.2 Fife Council Emergency Resilience Team

The role of Fife Council is to:

- Co-ordinate the Council response to an emergency.
- Arrange Rest Centres/Survivor Centres and any emergency. accommodation to be provided for those involved in the incident, including those who have to be evacuated.
- Facilitate the provision of Council and other resources to assist the emergency services.
- In the event of a mass fatality incident, consult with Police Scotland to select the most suitable designated emergency mortuary option.
- Co-ordinate the recovery from the emergency in conjunction with Fife Local Resilience Partnership (LRP) with health-specific input from Director of Public Health.

8.13.3 Military Assistance to Civil Authorities (MACA)

MOD's role is concentrated on 2 main areas:

- Providing niche capabilities which MOD needs for its own purposes and which would not be efficient for the rest of government to generate independently, for example Explosive Ordnance Disposal (EOD).
- Standing ready to support the civil authorities when their capacity is overwhelmed.

Scottish Government Ministers are solely responsible for authorising and

making a request to the Ministry of Defence (MOD) for military assistance under the MACA18 agreement. It is expected that the need for such assistance will have been fully discussed at the SHG and taken forward by the SG HSCD Incident Director. No direct request or approach should be made by NHS Boards to local Reservist Divisions. SG Health Resilience Unit will lead and coordinate the arrangements with MOD on behalf the SG HSCD. The situation must satisfy 4 criteria:

1. There is a definite need to act and the tasks the Armed Forces are being asked to perform are clear.
2. Other options, including mutual aid and commercial alternatives, have been discounted; and either:
3. The Civil Authority lacks the necessary capability to fulfil the task and it is unreasonable or prohibitively expensive to expect it to develop one; or
4. The Civil Authority has all or some capability, but it may not be available immediately, or to the required scale, and the urgency of the task requires rapid external support from MOD.

8.13.4 Military Support for Blast and High Velocity Injuries

In the event of a MI-MC resulting in blast and high velocity injuries, SG HSCD, can if necessary, via the UK Government, request the MOD to make available suitably experienced personnel from within the Defence Medical Service (DMS) to provide expert advice and guidance on treatment of these types of injuries. However there are a number of clinicians working in the NHS in Scotland who as active military reservists, have the relevant operational experience and may be able to act as a source of advice and guidance to colleagues within the Responding Territorial Boards.

9 VIPs

VIPs could present as casualties, relatives of casualties or on arranged visits following a Major Incident. Reference should be made to the NHS Fife VIP Operation Consort Plan which is a ‘restricted’ document only available to Executive Directors.

10 Fatalities

NHS Fife has a responsibility to sensitively deal with incident casualties who die within the hospital as a result of injuries sustained in a Major Incident. NHS Fife is responsible to maintain dignity and care of the deceased whilst preserving

forensic evidence. Police Scotland will provide Family Liaison Officers (FLO) at the time of notification and identification of the deceased. NHS Fife has a responsibility to assist in this process by providing staff to support care for the deceased & bereaved at this time.

11 Welfare support for staff during and after a Major Incident

11.1 TRiM/CISM

Support and qualified trauma management such as Trauma Risk Management (TRiM) or Critical Incident Stress Management (CISM) can reduce the severity of distress in staff and patients alike following their involvement in a Major Incident. Early intervention, along with continued monitoring and support, is vital in order to reduce the risk of people developing emotional disorders such as Post Traumatic Stress Disorder (PTSD) later.

11.2 Peer Support Network

Peer Supporters are trained colleagues available to listen and talk to NHS Fife staff. Peer Support is a voluntary, supportive and confidential conversation aiming to help the staff member regardless of the source of stress. Group support can also be offered. Peer Supporters aim to respond within 2 working days. Further details are available on Staff Link.

Staff can access peer support by emailing/phoning one of the following and leaving a message simply asking for peer support, leaving contact details (no other information is required initially):

- fife.staffpeersupport@nhs.scot
- fife.medicalpeersupport@nhs.scot
- fife.criticalcareps@nhs.scot
- 01592 729673

11.3 H&SCP Community Mental Health Services

As part of the immediate response to a Major Incident with Mass Casualties (MI-MC), the H&SCP will mobilise Community Mental Health Teams (CMHT) to:

- Arrange for the provision of information, advice and support for distressed individuals at the acute receiving hospital.
- Ensure adequate mental health assessment, care and support is offered with attention being given to follow up arrangements.
- Work collaboratively with ED staff to ensure professional advice on where to seek treatment and support and the issuing of the post incident leaflet (Coping

with Stress After a Major Incident - nhs_trauma_leaflet.pdf)

- Ensure that arrangements for psychosocial care and mental health support are in place, coordinated and signposting to other agencies, such as NHS 24 .
- Ensure adequate mental health liaison resources are made available to those care providers who have responded to the incident.

(Annex 7 & 13 to Major Incidents with Mass Casualties National Plan for NHS Boards and H&SCP 2019)

Advice available: NHS Fife Chaplaincy Team are the initial point of contact for Trauma Risk Management Support (TRiM) and Critical Incident Stress Management (CISM): NHS Fife-Department of Spiritual Care, Victoria Hospital, Kirkcaldy. Tel: 01592 648158 (Internal Ext: 28158)

12 Procurement

Where it is deemed essential to maintain short/long term stockpiles of equipment or products a range of measures will be established by Head of Procurement and Senior Procurement Team to mitigate any supply chain issues arising in any incident situation. In any incident level 4 (Major Incident) event contact should be made via the central Procurement phone line (01592 657320 or Internal ext. 61320). On contact please indicate to the call handler that the issue needs to be escalate immediately to the Head of Procurement/Senior Procurement Team**.**

13 Debrief

The debrief process is an important part of the learning cycle as it provides an opportunity to demonstrate continuous improvement within the resilience of the organisation whilst simultaneously providing an audit trail of all actions and procedures carried out during the incident. Each debrief should have an individual who assumes the lead and ownership for any outputs from the debrief. This person is referred to as the “sponsor” and would normally be a Senior Manager from the department or the directorate where the incident happened. Individual departmental or ward debriefs will be completed at a time deemed appropriate by the departmental or ward lead.

A **Hot** Debrief must be carried out as soon as possible once the Major Incident has been stood down. A further formal (**Cold**) Debrief should be completed within

6 weeks of the incident and may involve external agencies (this may be initiated by the Fife Local Resilience Forum).

A Debriefing Template can be found at Appendix 2

14 Training and Awareness

NHS Fife will provide mandatory training for all staff in Major Incident awareness. The level of training will be dependent on the level of responsibility of staff who undertakes key roles key roles in the event of a major incident will be given role specific training.

RESPOND

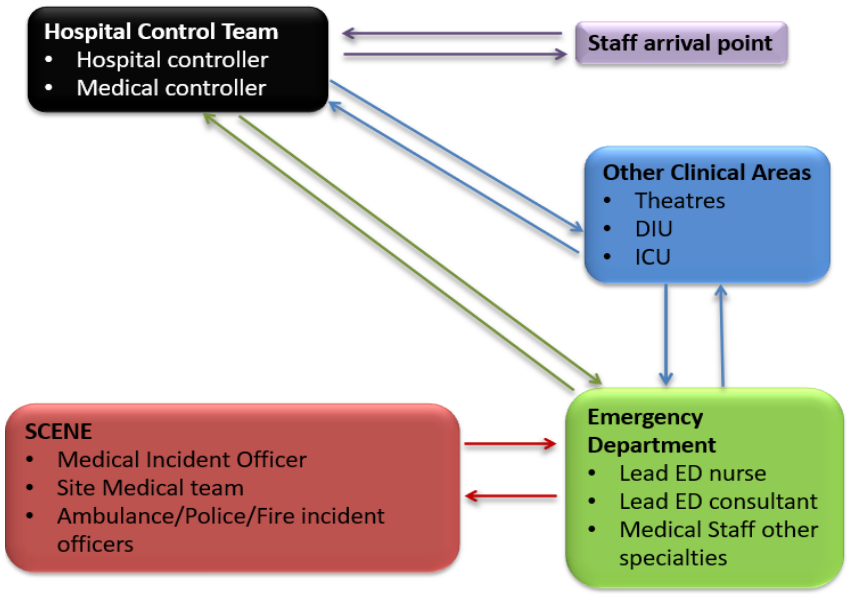
(Incident Level 4 - Category 1 Major Incident Declared / Receiving Hospital)

15 Respond: Major Incident Declared to Emergency Department (VHK)

This section covers the Category 1 response, commencing via Emergency Department VHK on notification of a Major Incident standby or declaration of a Major Incident via Scottish Ambulance Services (SAS). Internal incidents should be escalated through the *Internal/External Incident Escalation (Levels 1, 2, 3 & 4 Major Incident/Category 1 response).*

15.1 Lines of Acute Hospital Communication in Category 1 Response

The diagram below outlines the basic C3 structure with lines of communication between all areas of the Acute Hospital, the Control Team, and the scene of the declared incident:



15.2 Acute Guidance for Staff Call-Out

Not all staff will be required to attend during a major incident. This decision will be made by the Incident (C3) Controller in conjunction with the Medical and Nurse Controller.

The following should be considered when calling staff out:

- The nature of the incident.
- The number of casualties expected.
- The capacity within the hospital at the time of the incident.
- Staffing levels within the hospital at the time of the incident.
- How long the incident is likely to have an impact on the hospital.

15.3 Acute Staff Reporting Point – Maternity Out-Patients Department, Phase 3, VHK

15.4 Major Incident (Level 4) – Acute Call-out Procedure

- All wards and departments will keep an up-to-date call-out list. This must be checked on a regular basis.
- Staff will only be called in when the wards and departments are instructed to activate their call-out procedures by the Incident Controller; Staff will be asked to report to the Staff Reporting Point and not their usual place of work.
- All staff on duty at the time of the incident should stay in their ward or department and should attempt to stay on duty until stood down by the Incident Controller.
- When instructed by the Incident Controller, all off duty staff will be called out by a delegated individual allocated by the most Senior Manager on duty (Acute and H&SCP staff).
- See below for Call-Out Procedure scripting (can be printed and kept available in hard copy).

The following statement will be made:

Call-Out Procedure - Notification Script Major Incident (Incident Level 4):

"This is NHS Fife calling. This is not an exercise.

A Major Incident has been declared.

You are requested to attend work.

The staff reporting point is located at Maternity Outpatients VHK.

Bring your identification badge and uniform (if worn).

Confirm your ability to attend and expected time of arrival.

For Emergency Department - Go to Appendix 3 and 15.5 (below)

15.5 Accident & Emergency Department (ED) Notifications:

The ED Floor Co-ordinator will notify the following :
Switchboard
The senior doctor and nurse in the Emergency Department
The Emergency Medicine consultant on call (if not present in the department)
The Hospital co-ordinator 27902
The Hospital co-ordinator who will attend the Emergency Department for briefing and will also contact:
Day intervention co-ordinator Ext 29907
Theatre co-ordinator (phase 2) Ext 28293 Theatre co-ordinator (phase 3) Ext 29900
Hospital Switchboard will notify:
Executive On-Call & Chief Executive (or Deputy Chief Executive)
The Duty Manager who will contact the: Control Team (Acute and H&SCP)
Head of Resilience
Resident on-call doctors for all specialties (via page)
On-Call Healthcare Chaplain
Security
Porters
Medical records
Mortuary

The below senior staff, when notified of a Major Incident Standby, should attend the Emergency Department for briefing and to collect their action cards:

Role	**Ext No.**
Emergency Department Senior Doctor	29791
Emergency department Senior Nurse	29792
ED Floor Co-ordinator	29792
Co-ordinator	27902

Other staff notified of a Major Incident Declared **must** attend Maternity Outpatients and may be directed immediately to a clinical area or asked to remain in Maternity Outpatients until staffing need is identified.

All other responding staff **must** remain in Maternity Outpatients until directed to attend another area.

15.6 Declaring Major Incident with Mass Casualties (MI-MC)

A Mass Casualty Incident (MCI) for the NHS is defined as an incident (or series of incidents) causing casualties on a scale that is beyond the normal resources of the emergency and healthcare services' ability to manage where this would be navigated & coordinated via the National Major Incident Mass Casualties National Plan.

See: The National Plan for NHS Boards and Health and Social Care Partnerships 2019 (guidance link and QR code below):

Major Incidents with Mass Casualties - National Plan for NHS Boards and Health and Social Care Partnerships 2019

A Mass Casualties Incident should be declared by the Chief Executive or named Deputy based on a combination of factors. These include;

- The likely number of casualties
- The ability of local health services to cope with demand and the potential of the incident to overwhelm the combined resources of Health Boards in a local Regional Resilience Partnership (RRP) area.

The ability of local services to cope with demand may itself be affected if an incident has a direct impact on NHS sites or staff (e.g. through evacuation).

Several smaller scale major incidents may combine or occur in quick succession to become larger & geographically diverse; this may require a mass casualty incident response (including Regional Mass Fatalities Group) to be triggered due to the large volume of simultaneous casualties and the potential impact on one or more Territorial NHS Board areas.

15.6.1 Health Information Cell

The Health Information Cell (HIC) will be established at the request of the Strategic Health Group (SHG) in response to a Major Incident Mass Casualty event. The purpose of the HIC is to provide the Strategic Health Group with details on the location of casualties in NHS Fife and other supporting Boards. This information will be shared with other territorial and special Boards (SAS, NHS 24 etc,) the Scottish Government and the Police Scotland Casualty Bureau.

The SHG Chair will appoint a HIC Lead (appropriate Director who will also be a member of the SHG).

The HIC will:

- Coordinate information in relation to patients and patient transfers between healthcare facilities, and other key information;
- Act as the Single point of contact for the Casualty Bureau in relation to the patients in the care of NHS Scotland

Refer to: Major Incidents with Mass Casualties - National Plan for NHS Boards and Health and Social Care Partnerships 2019

15.6.2 Communication Between Scottish Health Boards During Major Incidents and Major Incidents with Mass Casualties

Predominantly, communication will be from the Scottish Ambulance Service to Territorial Health Boards in order to notify them of the incident and to share early thoughts on casualty numbers and distribution. However, critical in a Mass Casualty event will be to also communicate with the Scottish National Blood Transfusion Service (SNBTS) in order to facilitate the effective distribution of the finite supply of blood components to receiving hospitals. It will also be essential to inform NHS24 and the Golden Jubilee National Hospital so that they can support a national response as required.

Communication Between Scottish Health Boards During Major Incidents and Major Incidents with Mass Casualties official sensitive guidance plan can be found electronically in the Resilience folders in the "T:/ Drive" and also from within the Executive Virtual Incident Room folders. In any event that a hard copy is needed this is held with the Physical Major

Incident Framework folder in the education centre at VHK.

Once a board has been notified of an MI or MI-MC there will be a need for further strategic conversations to take place as the incident progresses. The strategic contact number should be for an individual within a board that is sufficiently senior and sighted on overall board capacity to be able to discuss board stress points, skills imbalance, etc. in order to inform further casualty distribution decisions.

15.6.3 Mortuary

In the event of a Major Incident with Mass Casualties (MI-MC), the national arrangements for Disaster Victim Identification (DVI) will be activated by the Procurator Fiscal and the Police DVI lead. Fatalities at the scene will be transported to one of the designated mortuaries which have been assessed as suitable for accommodating mass fatalities. Details of these Mortuaries can be found in the Major Incidents with Mass Casualties – National Plan for NHS Boards and Health and Social care Partnerships 2019 (See section 15.6 above).

The NHS Fife Mortuary facilities will be used to receive casualties who are certified ‘dead on arrival’ or following arrival at the Hospital. Deceased will be transferred to the hospital mortuary following normal hospital procedures.

NHS Fife Mortuary facilities are split across VHK and QMH. The VHK Mortuary has capacity for 76 deceased; this includes 4 freezer spaces and 8 bariatric spaces. QMH has capacity for 26 deceased. Two of these can accommodate bariatric patients. NHS Fife has contingency refrigerated units (Nutwells) for surge periods which have the capacity to store 60 deceased. The combined capacity across all sites is 158 spaces. This allows for space for BAU and deceased in the event of a major incident. If further storage space is required then the Mortuary and Fife Mass Fatalities Logistics Plan will be implemented.

The Procurator Fiscal is responsible for all deceased casualties that have been involved in the incident, although this responsibility may be delegated to the Police Scotland.

When a Mass fatalities incident occurs, Switchboard will contact the **Mortuary on Ext. 28122** (during working hours; Monday to Friday 8am – 4pm) or the Senior Anatomical Pathology Technician/Cellular Pathology Department Service Manager (out of hours). The Major Incident Action card will then be implemented.

15.7 Trauma Centres

NHS Scotland currently has four established regional Pre-Hospital Trauma Teams available:

- Medic 1, based in Edinburgh.
- Tayside Trauma Team, based in Ninewells Hospital, Dundee.
- Emergency Medical Retrieval Service, based in Glasgow.
- North Trauma Team, based in Aberdeen.

These are consultant-led and delivered services working closely with the Scottish Ambulance Service. They are deployed via Scottish Ambulance Service Trauma Desk. In addition to being a regional resource, they can be deployed by helicopter or road to the scene of any major or serious incident in Scotland through mutual aid.

Specialist highly qualified Medical Officers provide appropriate medical support, senior clinical decision making and critical care to casualties as Site Medical Teams. The teams can also provide the Medical Incident Officer capability.

15.8 Major Incident Patient Triage

Casualties are triaged via SAS into three categories.

NHS Fife, on receipt of an external Major Incident Standby message, or on a Major Incident being declared, puts into action preparations in order to receive incoming casualties classified as follows:

Medical Teams in ED follow National Clinical Guidelines for Major Incident Patient Care:

I. B0128- Clinical Guidelines Major Incident 2020
II. NHS Scotland Emergencies

Priority Group	Order of Treatment	Description of casualties needs
P1	1	**IMMEDIATE** Life-saving procedures required
P2	2	**URGENT** Intervention required within 4-6 hours
P3	3	**DELAYED** Less serious cases who do not require treatment within the times given above
		EXPECTANT Casualties whose injuries are so severe that they either cannot survive or would require so much input from the limited resources available that their treatment would seriously compromise the treatment of large numbers of less seriously ill casualties.
DEAD	DEAD	**DEAD** No medical attention required

15.9 Emergency Department associated local triage guidance:

(Appendices are hyperlinked below for ease)

Appendix 4: Executive Response Team. NHS Fife Major Incident (Incident Level 4) Command and Control Structure

Appendix 5: Major Incident (Incident Level 4) – Patient Outcomes from Emergency Department Triage

Appendix 6: Major Incident (Incident Level 4) – Patient Journey from ED

Appendix 7: P1, P2, P3 Patient Management & Triage

Appendix 8: Patient Discharge Records

Appendix 2: Hot/Cold Debrief Template

NHS Fife CBRN Framework (dependant on dynamic risk assessment and hazard management)

Category 1 Hospital Response Major Incident Action Cards 1 – 28

(physical copies located in ED Major Incident Store)

RECOVER

16 Incident Recovery

Recovery is the coordinated process of supporting progression to normal working conditions and support for the emotional, social, and physical wellbeing of those affected, it may also include the reconstruction of the physical infrastructure. Recovery should commence as soon as safely possible but also make allowances for a period of disruption whilst the response is ongoing. NHS Fife Chief Executive (or acting deputy) at an appropriate stage will establish a Recovery Coordination Group.

Key Recovery Objectives:

- Returning to normal business.
- Implications of, and solutions to, any lack of resources.
- An assessment of the Incident on NHS Fife (covering impacts on services and staff e.g. social, health, environment, economic, etc.) is carried out as soon as possible and is regularly updated.
- Determine opportunities for longer term regeneration and economic development as part of the recovery process.
- If affected, utilities (e.g. power & water) are brought back into use as soon as practicable.
- All affected areas are restored to an agreed standard so that they are 'suitable for use' for their defined future purposes.
- Environmental protection and recovery issues are co-ordinated.
- Information and media management of the recovery process is co-ordinated.

16.1 Recovery Co-ordination Group (RCG)

The Recovery Co-ordination Group (RCG) is responsible for the overall recovery from the incident and should be accountable to the Chief Executive and Director of Acute Services.

Group Membership:

- Director of Acute Services (Chair)
- Director of Public Health
- Director of Health and Social Care Partnership

- Representatives of affected directorates/teams
- Estates & Facilities Representatives
- Finance Representative
- HR Representative
- Emergency Planning Officer/Resilience Team
- Communications Team Representative
- Loggist

16.2 Recovery Resources

Directors setting the strategy in the Executive Directors Group (EDG) need to consider the conflicting demands of the immediate emergency response, the longer recovery period, and the maintenance of critical services. Resources should be prioritised accordingly to ensure a successful recovery as well as the continued delivery of critical services in order that normal business is resumed as quickly as possible. The RCG should liaise closely with the EDG to ensure co-ordination of resources.

16.3 Communications

Internally: It will be important for the RCG to keep staff informed as to the progress of recovery via regular updates. Additionally, NHS Board members will require regular briefing as the situation develops. Where an Incident Control Team remains in operation, liaison between it and the RCG is essential.

Externally: NHS Scotland and the Scottish Government may require regular situation reports. During recovery the RCG should ensure that all communications with outside agencies are coordinated via the NHS Fife Communication Team.

16.4 Finance

The role of the Finance team is vital to response and recovery, and there should be a finance representative in the RCG. Financial aspects of major incidents may be complex and open to interpretation. Two main processes need to be considered: expenditure whilst delivering services and reimbursement of costs afterwards.

Key areas:

- Future costs and long-term expenditure.
- Overall cost of the emergency cost of damage, loss of income, access to emergency funding.
- Agree who is responsible for authorising spend.
- Establishing systems for emergency expenditure
- Ensuring financial records have records of “non routine” spend so costs of incident and recovery can be easily identified.

16.5 Building Damage

If the usual place of work is damaged in the event of a major incident, the building should be assessed by the relevant Estates representative immediately to determine if it is safe, and to start repairs. If the building is deemed unsafe staff/patients may have to be deployed to other locations and services. Should a service need to be relocated NHS Fife Estates and Facilities teams may have to arrange to provide support services at alternative locations.

17 Reference Documents

- Management of Public Health Incidents: Guidance on the Roles and Responsibilities of NHS Led Incident Management Teams
- STAC | Ready Scotland
- Civil Contingencies Act 2004 (legislation.gov.uk)
- Civil Contingencies Act 2004 (Contingency Planning)(Scotland) Regulations 2005
- nhs_trauma_leaflet.pdf
- NHSScotland Resilience Preparing for Emergencies - Guidance for Health Boards in Scotland (www.gov.scot)
- Major Incidents with Mass Casualties - National Plan for NHS Boards and Health and Social Care Partnerships 2019
- Joint Doctrine Archive - JESIP Website

Appendix 1: SBAR:

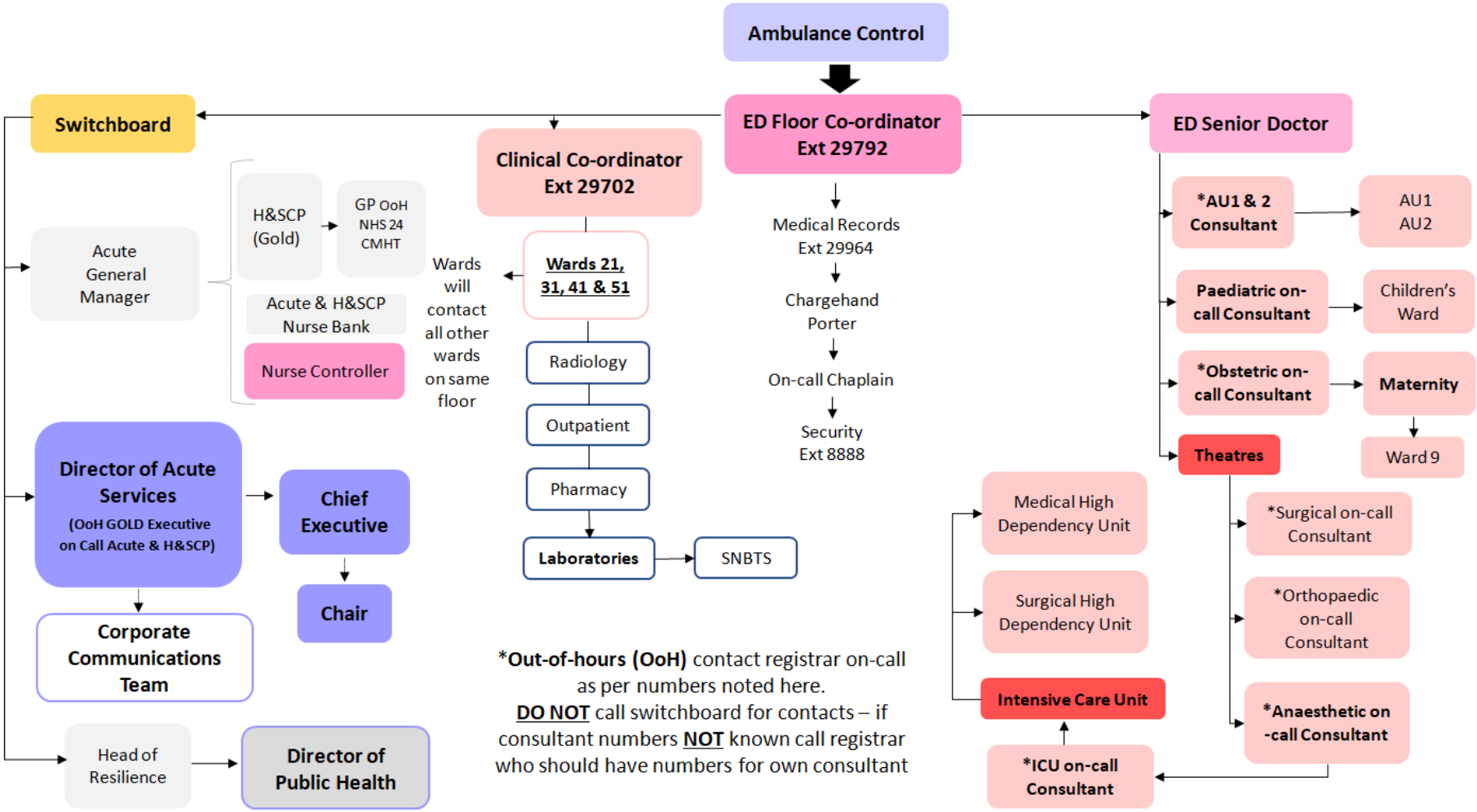
SBAR Report	
Situation	Describe situation/incident that has occurred i.e. Exceptional risks arising from weekend or overnight, surges in activity, increases in ED presentations, workforce.
Background	Explain history and impact of incident on services/patient safety – risk/s
Assessment	Confirm your understanding of the issues involved. What measures are in place. What has already been exhausted other than business as usual. Have all organisations confirmed that hey have implemented all relevant actions from their own internal escalation plans. Has any provider declared or is about to declare an internal critical.
Recommendation	Explain what you need, clarify expectations and what support is needed. What benefit / outcome do we need to achieve de-escalation.
Ask receiver to repeat information to ensure understanding	

SBAR Template	
Situation	
Background	
Assessment	
Recommendations	

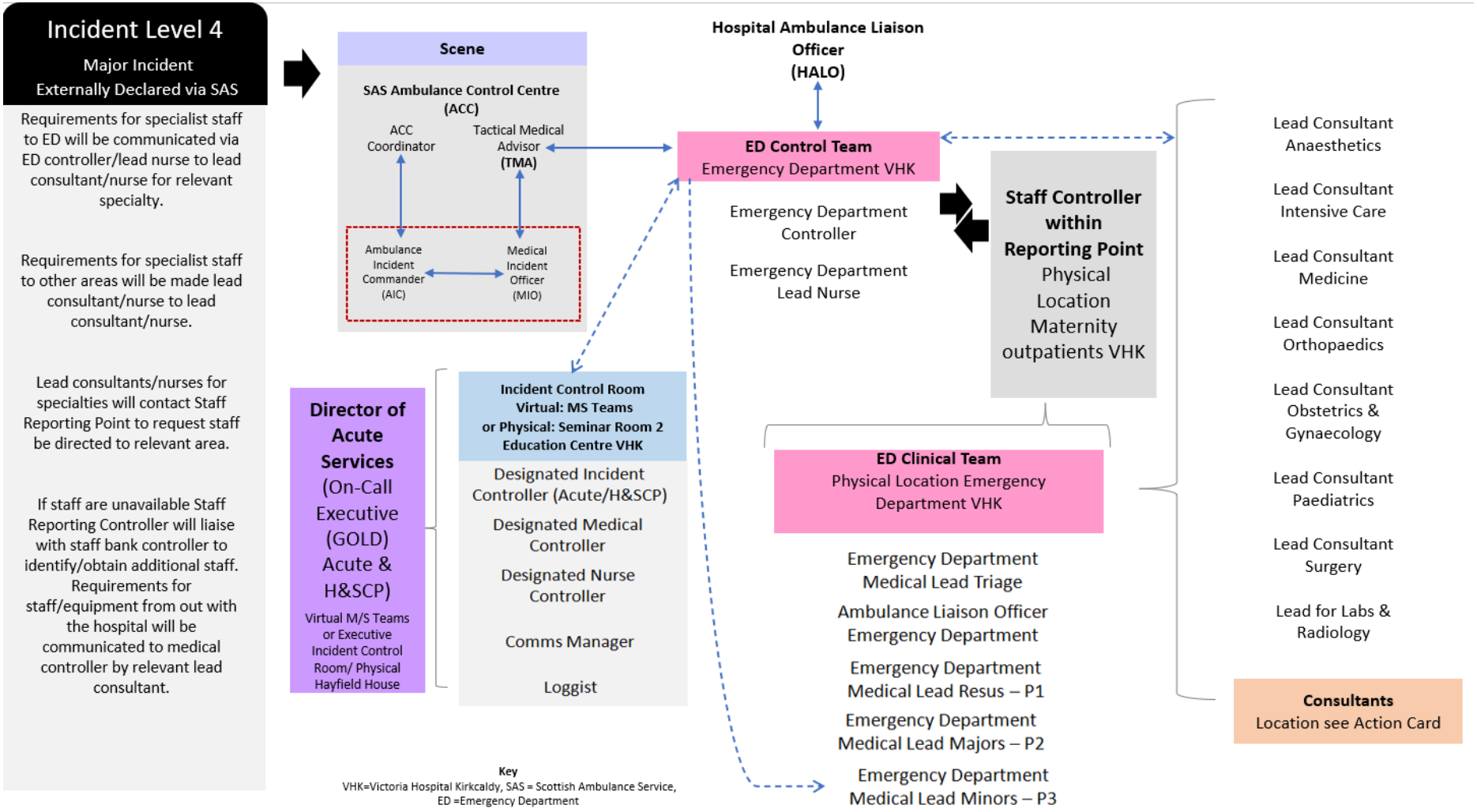
Appendix 2: Hot/Cold Debrief Template

1. Incident Reference	
Provide a reference / title for this incident.	
2. Details of Incident	
Provide a brief summary of incident*:* *include details of the following where relevant: dates when incident started/ended; case definition; description, number, and features of cases; care areas/locations affected; source and modes of cross-transmission/exposure; diagnosis and treatment, any enhanced surveillance of interventions, any hypotheses.*	
3. What went well?	
Please list aspects of the incident considered to have been managed well:	
4. What did not go well?	
Please list aspects of the incident considered not to have been managed well:	
5. Lessons Learned	
Please provide details of any learning points or recommendations:	
6. IMT lead details	
Name:	Email:
Job Title:	Address:
Contact number:	Contact number (mobile):
Date:	Signed:

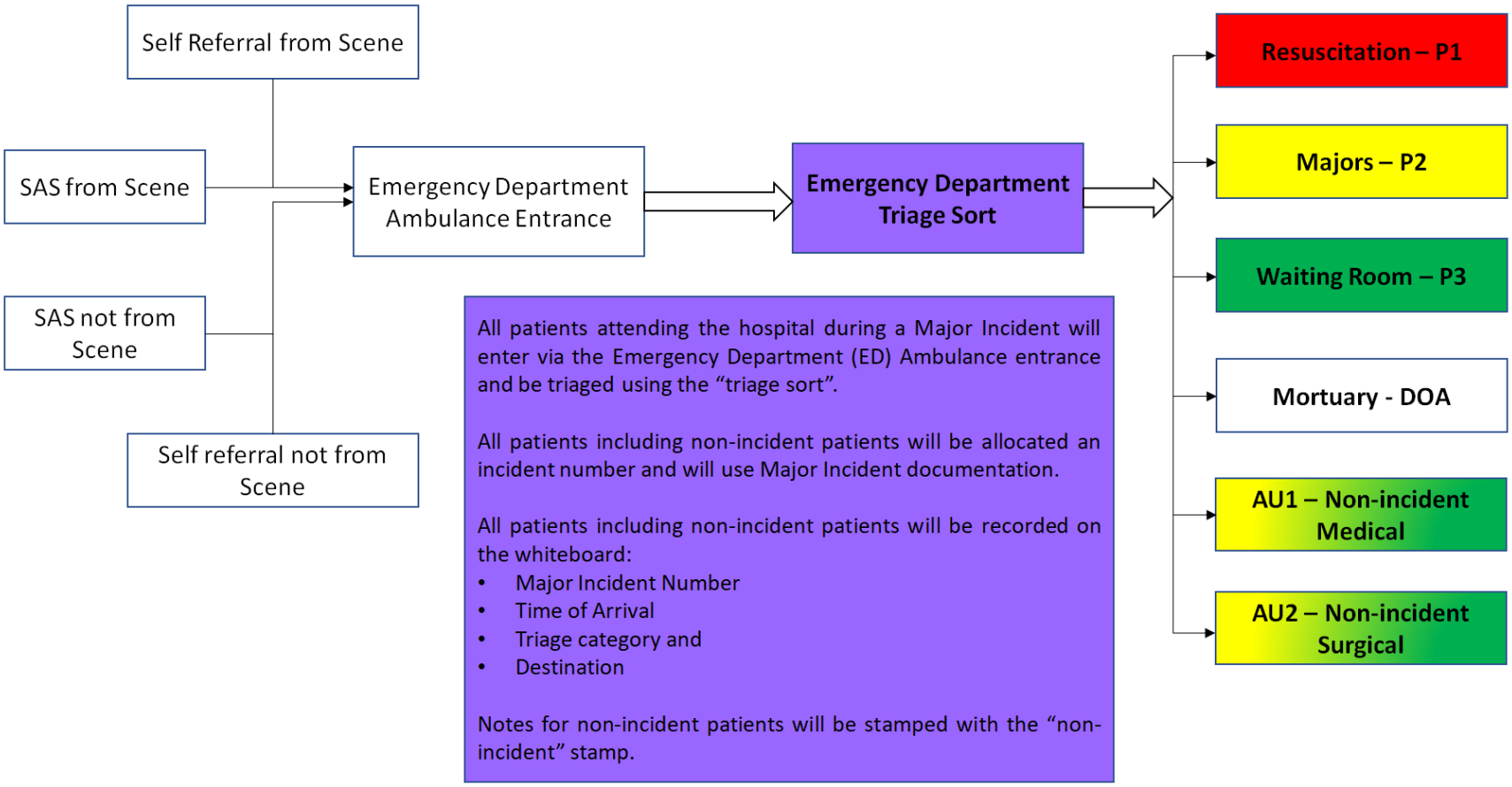
Appendix 3: NHS Fife Emergency Department Major Incident (Incident Level 4) Notification Plan:



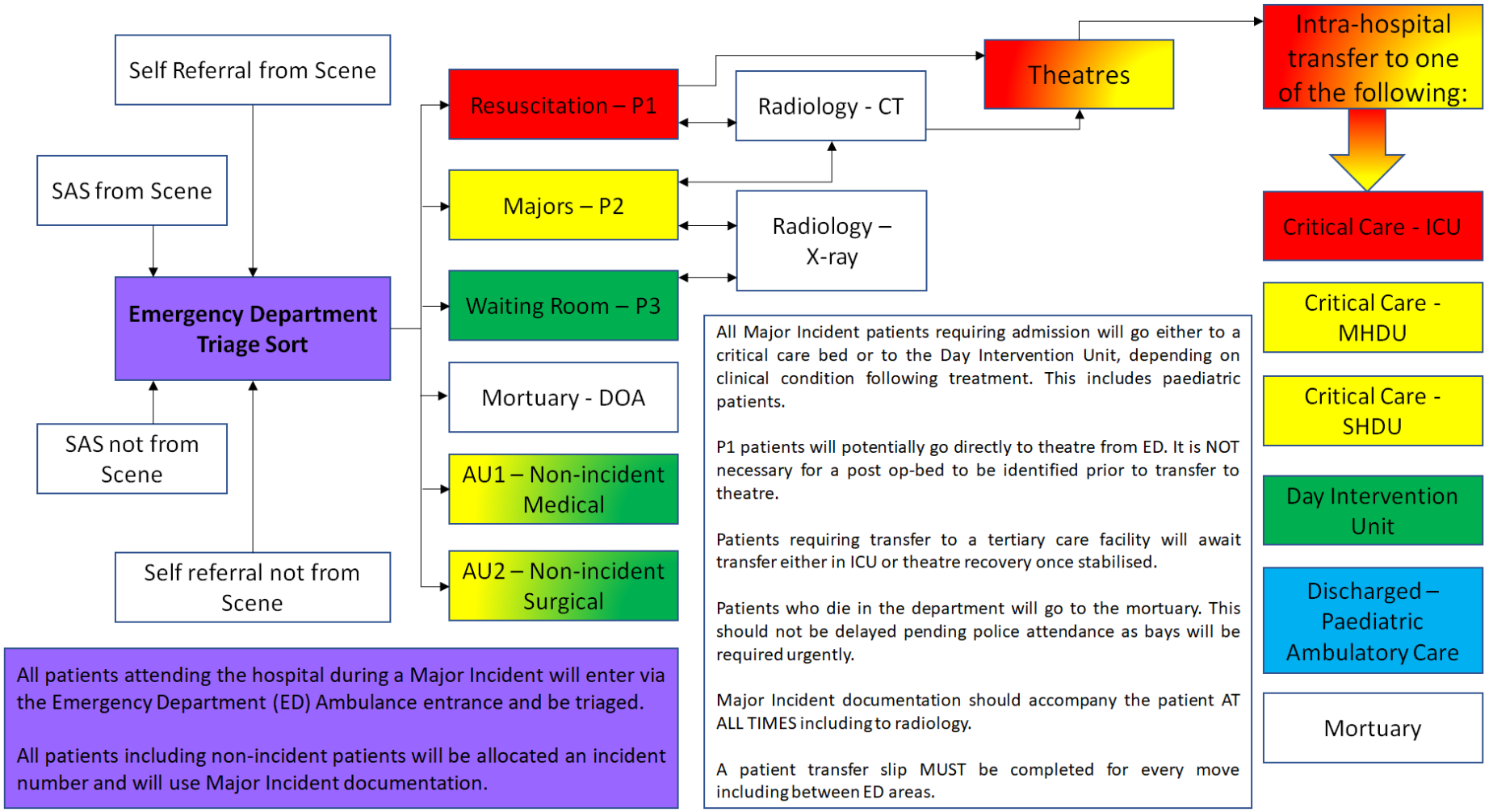
Appendix 4: Executive Response Team. NHS Fife Major Incident (Incident Level 4) Command and Control Structure:



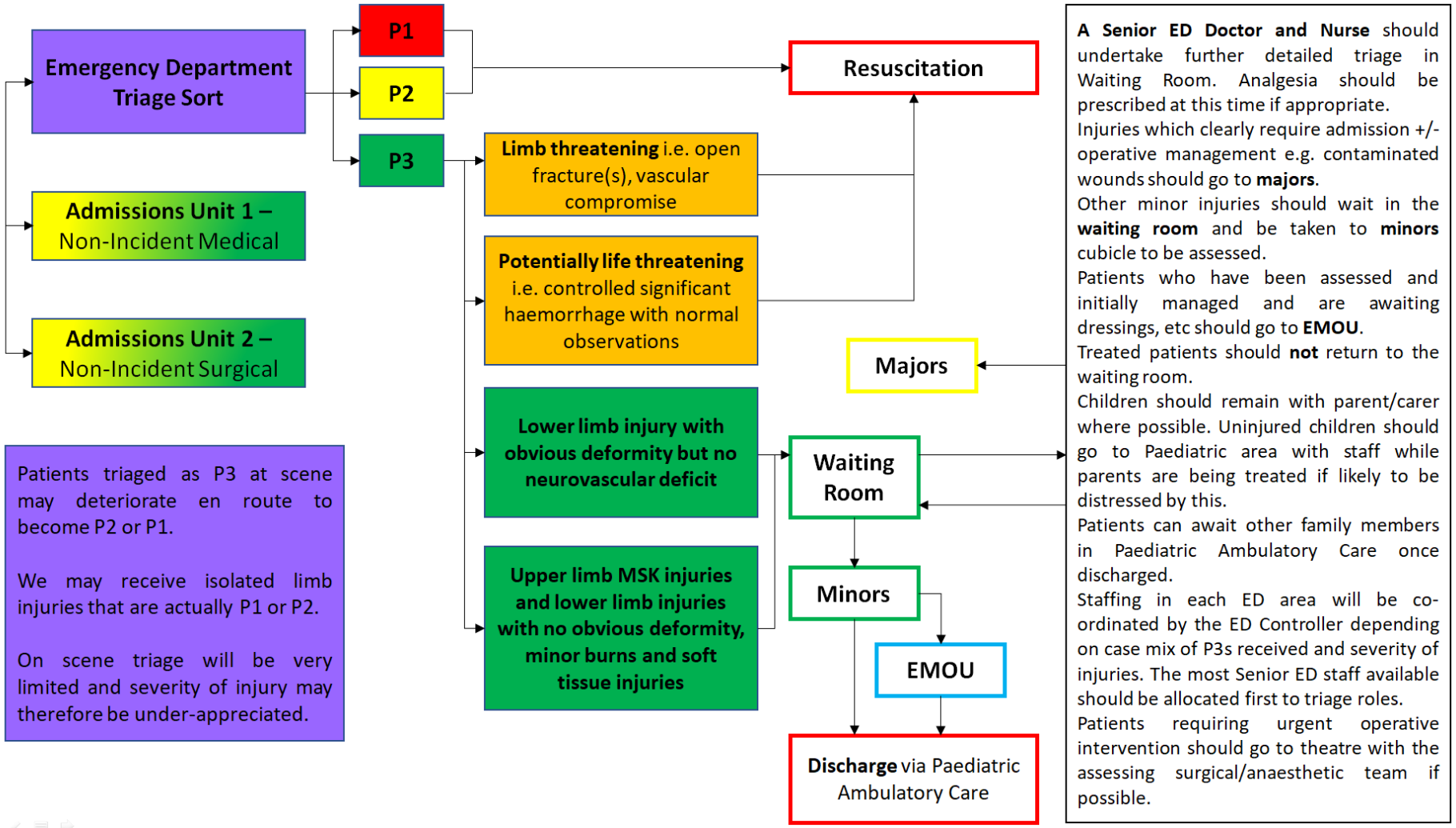
Appendix 5: Major Incident (Incident Level 4) – Patient Outcomes from Emergency Department Triage:



Appendix 6: Major Incident (Incident Level 4) – Patient Journey from ED:



Appendix 7: P1, P2, P3 Patient Management & Triage:



Appendix 8: Patient Discharge Records

Major Incident Declared

Patient Discharge Record - current non-incident patients

This refers to patients discharged rapidly in the event of a major incident for bed availabilty

Ward/Unit:

Date:

Time:

Patient Details/Label	Time of Discharge	Discharge Destination	Contact needed within 48hrs?	Follow-up Required?	Follow up Arranged
		Home Y/N Hospital: Ward:	Contacted needed Y/N Made by; Date: Time:	☐ Date for procedure ☐ Review appt ☐ GP review ☐ Other:	Follow up: Arranged by: Date: Time:
		Home Y/N Hospital: Ward:	Contacted needed Y/N Made by; Date: Time:	☐ Date for procedure ☐ Review appt ☐ GP review ☐ Other:	Follow up: Arranged by: Date: Time:
		Home Y/N Hospital: Ward:	Contacted needed Y/N Made by; Date: Time:	☐ Date for procedure ☐ Review appt ☐ GP review ☐ Other:	Follow up: Arranged by: Date: Time:

Major Incident Patient Discharge Record

Date of Incident:
Date of discharge:

Patient details/Label	Time of discharge	Discharge destination	Follow-up required?	Follow up information given?
		Home Y/N Other:	☐ General ☐ Plastics ☐ Ortho ☐ Surgery ☐ Other: Imaging required Yes/No/not known	Yes/No By: If no, please document reason:
		Home Y/N Other:	☐ General ☐ Plastics ☐ Ortho ☐ Surgery ☐ Other: Imaging required Yes/No/not known	Yes/No By: If no, please document reason:
		Home Y/N Other:	☐ General ☐ Plastics ☐ Ortho ☐ Surgery ☐ Other: Imaging required Yes/No/not known	Yes/No By: If no please document reason:

Discharge Letter

Victoria Hospital
Hayfield Road
Kirkcaldy
KY2 5AH
Tel 01592 643355

Major Incident Label

Date of incident:

Date of discharge:

Time of discharge:

Discharge destination: home / other

If other please specify: _____

Patient Name: Address:

Date of Birth (dd/mm/yyyy):

CHI (if known): Contact telephone number:

GP (if known):

Treating Clinician (name, grade):

Diagnosis:

Procedures/treatments:

Discharge medications given:

Hospital follow up date: time:

☐ General ☐ Ortho ☐ Surgery ☐ Other

Primary Care Follow up:

☐ Suture removal ____ days ☐ Wound dressing _____days ☐ Other

Other – please specify.

MAJOR INCIDENT DECLARED

Patient Information Leaflet

NHS Fife is currently responding to a declared Major Incident and is therefore only managing the highest priority patients.

Your presenting problem has been assessed as not being immediately life-threatening and you have therefore been advised to leave the Emergency Department and seek advice elsewhere.

Options for advice and support include:

NHS 24 will have up-to-date information about the situation at the Victoria Hospital, Minor Injuries units in Fife and Emergency Departments in other areas.
They can advise on self-care if appropriate.
They can assist with review at GP surgeries or out-of-hours services.
Freephone 111 www.nhs24.scot

NHS inform is Scotland's health information service. It offers quality assured health and care information via a website and phone service.
Helpline: **0800 22 44 88**
www.nhsinform.scot

Community Pharmacists can offer advice on minor ailments and injuries and suggest/supply over the counter medications.

Contact your own GP to arrange an appointment.
Attend a Minor Injuries Unit in Fife – if you wish to check that they can deal with your concern before travelling you can either contact NHS 24 or the MIU directly.

St Andrews Hospital	01334 465683
Adamson Hospital Cupar	01334 651200
Queen Margaret Hospital	01383 623623

Attend an ED out with Fife – please be aware that adjacent Health Boards may also be receiving casualties from the incident, and even if not will probably have a higher number of attendances than normal, so your wait may be longer than usual.

There will be regular updates posted on NHS Fife social media sites.

ACTION CARDS

Appendix 9: Incident Level 4 Executive Action Card – Chief Executive

Incident Level 4 Action Card – Chief Executive				
Board	**Version**	**Ratified Date**	**Review Date**	**Date Published**
NHS Fife				
Location	Incident Management Team: **PRIMARY** Meeting Space: MS Teams - NHS Fife Executive Virtual Control Room **SECONDARY** Location: Chief Exec Office, Hayfield House **ALTERNATIVE** Location: Education Centre, VHK (IMT) All locations will have Major Incident boxes with copies of all relevant plans, procedures, and action cards.			
Role Description	To consider the wider impact of the incident on NHS Fife services for the immediate & long-term future to enable a recovery plan to be developed.			
Key Contacts:				
Switchboard	**01592 643 355**			
NHS Fife Communications Email:	Ext: 27971 Tel: 01592 647971 (Monday – Friday 9am-5pm) fife.communications@nhs.scot Out-of-hours contact Switchboard			
Scot Gov Health EPRR Contact Numbers:	**0131 244 2429** – Weekday working hours (08:30 to 17:00) **07623 909981** (Out of hours Emergency pager)			

GATHER INFORMATION AND INTELLIGENCE

- **Emails**: If during working hours and of significant scale, instruct PA to monitor emails and inform you immediately of any significant ones relating to the incident.
- **Base yourself in the Chief Executive's Office** (where practicable); this is to ensure you maintain a strategic Board-wide perspective & don't get involved with Silver or Bronze level actions/issues.
- **Establish** and maintain close liaison with the Gold On-call Executive, Director of Acute Services and Silver On-Call Manager. If comms systems are down, consider nominating a runner to relay messages.
- Following a MI-MC declaration, **Establish** a Strategic Health Group (SHG). **Consider** passing on the role of SHG Chair to another Chief Executive at the outset, according to assessment of circumstances/incident. The decision for doing so must be logged.
- The SHG may consider the requirement for a Health Information Cell (HIC). **Refer to MI-MC National Guidance** for HIC templates.

ASSESS RISKS AND DEVELOP A WORKING STRATEGY

- **Receive** regular updates from the Incident Control Team of the situation.
  - **What? – So What? – Now What?**
  - Details will be communicated and logged using the (M)ETHANE Acronym.
    - **M**: Has a major incident been declared, by whom & what type?
    - **E**: Exact location of incident
    - **T**: Type & details of the incident
    - **H**: Hazards present or suspected

- **A**: Access routes that are safe to use
- **N**: Number & Types of casualties
- **E**: Emergency service present or requested

- **Consider** standing up a Scientific & Technical Advisory Cell (STAC), depending on type of incident.
- **Consider** the requirement to escalate to the Fife Local Resilience Partnership and the East of Scotland Regional Resilience Partnership.
- **Escalate** to Scottish Government Health EPRR through the **EPRR Sitrep.**
- **Other CEs**: When appropriate, establish contact with CEs of local partners and stakeholders. Provide information on the Board's response when necessary.
- **Comms/Media**: Maintain close links with the Comms Team; ensure that you are available (when required) to give media statements that you and the Corporate Comms Team have prepared, with input from Police Scotland where necessary.

CONSIDER POWERS, POLICIES AND PROCEDURES

- **Ensure** incident-specific plans are being implemented.
- **Two Hourly Major Incident briefing**: Maintain awareness of 2-hourly Major Incident briefing within the Incident Control Team and prepare to be briefed by exception by Exec On-call.

IDENTIFY OPTIONS AND CONTINGENCIES

- **Relief**: If it is a prolonged incident assess need to call in the Deputy Chief Executive to take over from you after 6-8 hours or when necessary. Conduct a full Handover/Takeover (HOTO).

STAND DOWN, RECOVER AND REVIEW

- **Recovery**: Begin to consider the wider impact of the incident on the Board's services for the immediate & longer-term future. Oversee the Board's recovery and return to 'normal' service.
- **Stand down**: The decision to stand down must be made in liaison with the Incident Management Team (Strategic/Gold) having performed a full assessment of the continuing impact of the incident on the Board. Ensure Incident declaration update is communicated ("**Major Incident – STAND DOWN**) to all Staff and any external agencies initially informed.
- **Post incident**: Consider the post incident requirements, such as business continuity issues, finance, VIP visit, media etc.
- **Debrief**: Arrange a 'hot' debrief with workforce involved immediately after the incident.
- **Sitrep**: Ensure details of the incident are included as required in Sitrep reports.

Appendix 10: Incident Level 4 Executive (Gold) Action Card

Incident Level 4 Action Card - Executive (Gold) / OoH Gold On-Call				
Board	**Version**	**Ratified Date**	**Review Date**	**Date Published**
NHS Fife				
Location	Incident Management Team: **PRIMARY** Meeting Space: MS Teams - NHS Fife Executive Virtual Control Room **SECONDARY** Location: Chief Exec Office, Hayfield House **ALTERNATIVE** Location: Education Centre, VHK (IMT) All locations will have Major Incident boxes with copies of all relevant plans, procedures, and action cards.			
Role Description	To lead NHS Fife's strategic response to a Level 4 Major Incident, set the aim and support decision making. Responsible for analysing the overall impact of the incident on staff, patients & services & planning the return to regular service delivery.			
Key Contacts:				
Switchboard	**01592 643 355**			
NHS Fife Communications	Tel: 01592 647971 (Monday – Friday 9am-5pm) or Ext: 27971 Email: fife.communications@nhs.scot			
Scot Gov Health EPRR	**0131 244 2429** – Weekday working hours (08:30 to 17:00) **07623 909981** (Out of hours Emergency pager) - Follow up within 1 hour if no response.			

GATHER INFORMATION AND INTELLIGENCE

- **Assume the role of Gold Commander**. Commence **Incident Decision Log** to ensure you document decisions made and/or actions taken. Utilise (physical) personal Decision Logbook (until a loggist has been identified)
- **For incidents where physical presence is required, base yourself in the Chief Executive's Office** (where practicable); this is to ensure you maintain a strategic Board-wide perspective & don't get involved with silver or bronze level actions/issues. Keep in regular contact with the On-Call Manager. If comms systems are down, consider a team of runners to relay messages.
- **Check details** of current situation with Incident Manager (manager of affected area who instigated escalation/or multiagency MACC, Mass Casualties: Mortuary capacity)
- **Notify**: The Chief Executive and Executive Directors Group
- **Establish Incident situation**: Obtain a (M)ETHANE report from Emergency Department (ED) if available. If unavailable, known details should be logged using the (M)ETHANE Acronym. Log this in **Incident Decision Log** and display this in the central Control Room
- **For incident-specific guidance**, refer to associated Framework Documents and Action Cards within the Incident Management Framework (example – Lockdown, CBRN)
- **Ensure** all above actions have been taken and are logged (Level 4 standby & response)

ASSESS RISKS AND DEVELOP A WORKING STRATEGY

- **Formulate the Strategy**: Formulate a written strategy & identify the Board's aims and objectives to drive the resolution of the incident. Share this with the Duty/Service Manager or On-Call Manager / Designated NHS Fife MACC Lead
- **Establish Incident Management Teams required** and convene initial meeting (refer to Major Incident Framework) – Director of Acute Services, Director of Public Health, Director of H&SCP, Estates Lead, Finance Lead, Incident-specific Specialists, Resilience Team, Comms Lead, Loggist support.

- **Locate Airwave Radios** as contingency against loss of normal comms. IBIS (Airwave) radios, provided to NHS Fife by Police Scotland for Major Incidents, should then be used to contact all multi-agency partners.
- **Contact other agencies:** Ensure that contact has been made with H&SCP, Police Scotland, Scottish Fire & Rescue, Scottish Ambulance Service control rooms, neighbouring Boards and Local Authorities if necessary and mutual aid requested through LRP if needed.
- **Consider** requirement to contact NHS24 to redirect patients/reduce site footfall.
- **Consider** standing up a Scientific & Technical Advisory Cell (STAC) or Mass Fatalities Group, depending on type of incident.
- **Consider** the requirement to escalate to the East of Scotland Regional Resilience Partnership (EOSRRP)
- **Escalate** to Scottish Government Health EPRR through the **EPRR Sitrep**
- **Comms**: Ensure that the Comms Team and Directorate Leads inform all staff of the incident & nature of the Board's response. Comms Team will work with Police Scotland on messages out to the public.
- **Support** the Duty/Service Manager/Silver's decision making as necessary during the incident.
- **Estates and Security**: Consider Site lock down with Facilities & Security

CONSIDER POWERS, POLICIES AND PROCEDURES

- **Invoke** incident-specific plans and ensure actions within those plans are implemented.
- **Consider** the need to have staff allocated to relieve those allocated earlier.
- **Consider the psychological impact** of the incident on staff within these areas.
- **Two Hourly Major Incident briefing**: Establish & Chair 1 to 2-hourly Major Incident briefing within the Incident Control Team (Silver), documenting updates & actions for completion. Brief by exception the Chief Executive.

IDENTIFY OPTIONS AND CONTINGENCIES

- **Relief**: If it is a prolonged incident assess need to call in another Executive & Manager to take over from you & within the Incident Control Team after 6-8 hours or when necessary. Conduct a full Handover/Takeover (HOTO).
- **Identify a Recovery Lead** and ensure they are developing plans for incident recovery (in liaison with Director of Acute Services)

STAND DOWN, RECOVER AND REVIEW

- **Recovery**: Start to consider the longer-term recovery issues & the need to enact part/all of the Business Continuity Plans. If it is a prolonged incident or a large impact on Board operations is expected, a Recovery Team will need to begin this process early.
- **Stand down**: The decision to stand down must be made by the Incident Management Team (Strategic/Gold) having performed a full assessment of the continuing impact of the incident on the Board. Ensure Incident declaration update is communicated ("**Major Incident – STAND DOWN** to all Staff and any external agencies initially informed.
- **Check** arrangements staff support post-incident in place.
- **Post-incident**: Consider the post-incident requirements, such as Business Continuity issues, finance, VIP visit, media etc.
- **Debrief**: Attend the 'hot' debrief immediately after the incident.
- **Recovery**: Oversee the Board's recovery and return to 'normal' service. Following a long incident, it may be necessary for you to handover to the nominated Recovery Team.
- **Sitrep**: Ensure details of the incident are included as required in Sitrep reports.
- **Documentation**: Complete any documentation created during the incident, and file in agreement with Chief Executive, Director of Acute Services, (and Director H&SCP, and Director Public Health if those services are involved/affected).

Appendix 11: Incident Level 4 Action Card – Manager/Silver On-Call

Incident Level 4 Action Card – Manager/Silver On-Call				
Board	**Version**	**Ratified Date**	**Review Date**	**Date Published**
NHS Fife				
Location	Incident Management Team: **PRIMARY** Meeting Space: MS Teams - NHS Fife Executive Virtual Control Room **SECONDARY** Location: Education Centre, VHK (IMT) **ALTERNATIVE** Location: Meeting Room 1, Hayfield House. All locations will have Major Incident boxes with copies of all relevant plans, procedures, and action cards.			
Role Description	**Major Incident Declared:** lead the Board's operational activity & formulate the Silver/tactical plan to achieve the strategic aim set by the Strategic (Gold) Command. Determine priorities in obtaining & allocating resources as required, planning & coordinating tasks			
Key Contacts:				
Switchboard	**01592 643 355**			
NHS Fife Communications Email:	Ext: 27971 Tel: 01592 647971 (Monday – Friday 9am-5pm) fife.communications@nhs.scot Out-of-hours contact Switchboard			
Scot Gov Health EPRR Contact Numbers:	**0131 244 2429** – Weekday working hours (08:30 to 17:00) **07623 909981** (Out of hours Emergency pager)			

GATHER INFORMATION AND INTELLIGENCE

- Proceed to the Education Centre, VHK (ICT) **Ensure it is set up** & control access to those with specific roles. (If H&SCP, then establish virtual meeting room or central meeting room as per direction by H&SCP Incident Controller)
- Commence **Incident Decision Log** to ensure you document decisions made and/or actions taken. Utilise personal Decision Logbook (until a loggist has been identified)
- **Establish Incident situation**: Obtain a (M)ETHANE report from Emergency Department (ED) if available. If unavailable, known details should be logged using the (M)ETHANE Acronym. Log this in the **Incident Decision Log** and display this in the Incident Control Room (ICT)
  - **M**: Has a major incident been declared, by whom & what type?
  - **E**: Exact location of incident
  - **T**: Type & details of the incident
  - **H**: Hazards present or suspected
  - **A**: Access routes that are safe to use
  - **N**: Number & Types of casualties
  - **E**: Emergency service present or requested
- **Establish Board situation**: Establish current situation within the Board relating to capacity, staffing, ED, theatre & outpatient activity & anything else that may affect the Board's ability to receive patients upon escalation & display in the ICT.
- **Brief Exec (Gold) On-Call:** With the Lead ED Consultant brief the Exec (Gold) On-Call of incident details & current Board situation.
- **Consider** the need to call in specific staff now prior to a declaration of a major incident.

If Staff don't need to come in yet create a list of the staff you might need to call in at Declared Status & ensure you have their contact details to hand.

ASSESS RISKS AND DEVELOP A WORKING STRATEGY

- **Liaise** with Scottish Ambulance Service, ensure divert of Non-Critical, Non-major incident patients is requested. An Ambulance Liaison Officer (ALO) may join the ICT.
- **Awareness of the Strategy**: Obtain the written strategy from Gold (Exec) On Call
- **Consider** the level of response required by departments in light of information received from the incident scene e.g. do you need to open Out-Patients as a relatives' reception area or another area as extra capacity for Minor Injuries etc.
- **Capacity**: Liaise with the Clinical Co-ordinators re regular bed states and the possible requirement for extra bed spaces aligned to OPEL Framework guidance
- **Liaise** with Mortuary Manager/Department in Mass Casualty incidents.
- **Board-wide activity**: Decisions will need to be taken concerning cancellation of electives & outpatient clinics to free up resources (liaise with the Director of Acute Services or Gold Exec On-Call). This info must be relayed to all appropriate service managers.
- **Staffing**: In conjunction with the Service Managers/Heads of Department and Clinical Nurse Managers deploy nursing & support staff to the following areas if necessary (ensure they are given their action cards to follow):
  - Discharge Lounge Ambulatory Care Outpatients – for the reception of rapid discharges created by the discharge ward round. Ensure Pharmacy aware of extra capacity areas that may need their input Deploy coordinator.
  - Staff Reporting Point (Maternity Outpatients) – Nominate a staff coordinator to ensure staff are deployed where required. If available, use Nurse Bank Manager
  - Relative Reception (Main Outpatients) – include a senior member of nursing staff to act as liaison between the ED & further support staff. Utilise chaplaincy, H&SCP, volunteers & WRVS to support this.
- **Media**: Contact Comms & decide with the Comms Lead on the need for a Media Reception Area. If needed ensure it has been opened, that signage (from Education Centre) is in place & that staff are available to log in and chaperone the media.

CONSIDER POWERS, POLICIES AND PROCEDURES

- **Security**: Consider Site lock down with Facilities & Security
- **Consider** the need to identify staff to relieve those allocated earlier.
- **Consider the psychological impact** of the incident on staff within these areas. (Liaise with H&SCP partners who will be deploying support via Community Mental Health Teams (CMHT) to ED)
- **Two-Hourly Major Incident briefing**: Attend 2-hourly Major Incident briefings within the Incident Control Team chaired by Gold (Strategic) Controller. Ensure an update is sent out to all relevant staff/departments.

IDENTIFY OPTIONS AND CONTINGENCIES

- **Relief**: If this is likely to be a prolonged incident assess the need to call in another Manager to take over from you after 6-8 hours or when necessary. Conduct a full Handover/Takeover (HOTO).

STAND DOWN, RECOVER AND REVIEW

- **Stand down**: Switchboard will inform you that Scottish Ambulance Service have notified the Board of 'Casualty evacuation complete'. This is not an instruction for the Board to stand down.
  - The decision to stand down must be made by the Chief Executive, Director of Acute Services or Gold (Exec) On-Call (or Director H&SCP and Director of Public Health where those services are involved/affected), having performed a full assessment of the continuing impact of the incident on the Board.
  - Inform Switchboard, the Comms Team & the Directorate Leads when the decision to Stand down has been made to allow them to communicate this to all areas. This will be achieved through the Comms Team (all staff emails/Intranet/NHS Fife Website etc) & via Operational (Bronze)Teams and senior nurses.
  - Notify all external agencies previously notified of the stand down declaration.
- **Recovery**: Together with the Chief Executive, Director of Acute Services or Gold (Exec) On-Call, consider the business continuity implications caused by the incident & work with the Recovery Team who will prepare a plan to address them.
- **Post-incident**: Consider, with Gold Command, the post-incident requirements, such as business continuity issues, finance, VIP visit, media etc.
- **Establish** a '**hot' debrief** for staff that responded to the incident. Ensure ALL staff involved are aware.
- **Maintain ICT**: Ensure that the Incident Control Team remains established – with phones connected & staff present, for 1-2 hours after stand-down.
- **Documentation**: Complete and secure any documentation created during the incident, and file in agreement with Chief Executive and Director of Acute Services.

Appendix 12: Mortuary Action Card

Incident Level 4 Action Card – Mortuary Services				
Board	**Version**	**Ratified Date**	**Review Date**	**Date Published**
NHS Fife				
Location	Mortuary, VHK.			
Role Description	Consider the need to increase capacity or utilise alternative body storing facilities. Assess the need to contact further mortuary staff.			
Key Contacts:				
Switchboard	**01592 643 355**			
Porters	VHK: QMH:			
Procurator Fiscal	Tel: 08445614110 david.degnan@copfs.gov.uk; _sfiueast@copfs.gov.uk			
Fife Council	**Team 24/7 Tel: 01592 583544** Mobile: 07985718243 duty.officerppt@fife.gov.uk ; Tel: 03451 555550			
Police appointed Funeral Director	07714598892 Co-op Funeralcare ross.drummond@coop.co.uk			
Head of Laboratory Services	robyn.gunn@nhs.scot Ext. 28055			

GATHER INFORMATION AND INTELLIGENCE

- ☐ Base yourself in the APT office, VHK Mortuary.
- ☐ Check details of incident & current situation and Establish Incident situation.
- ☐ For incident-specific guidance, refer to Major Incident Plan, Action Card and Contingency SOPs within QPulse or Business Continuity Folder in the Service managers Office.
- ☐ Identify the number storage spaces available for use including BAU requirements.
- ☐ Identify number of body bags in stock and make available to services as required.
- ☐ Liaise with (Gold) Incident Control Team, ED Controller and (Silver) Incident Management Team in order to clarify current storage situation and receive update on number of deceased expected following the incident.
- ☐ Consider the need to call in staff. If Staff don't need to come in yet create a list of the staff you might need to call in & ensure you have their contact details to hand.
- ☐ Ensure all above actions have been taken and are logged.

ASSESS RISKS AND DEVELOP A WORKING STRATEGY

- ☐ Consider the level of response required by the department in light of information received above.
- ☐ During working hours inform the Departments Clinical Lead or Deputy.
- ☐ During working hours inform the head of Laboratory Services.
- ☐ Contact charge hand porter to confirm transport arrangements for deceased to the Mortuary.
- ☐ Contact the Procurator Fiscal, to inform them that a Major Incident has been declared and Post-mortems will be deferred, and any urgent PM will have to be transferred to alternate mortuary.

CONSIDER POWERS, POLICIES AND PROCEDURES

- Implement BAU procedures for receipt and release of deceased (See QPulse ALML 013).
- When the number of critically or fatally injured casualties is high, consider the need to increase capacity or utilise alternative body storing facilities. See QPulse or folder in Service Managers office for AMAA 027 Business Continuity Plan for Cellular Pathology Services.
- Consider the requirement to escalate to the Fife Mass Fatalities Group.

IDENTIFY OPTIONS AND CONTINGENCIES

- BAU processes will continue to be carried out until permanent storage capacity at Victoria Hospital and Queen Margaret Hospital Mortuaries reaches 80%. At that point, all partners in the Mass Fatalities Group will be informed. The coordination team will meet to explore options to increase capacity e.g. mutual aid, lease of alternative storage etc.
- Implement contingency plans (See QPulse or Business Continuity Folder in Service Manager's office: AMAA 027, ALML 022, ALML 017).
- Contact Funeral Directors to arrange the collection of deceased that are cleared for collection.
- Put all four contingency Nutwell storage units into use.
- Contact facilities to inform them that the Nutwell units are in use.
- Identify any deceased that can be transferred to the QMH Body store and arrange for transfer by Police appointed Funeral Directors.
- Call in additional staff to assist with implementation of contingencies if needed.
- Update (Gold) Incident Control Team at regular intervals, or immediately if there is a sudden surge in numbers, on capacity and projected challenges.

STAND DOWN, RECOVER AND REVIEW

- Prepare a list of all deceased patients from the major incident and their current locations.
- Keep the next of kin informed of the location of deceased casualties.
- Liaise with the Police and the Procurator Fiscal regarding the undertaking of post mortems.
- Ensure staff are available to help in the mortuary until recovery to BAU and then Stand down.
- Record the details of all staff involved in the incident and contact Chaplaincy/OH regarding counselling/wellbeing support.
- Facilitate Department 'hot' debrief and attend NHS Fife 'hot' debrief if required.
- Complete any documentation created during the incident.
- Liaise with Mass Fatalities Group regarding the recovery phase.
- Release deceased to appointed Funeral Directors when instructed 'clear' by the Procurator Fiscal.

Appendix 13: Public Health Incident Consultant in Public Health Medicine/On-call Consultant.

Public Health Incident Action Card				
Board	**Version**	**Ratified Date**	**Review Date**	**Date Published**
NHS Fife				
Location	Incident Management Team: **PRIMARY** Meeting Space: MS Teams - NHS Fife Executive Virtual Control Room **SECONDARY** Location: Education Centre, VHK (IMT) **ALTERNATIVE** Location: Meeting Room 1, Hayfield House. All locations will have Major Incident boxes with copies of all relevant plans, procedures, and action cards.			
Role Description	Provide expert advice about issues and incidents likely to affect the public.			
Key Contacts:				
Switchboard	**01592 643 355**			
Director of Public Health	Office Hours - 01592 226514 Out of Hours - 01592 643355			
Duty Microbiologist	EXT 28176 or Switchboard, then Option 1 After hours dial Switchboard			
ED Duty Consultant	Ext 20622 (between 0600hrs - 1800hrs) After 1800hrs contact Switchboard and ask for On-call Consultant (mobile)			
Infection Prevention and Control	01592 643355 or EXT 28833 Infection Control Nurse (Out of Hours) - 01383 623623			

GATHER INFORMATION AND INTELLIGENCE

- **Establish Incident situation**: Obtain a (M)ETHANE report from Emergency Department (ED)/multiagency partners if available. If unavailable, known details should be logged using the (M)ETHANE Acronym. Log this in the **Incident Decision Log** and display this in the Incident Control Room (ICR)
  - **M**: Has a major incident been declared, by whom & what type?
  - **E**: Exact location of incident
  - **T**: Type & details of the incident
  - **H**: Hazards present or suspected
  - **A**: Access routes that are safe to use
  - **N**: Number & Types of casualties
  - **E**: Emergency service present or requested

- **Establish current situation** within the Board relating to capacity, staffing, activity and resources that may affect the ability to receive and manage patients. Consider contacting NHS24 to redirect patients.
- **Refer** to NHS Fife Incident Management Framework
- **Refer** to Health Protection Manual
- **Facilitate the coordination of IMT**; (Chair and lead). Include detail of membership and rotas to ensure staff can be relieved.
- **Commence Incident Decision Log** to ensure you document decisions made and actions taken. Utilise a physical personal Decision Logbook until a loggist is available.

- **Formulate the Strategy**: Formulate a written strategy & identify the Board's IMT aims and objectives to drive the resolution of the incident. Share this with the Duty/Service Manager or On-Call Manager / Designated NHS Fife MACC Lead
- For incident-specific guidance, refer to associated Framework Documents and Action Cards within the Incident Management Framework (example – Lockdown, CBRN)
- Utilise issued **Airwave Radios** as contingency against loss of normal comms. IBIS (Airwave) radios will be provided by Police Scotland for such incidents and should be used to contact all multi-agency partners.
- Be prepared to provide information to the **MACC** on request of the MACC chair (virtually or in person)

ASSESS RISKS AND DEVELOP A WORKING STRATEGY

- **Brief Executive On-Call** (or Gold Commander): brief the Exec (Gold) On-Call of incident details & current Board situation. Where appropriate include the Lead ED Consultant. Inform the Director of Public Health and the Board's Communications Manager when an incident is declared.
- **Obtain CHEMET** from SFRS
- **Liaise** with other agencies and multiagency partners as required e.g. Met office, Scottish Water, DEFRA.
- **Contact Microbiologist** & Infection Control & Labs – initiate planning swabbing/testing where required.
- **Consider** the need to call in specific staff now prior to a declaration of a major incident. If staff don't need to come in yet create a list of the staff you might need to call in & ensure you have their contact details to hand.
- **Liaise with Mortuary** Manager/Department in Mass Casualty incidents.
- **Media**: Contact Comms about public messaging.
- **Two Hourly Major Incident briefing**: Establish & Chair 1 to 2-hourly Major Incident briefing within the Incident Control Team (Gold/Silver), documenting updates & actions for completion. Brief by exception the Chief Executive.
- **Estates and Security**: Consider site lock down with Facilities & Security with any exposure risks.
- **Ensure exposure controls are put in place** (risk management) Hazmat/CBRN – PPE etc.
- **Ensure information is made available** to the incident lead or external agencies.
- **Liaise with East Region Health Protection Team.**

CONSIDER POWERS, POLICIES AND PROCEDURES

- **STAC**: Consider standing up a Scientific & Technical Advisory Cell (STAC) or Mass Fatalities Group, depending on type of incident.
- Issue a preliminary report within 48 Hours and subsequent reports as necessary.
- **Advise** nearby sites and adjoining NHS boards about the incident and subsequent investigation and control measures as appropriate.

IDENTIFY OPTIONS AND CONTINGENCIES

- **Relief**: If this is likely to be a prolonged incident assess the need to call in another consultant to take over from you after 6-8 hours or when necessary. Conduct a full Handover/Takeover (HOTO).
- Be responsible for communicating with (including issuing the final report) the NHS Board, PHS and others, as appropriate.
- Liaise with the Board Chief Executive who may set up a Strategic Health Group and Health Information Cell where required.
- Liaise with Police Scotland about any forensic issues.

STAND DOWN, RECOVER AND REVIEW

- IMT Undertake a **Hot Debrief** using Public Health Scotland Template
- **Stand down**: The decision to stand down must be made by the Incident Management Team (Strategic/Gold) having performed a full assessment of the continuing impact of the incident on the Board. Ensure Incident declaration update is communicated (“Major Incident – STAND DOWN") to all Staff and any external agencies initially informed.
- Check support and care arrangements for staff are in place.
- **Post-incident**: Consider the post-incident requirements, such as Business Continuity issues, finance, VIP visit, media etc.
- **Recovery**: Support the Board’s recovery and return to ‘normal’ service. Following a long incident, it may be necessary for you to handover to the nominated Recovery Team.
- **Sitrep**: Ensure details of the incident are included as required in Sitrep reports.
- **Documentation**: Complete any documentation created during the incident, and file in agreement with Chief Executive, Director of Public Health, Director of Acute Services, and Director H&SCP

Annex 1 : Radio Handset Guide

- When using IBIS Radios to pass on information, always remember A,B,C,D: **A**ccuracy, **B**revity, **C**larity, **D**iscipline.
- All dates must be in dd/mm/yyyy format and timings in 24-hour clock.
- All numbers must be read out in full, for example 12th Feb 2023 would be said as *"one two, zero two, two zero two three".*
- All letters when spelling out information should be given using the NATO Phonetic Alphabet (see table below).

A Alpha	**B** Bravo	**C** Charlie	**D** Delta	**E** Echo
F Foxtrot	**G** Golf	**H** Hotel	**I** India	**J** Juliet
K Kilo	**L** Lima	**M** Mike	**N** November	**O** Oscar
P Papa	**Q** Quebec	**R** Romeo	**S** Sierra	**T** Tango
U Uniform	**V** Victor	**W** Whiskey	**X** X-ray	**Y** Yankee
Z Zulu				

Some basic tips for radio etiquette:

- Use the callsign of the person you are calling twice at the beginning of your message, followed by "from" and your callsign once.
    - If your callsign is NHS 1 and you wish to speak to PC1 you should state: *"Papa Charlie one, Papa Charlie one from November Hotel Sierra 1, over".*
- Acknowledge you have understood any message to you by stating *"received"*, and if you wish the caller to repeat the message state *"Say Again, over".*
- If your message is long and detailed, pause every so often and state *"so far?".* This will allow the person on the other end of the call to clarify they have noted all of the information so far and will avoid the need to repeat the whole message from the start.

Annex 2: PHS Debrief Template

Public Health Scotland

Hot debriefing template

The Scottish Government **Guidance on the Roles and Responsibilities of NHS Led Incident Management Teams for the Management of Public Health Incidents**, highlights the need to learn from experience.

The IMT Chair should complete this document as soon as possible following the end of an incident. This is to capture initial lessons learnt immediately (a “hot debrief)”, recognising that some IMT reports take months/years to be published.

Incident reference.

Please provide a descriptive reference/title for this incident (e.g. incident/place/date)

IM&T Lead details

Name:

Email:

Job Title:

Contact number:

Contact number (mobile):

Address:

Date:

Signed:

Details of incident.

Please provide a brief summary of incident:

What went well?

Please list aspects of the incident that were managed well:

What did not go well?

Please list aspects of the incident that were not managed well.

Lessons learned.

Please provide details of any learning or recommendations for national consideration:

Return completed form to: phs.shpn-pmt-submissions@nhs.net

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**3 November 2023**
Title:	**Hospital Standardised Mortality Ratio (HSMR) Update Report**
Responsible Executive:	**Dr Chris McKenna, Medical Director**
Report Author:	**Dr Shirley-Anne Savage, Associate Director of Quality and Clinical Governance**

1 Purpose

This is presented for:

- Assurance

This report relates to a:

- National Health & Well-Being Outcomes

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This report provides:

- A summary of what Hospital Standardised Mortality Ratio (HSMR) is used for,
- An overview of HSMR in NHS Fife for the period April 2022- March 2023 and
- An update as to how HSMR methodology has been updated in view of the pandemic.

2.2 Background

HSMR data takes into consideration the factors which are recognised to affect the risk of death. Public Health Scotland collate and oversee HSMR data at a national level. The case mix of patients between different hospitals varies and as such the HSMR data is adjusted to

allow comparison between hospitals. This approach is more effective than using crude mortality rates as a means of bench marking across Scotland.

The HSMR data is calculated using records which relate to acute inpatient and day case admissions (SMR01 coded data). Data excludes obstetric and psychiatry specialities. Any death with occurs within 30 days of hospital admission is included in the data. If the HSMR value is less than 1.0 this means that the number of deaths is less than predicted, if the value is more than 1.0 this means the number of deaths is more than predicted. It is important to note that the data does not account for deaths that were unavoidable or expected.

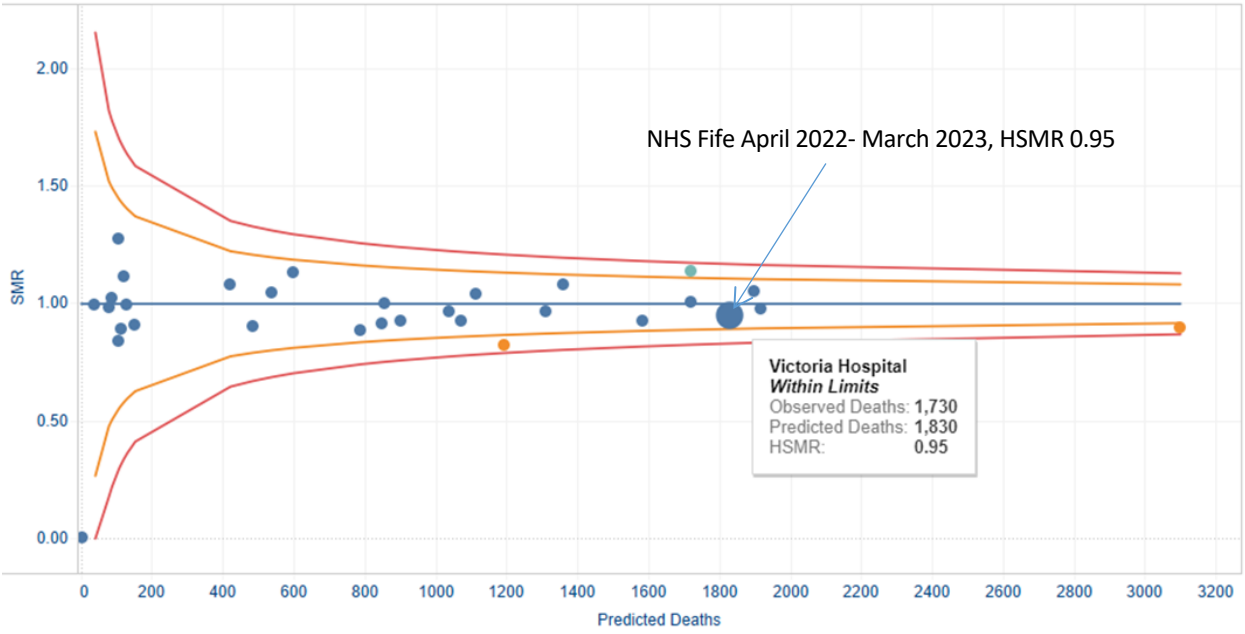
NHS Fife monitors HSMR as one of the key quality performance indicators for safety and quality. HSMR data is published in the Integrated Performance and Quality Report (IPQR).

2.3 Assessment

HSMR in NHS Fife

The HSMR for NHS Fife during 2022-2023 was 0.95 which provides assurance that the local mortality ratio was at level in keeping with the national average and in keeping with the local HSMR levels (as demonstrated in chart 1).

Chart 1.
HSMR for deaths within 30 days of admission by hospital: April 2022 to March 2023



*Note that data is representative of Victoria Hospital only as the Queen Margaret Hospital does not include any acute wards.

The NHS Fife data for this period is summarised below:

Period	Hospital	Observed Deaths	Predicted Deaths	Patients	HSMR	Crude Mortality Rate (%)
April 2022-March 2023	Victoria Hospital	1730	1830	29273	0.95	5.9

The PHS HSMR report 2022-2023 highlighted two main points:

- No hospitals had a significantly higher or lower standardised mortality ratio than the national average.
- Non-elective admissions consistently account for the largest proportion of deaths within 30-days of admission.
- Patients from the least deprived areas of Scotland consistently have lower levels of crude 30-day mortality than patients from more deprived areas.
- Around 4 in 5 deaths within 30-days of admission take place in hospital while the remaining deaths take place in the community.

The PHS Report 2022-2023 can be accessed via the following link:
Hospital Standardised Mortality Ratio (publichealthscotland.scot)

HSMR Methodology

PHS regularly reviews the HSMR methodology. In view of the COVID-19 pandemic the HSMR methodology was updated in August 2019 to include COVID-19 codes. Consequently, HSMRs published after August 2019 cannot be compared to earlier publications.

2.3.1 Quality/ Patient Care

Proactive review of HSMR data combined with other clinical governance quality performance indicators is fundamental to ensuring the assessment and monitoring of quality and safety.

2.3.2 Workforce

N/A

2.3.3 Financial

N/A

2.3.4 Risk Assessment/Management

N/A

2.3.5 Equality and Diversity, including health inequalities

HSMR data demonstrates that patients domiciled in the least deprived areas of Scotland have lower levels of 30-day mortality post admission compared with the more deprived areas.

2.3.6 Other impact

N/A

2.3.7 Communication, involvement, engagement and consultation

N/A

2.3.8 Route to the Meeting

This paper has been developed in consultation with Dr Chris McKenna (Medical Director, NHS Fife), Janette Owens (Director of Nursing NHS Fife) and presented at the Clinical Governance Oversight Meeting on the 24th October 2023.

2.4 Recommendation

The Clinical Governance Committee are recommended to:

- Note the update provided,
- Take assurance that HSMR is monitored as a key quality performance indicator; and
- Take assurance that the HSMR for NHS Fife is in keeping with the national average.

Report Contact

Dr Shirley-Anne Savage
Associate Director of Quality and Clinical Governance
Email shirley-anne.savage@nhs.scot

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**3 November 2023**
Title:	**Infection, Prevention and Control Report 2022**
Responsible Executive:	**Janette Keenan, Executive Director of Nursing**
Report Author:	**Julia Cook, Infection Control Manager**

1 Purpose

Update for NHS Fife Infection Prevention and Control Annual Report 2022 to provide assurance that all IP&C priorities are being and will be delivered.

This report is presented for:

- Assurance

This report relates to:

- Annual Delivery Plan
- Government policy / directive
- Local policy
- National Health & Wellbeing Outcomes / Care & Wellbeing Portfolio

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of this report is to provide information to the Infection Control Committee (ICC), Clinical Governance Committee (CGC), NHS Fife Board and all other interested parties on progress against the main objectives of the *Prevention & Control of Infection Work Programme (2022-23),* and the management of COVID-19. The format ensures all elements that are required by the *NHS Health Improvement Scotland (HIS) Standards (2022)* are included

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 2023, utilising 2018/19 as baseline data.
- Outcome measure - achieve 10% reduction by 2023 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 2023, 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 2022/23 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 2023, 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 2022/23 is 33.0 per 100,000 total bed days.

2.3 Assessment

ECB

During the surveillance period of 2022 there was a total of 280 ECB. Bloodstream infections with *E. coli* are widespread in NHS Fife and were identified in patients in hospitals care homes, community and under social care.

- There was a 12.4% increase in the number of ECB in 2022 compared to 2021.
- Hospital patients account for16.4% of the total ECB. This is down from ~20% in 2021.
- NHS Fife had higher annual rates of community associated ECB compared with the Scottish average rate.
- In both hospital acquired infections and non-hospital acquired infections the renal tract is the major source of infection with lower UTI the major entry point.
- In non-hospital acquired infections hepato-biliary infections are the second most common cause of an ECB followed by the "Not known" category.
- Catheters account for 26.27% of all healthcare associated infections.

CDI

NHS Fife & Fife Health & Social Care Partnership has seen a steady reduction in the number of CDI cases during the past 5 years. Much improvement work has taken place to ensure a better outcome for patients and service users.

- Between 1st January and 31st December 2022 there were a total of 40 cumulative episodes of CDI in patients aged ≥ 15 years in Fife.

- There were 16 hospital associated infection (HAI) CDI, 8 healthcare associated infections (HCAI) and 6 unknowns. Further to this, 10 CDI infections were community associated infections (CAI).
- Of the 40 cases there were 4 episodes of recurrent CDI

SAB

- During 2022 in NHS Fife there was a total of 92 SABs, compared to 2021 there has been a 15% increase in the number of SAB.
- The proportion of hospital acquired SAB in 2022 was 35.9% which was slightly less than the 37.5% in 2021
- In 2022 there were no MRSA bacteraemia. **NHS Fife has achieved the local improvement target** set by the ICC for ≤5% of total *S. aureus* bacteraemia to be due to MRSA.
- The proportion of VADs resulting in a hospital acquired SAB in 2022 was 18.18%. **NHS Fife has achieved the local improvement target** set by the ICC of ≤35% of hospital acquired SAB due to VAD.
- Three SAB were associated with PVC. **NHS Fife has achieved the local improvement target** set by the ICC.
- When the entry point was identified, skin and soft tissue infections (SSTI) along with IVDA sites were the primary cause of non hospital acquired SAB. The number of non-hospital SAB due to illicit IV drug use increase to 11 episodes in 2022.
- To reduce SAB further focus on; Medical devices including vascular access devices and non-VA medical devices, skin & soft tissue infections plus people who inject drugs.
- SAB where the entry point is not known remain a significant problem and accounted for 19.56% percent of the total in 2022

COVID-19 Care Homes

The IPC Care Home Team continued to provide support for all care homes in Fife to implement and facilitate the IPC standards according to the Care Home Infection Prevention and Control Manual (CH IPCM) and Care Home Cleaning Specification.

Quality Improvement (QI) projects have also strengthened relationships with care home managers and improved professional collaborative relationships.

The latest CNO Advice Note, published on 14th December 2022, details the new arrangements for enhanced collaborative clinical and care support for Care Homes. Promotes a partnership approach, which recognises the experience of care home staff and the provision of support to care homes in the context of ensuring a homely environment in which people live and work. In light of this, the target going into 2023 will be focussed on collaborative working with care home managers and staff to ensure the service is supported in partnership as opposed to assurance teams having oversight of practice.

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 2022

- **Norovirus**

There has been 5 Norovirus outbreaks and 1 GI outbreak pathogen unknown

- **Seasonal Influenza**

There have been 3 ward closures due to confirmed Influenza outbreaks and a closure due to Respiratory Syncytial Virus (RSV).

- **COVID-19**

NHS Fife did experience a significant increase in incidents and clusters of COVID-19, with 129 clusters in 2022 compared to 37 incidents in 2021. Staff demonstrated great commitment and effort working with the IPCT during outbreaks

Hospital Inspection Team

- NHS Fife received no inspections during 2022

Hand Hygiene

- Good hand hygiene by staff, patients and visitors is a key way to prevent the spread of infections.
- Hand Hygiene audit results of all staff groups by individual ward, hospital or directorate within both the Acute services & HSCP was able to be viewed on 'Ward Dashboard' until late 2022
- The IPCT carry out Hand Hygiene quality assurance audits as part of the *HCAI Prevention and Control of Infection Assurance Framework*.

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%.

National Cleaning Services Specification and Estates Monitoring

- NHS Fife achieving **Green** status, reported via bi-monthly ICC

Estates – Built Environment

Throughout 2022, there continued to be a focus on reducing risk in the healthcare built environment - from the design, construction and adaptation phases of buildings and

associated environments, to how they are occupied and maintained by the health care teams using them.

NHS Fife created the new role of Senior IPC Nurse to provide specialist advice regarding the built environment and HAI-SCRIBE, who worked collaboratively with NHSScotland Assure Assurance, to ensure an overarching focus on IPC and infection risk during all stages of the building lifecycle in the KSAR reviews for the 2 capital projects:

- NTC Fife Elective Orthopedic Centre
- Lochgelly and Kincardine Health Centers

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.

Quality Improvement Projects for 2022 include:

- People Who Inject Drugs (PWID) SAB Project
- Urinary catheter improvement Group (UCIG)

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.

Recruitment and retention of IPC specialist workforce has been challenging.

Significant focus on IPC Team professional development and recruitment

Creation of the new Senior IPCN for the Built Environment and HAI-SCRIBE to support both large, complex and capital projects.

2.3.3 Financial

With increases in demand for IPCT support across NHS Fife due to the COVID-19 response, also saw a requirement for IPC and Care Home Support, with additional funding granted in December 2020. This has allowed a recruitment drive, with trainee IPCNs joining the NHS Fife IPCT in 2021 and development of a Band 7 Senior IPCN.

Senior IPCN for the Built Environment and HAI-SCRIBE funded via capital planning.

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 and Anchor Institution ambitions

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

2.3.6 Climate Emergency & Sustainability 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.

NHS Fife IPCT

2.4 Recommendation

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

3 List of appendices

The following appendices are included with this report:

NHS Fife Prevention and Control of Infection Annual Report 2022

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

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

NHS Fife

IPCTeam
Infection Prevention & Control

NHS Fife Prevention and Control of Infection Annual Report 2022

Julia Cook Infection Control Manager

Approval Record	Date of Approval
NHS Fife Infection Control Committee	December 2023
NHS Fife Clinical Governance Committee	November 2023
Chief Executive for NHS Fife Board	November 2023

CONTENTS

1.0 INTRODUCTION

Infection Prevention and Control Team (IPCT)

Julia Cook, Infection Control Manager
Craig Webster, Deputy Infection Control Manager (Secondment – Sept 2022)
Margaret Selbie, Acting Lead Infection Prevention and Control Nurse (March 2022)
Elizabeth Dunstan, Senior Infection Prevention and Control Nurse
Mirka Barclay, Senior Infection Prevention and Control Nurse (HAI-SCRIBE and Built Environment, from September 2022)
Nykoma Hamilton, Infection Prevention and Control Nurse
Janice Barnes, Infection Prevention and Control Nurse
Catherine McCullough, Infection Prevention and Control Nurse
Elaine Tate, Infection Prevention and Control Nurse
Ashley Norcross, Infection Prevention and Control Nurse
Pauline Young, Infection Prevention and Control Nurse
Rosemary Shannon, Infection Prevention and Control Audit Nurse (Bank)
Suzanne Watson, Senior Infection Prevention and Control Nurse (Care Homes)
Sharon Bernard, Infection Prevention and Control Nurse (Care Homes)
Sharon Reid, Infection Prevention and Control Nurse (Care Homes, from May 2022)
Jodie Gear, Infection Prevention and Control Nurse (Care Homes, from May 2022)
Lynsey Delaney, Infection Prevention and Control Surveillance Midwife
Kathleen Diamond, Clerical Officer
Lori Clark, Personal Assistant/Office Manager (March 2022)
Beverley Young, Personal Assistant/Office Manager (from June 2022)

Consultant microbiologist	**Number of PAs**	
Dr Keith Morris	4	Provide clinical advice and chair ward outbreaks and incidents within the ASD. Responsible for alter organism surveillance Responsible for SAB, ECB and SSI surveillance and LDP targets
Dr Stephen Wilson	3	Clinical advice, HAI-SCRIBE, Water Safety, Ventilation and Decontamination
Dr Priya Venkatesh	4	IPC advice for HSCP, Oversee CDI surveillance and LDP targets for NHS Fife
Dr David Griffith	1	IPC general duties and AMT
Vacancy	1	General clinical advice
Total	13	

Celebrating Success

During 2022, the Infection Prevention and Control Service have:

- Continued to develop the IPC Care Home Team.

- Support new IPC team members with post graduate study towards the MSc specialist practitioner qualifications in Infection Prevention and Control.

- Three of the IPCT have successfully completed the University of Highland and Islands MSc module *The Built Environment (Infection Prevention and Control).*

- NHS Fife IPC team have been supporting capital projects such as the National Treatment Centre for Elective Orthopaedic at the Victoria Hospital in Kirkcaldy, Lochgelly and Kincardine Health Centre Project Team.

Nationally recognised work

The IPCT supported and continue to support work across a broad range of national stages. The team supported/are supporting:

- **NHS Tayside and the University of Dundee** with a four-year research study; *ARCH: Antibiotic Research in Care Homes*. The aim of the study is to carry out a programme of in-depth multidisciplinary research around how we might safely improve/reduce antibiotic use and ultimately Antimicrobial Resistance (AMR) in care homes, which concluded in 2022.

- Participated in the Scottish Antimicrobial Nurses' Group meetings virtually and deputise (as required) representing the Infection Prevention Society (IPS) at the Scottish Antimicrobial Prescribing Group meetings.

The team continued to develop the Infection Prevention and Control Service to;

- ✓ focus more on prevention than control
- ✓ sustain and build on achievements and strengths to date
- ✓ ensure that what works is implemented across the healthcare system
- ✓ support greater integration and partnership across the healthcare system
- ✓ ensure we prepare for the future and respond to emerging threats
- ✓ demonstrate our commitment to sustainable improvement
- ✓ promote a culture of zero tolerance of avoidable infections

The Board recognises our collective responsibility towards Healthcare Associated Infection (HCAI) risk and continuously supports our implementation of new initiatives to control these risks. Development, implementation and review of policies alongside surveillance and education are key components of the Infection Prevention and Control Team's proactive approach to addressing the HCAI agenda.

Prevention and control of infection is everyone's responsibility and, as a multidisciplinary team, every member of staff is dedicated to maintaining consistently high standards to ensure patients receive clean, safe care.

2.0 EXECUTIVE SUMMARY

- IPCT continues to work towards improving surveillance, prevention and control of Healthcare associated infections across Fife through collaborative joint working.

- During 2022, the IPCT workforce challenges including recruitment and retention of staff. The substantive post of Lead Infection Prevention and Control Nurse was unsuccessful in recruitment and the post filled by acting Lead IPCN (retired March 2022) and Deputy Infection Control Manager (secondment until September 2022).

- NHS Fife developed a new role, Senior IPC Nurse for HAI-SCRIBE and the Built Environment.

- Fife continues to comply with national mandatory surveillance requirements.

- Surgical Site Infection (SSI) - pause to national programme.

- The Scottish Government's CNO in October 2019 announced the new standards for the reduction of Healthcare Associated Infections (Hospital acquired (HAI) & Healthcare associated (HCAI)) for the following: ECB, CDI and SAB, further updated DL (2022) 13.

- *Escherichia coli* bacteraemia (ECB) surveillance continued during 2022. There was a increase in the cumulative number of ECB in 2022 compared to 2021, however there was a slight decrease in the number of HCAI cases from 2021.

- *Clostridioides difficile* infection (CDI) rates continue at a level below the national average. NHS Fife had a total of 40 CDI cases reported for 2022, this is lower than 2021, when there were 44 cases.

- The SAB rate for NHS Fife in 2022 was slightly higher than the previous year.

- 2022 saw 5 Norovirus outbreaks, 3 outbreaks of influenza, 1 GI outbreak (pathogen unknown).

- NHS Fife did experience incidents and clusters of COVID-19, with 129 incidents involving 2 or more patients and/or healthcare workers reported to ARHAI Scotland. This was a significant increase from 2021 where there were 37 incidents. Staff demonstrated great commitment and effort working with the IPCT during outbreaks.

- Fife remains GREEN in the National Cleaning Specification monitoring reports.

- The Healthcare Environment Inspectorate – there were no inspections in NHS Fife during 2022.

- The IPCT promoted throughout NHS Fife the new Healthcare Improvement Scotland (HIS) Infection Prevention and Control Standards, 2022.

- July 2022 saw the transition from the Scottish Winter 2021/22 Respiratory Infections in Health and Care settings - Infection Prevention and Control Addendum to the National Infection Prevention and Control Manual.

NHS Fife has responded to the COVID-19 pandemic, by adopting the best evidence available, responded quickly and effectively to developments and changes in national guidance. Fife has made significant progress in the prevention and control of infection and the management of SAB, ECB and CDI HCAI during 2022, and responded quickly and effectively to developments and changes in national strategy. This will form a strong base from which to move forward on the challenges of the next twelve months.

Julia Cook, Infection Control Manager on behalf of the Infection Prevention and Control Team

3.0 PURPOSE OF REPORT

The purpose of this report is to provide information to the Infection Control Committee (ICC), Clinical Governance Committee (CGC), NHS Fife Board and all other interested parties on progress against the main objectives of the *Prevention & Control of Infection Work Programme (2021-22) and (2022-23),* and the management of COVID-19. The format ensures all elements that are required by the *NHS Health Improvement Scotland (HIS) IPC Standards (2022)* are included.

4.0 INFECTION CONTROL STRUCTURE AND ORGANISATION

4.1 Structures

Infection Control structure is defined within the *Prevention & Control of Infection Implementation Framework* which lays down individual responsibilities and committee accountability for delivery of Infection Prevention & Control in NHS Fife and the Health and Social Care Partnership.

In 2022, the IPCT reported through the NHS Fife Infection Control Committee (ICC), to the NHS Fife Clinical Governance Committee (NHSF CGC), the HSCP Clinical and Care Governance Committee and the Executive Directors Group (EDG). The ICC meets bi-monthly with minutes of the meeting being widely distributed.

NHS Fife has systems in place to ensure that national requirements for infection control, decontamination and cleaning as laid down in Chief Executive Letters (CEL), Chief Medical Officer for Scotland (CMO) letters, Chief Nursing Officer for Scotland (CNO) letters and other mandatory guidance are identified and addressed. These are disseminated direct to the Infection Control Manager (ICM) from the Scottish Government Health & Social Care Directorate (SGHSCD) Healthcare Associated Infection (HCAI) Policy unit or via the Chief Executive and the Executive Lead for Infection Prevention & Control.

4.2 Staffing and Resources

- Absence was a challenge during 2022, with long term sickness and COVID-19 related absences impacted the service.
- Retention of staff in the IPC Care Home Team prove challenging, adding pressure on resources to allow for shadowing, mentoring and the orientation of new team members to build competency to undertake the care home team role autonomously.
- The IPCT were unsuccessful in recruiting to the substantive post of Lead Infection Prevention and Control Nurse and IPC Surveillance and Auditor.
- The IPC Care Home Team secured funding for the full time substantive band 7 role. Successfully recruiting into the role in May 2022.
- NHS Fife developed a new role, Senior IPC Nurse for HAI-SCRIBE and the Built Environment.

The challenges of COVID-19 have compelled the NHS to make the best use of our people's skills and experience, to provide safe and effective person-centred care. The IPCT has risen to the challenge and has been flexible and adaptable – with new ways of working such as MS Teams meetings training, and safety huddles. Infrastructure to enable staff to work from home has been facilitated by an increased investment in IT services and software.

IPCT resource challenges have been highlighted in the HAIRT report and to the ICC and HAI Executive, with assurance there have been interim measures introduced to ensure the safety of the service. This includes seeking supplementary staffing and offering additional hours to existing team members.

5.0 GOVERNANCE

5.1 Internal Audit

The IPCT did not receive any requests for review of IPC services, from the Internal Audit team for this reporting period.

6.0 NATIONAL STRATEGY

6.1 COVID-19 PANDEMIC RESPONSE

A coordinated hospital-wide approach was taken to infection prevention and control including close collaboration with ARHAI Scotland. The IPCT have provided NHS Fife and the HSCP with support and advice for health care workers involved in receiving, assessing and caring for patients who are a possible or confirmed case of COVID-19 in line with national guidance.

The IPC advice in response to the COVID-19 pandemic is based on the best evidence available from previous pandemic and inter-pandemic periods and the emerging evidence base on COVID-19 which is rapidly evolving. The IPCT have attended national meetings with ARHAI Scotland to be fully informed of the most up to date situation with COVID-19 and current national guidance.

The IPCT annual work plan was reviewed and COVID-19 response prioritised:

- An increase in frequency of IPCT ward/department visits
- Focus on education and training
- Focus on preventing infection in healthcare
- Support to clinical teams to investigate and implement control measures during outbreaks
- Participated in local and national COVID-19 meetings

During the pandemic the IPCT have been working collaboratively with key stakeholders and senior management teams. Local meetings include Hospital Control Teams, Silver Command Procurement, Scientific Technical & Advisory Cell (STAC), Care Home Oversight Group and Care Home Safety Grand Round.

As part of these MDT meetings, IPCT has provided input into the development of patient pathways and the transition from the Winter 2021/22 Respiratory Illness Addendum back to the NIPCM and CH NIPCM. Winter planning, outbreak management and supporting the, seasonal influenza vaccination programme and the COVID-19 vaccination programme

were a key focus for the IPCT to prepare for the winter season. Education and training has been provided to all levels of NHS Fife staff.

6.2 IPC Care Home Team

The IPC Care Home Team continued to provide support for all care homes in Fife to implement and facilitate the IPC standards according to the Care Home Infection Prevention and Control Manual (CH IPCM) and Care Home Cleaning Specification. Support was identified through the team receiving referrals from the Health Protection Team (HPT) and the Care Home Liaison Nurse Team (CHLNT). Support offered to managers included an IPC walkabout, which identifies good practice and areas for improvement in regards to Standard Infection Control Precautions (SICPs). Education and training was offered for staff where managers felt this was required, based on feedback from the multidisciplinary team, Care Inspectorate (CI) and IPC walkabout findings. Other support given to care homes included signposting of relevant guidance and explanation and interpreting the guidance to promote best IPC practice.

Predominantly, Breaking the Chain of Infection, Hand Hygiene and Personal Protection Equipment (PPE) donning and doffing training was delivered to care homes in 2022 as well as bespoke training.

Quality Improvement (QI) projects have also strengthened relationships with care home managers and improved professional collaborative relationships.

The latest CNO Advice Note, published on 14th December 2022, details the new arrangements for enhanced collaborative clinical and care support for Care Homes. This promotes a partnership approach, which recognises the experience of care home staff and the provision of support to care homes in the context of ensuring a homely environment in which people live and work. The note provides guiding principles and a framework which recommends that health and social care professionals continue to work together to identify ways to improve the health and wellbeing of people living in care homes. In light of this, the target going into 2023 will be focussed on collaborative working with care home managers and staff to ensure the service is supported in partnership as opposed to assurance teams having oversight of practice.

6.3 NHS HIS IPC Standards (May 2022)

The HIS HAI 2015 standards provide the core structure for inspection tools used by the Healthcare Environment Inspectorate (HEI) for hospital inspections. This was updated in 2022 to the HIS IPC Standards.

NHS Fife received no inspections during 2022

6.4 HAIRT reporting to Board

As part of the National HCAI Action Plan, all NHS Boards are required to provide a report on HAI during the public session of their bimonthly Board meetings, and to publish this on their website. A national HAI Reporting Template (HAIRT) produced by SGHSCD and revised in June 2010 has been used to update the NHS Fife Board. The report provides a spreadsheet of monthly case numbers and comparative data for ECB, CDI and SABs for individual acute hospitals, for community hospitals and for the community. It also highlights key actions and improvement work aimed at reducing these infections.

7.0 PROGRESS AGAINST INFECTION CONTROL PRIORITIES 2022

The Prevention and Control of Infection Work Programme 2022-23 is the NHS Fife delivery plan to comply with the national strategic objectives. The programme of work supports the National Quality Strategy ambitions as below.

National Quality Strategy ambitions

Patient centred

Control and prevention of HCAI measures will be proportionate and appropriate for the person receiving healthcare and the environment that healthcare is delivered.

Safe

A clean safe environment and the control and prevention of HCAI and antimicrobial resistance will reduce the risk of the population being exposed to or acquiring an HCAI (including resistant organisms) within any setting, that healthcare is delivered.

Effective

Control and prevention of HCAI measures and programmes, including prudent use of antimicrobial agents, surveillance, new technologies, education, training and research will support effective, equitable and consistent delivery of healthcare.

The *Prevention and Control of Infection Communications Plan 2021 - 2023* separately details how the Infection Prevention and Control Team communicate on a formal and informal basis with other colleagues, departments and the public.

7.1 Antimicrobial Prescribing and Resistance

AMR is a global concern. In January 2019, the UK Government published a vision for AMR in 20 years 'Contained and controlled: The UK's 20-year vision for antimicrobial resistance' and a five-year national action plan 'Tackling antimicrobial resistance 2019–2024'.

7.1.1 Antimicrobial Prescribing Guidelines

NHS Fife has an established antimicrobial management team (AMT) which reports to the NHS Fife Managed Services Drug and Therapeutic Committee. Minutes are provided to the ICC. The group last met June 2022 due to resource pressures.

The AMT has produced antimicrobial prescribing guidance since 2009 covering adult and paediatric prescribing in both primary and secondary care. Since 2014, the guidance is available as a Smartphone app and via a web viewer. Guidance is reviewed at least every 2 years but with the introduction of the app, it can now be updated instantly and this is done as required.

The aim of guidance is to restrict use of agents particularly associated with *Clostridioides difficile*, to limit the use of very broad-spectrum antimicrobial that may promote emergence of resistant strains, and to ensure that Scottish Antimicrobial Prescribing Group (SAPG) policy on hospital antimicrobial prescribing was met. Guidance takes into account local resistance data collected by the labs.

A protected antimicrobial list covering all wards has been in place since March 2009 and is updated annually or when required.

The antimicrobial pharmacist should maintain a database of all AMT guidelines with review dates to ensure they are reviewed every two years (or sooner if necessary), as per the most recent recommendation from SAPG. This activity has been necessarily displaced by activity related to the COVID-19 pandemic.

7.1.3 Antimicrobial Prescribing Education and Training

IPCT nurses promote the NES AMS workbook for nurses during induction/core update training. Information on the importance of appropriate antimicrobial use is communicated to all staff at NHS Fife Corporate Induction and Statutory Training.

7.1.4 Outpatient Parenteral Antimicrobial Therapy (OPAT)

The OPAT service contributes to prevention of healthcare-associated infections (such as MRSA and *Clostridioides difficile*) by allowing earlier discharge or admission avoidance for patients who would otherwise be confined to hospital solely for the delivery of intravenous antibiotic treatment.

The service also promotes the rational use of antimicrobials, and effective antimicrobial stewardship, through close clinical supervision by infection specialist doctors.

7.2 Cleaning, Decontamination and Estates

7.2.1 Cleaning and Estates Monitoring

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

The *National Cleaning Services Specification* – quarterly compliance report results for 2022 consistently showed NHS Fife achieving GREEN status for both cleaning and for estates monitoring. Results are reported bimonthly to the ICC via the HAIRT report.

7.2.2 Decontamination

The Decontamination Group meets quarterly and receives reports on primary care decontamination in dental Local Decontamination Units (LDU), endoscope decontamination in Endoscope Decontamination Units (EDU), and central decontamination delivered through a Service Level Agreement with Tayside CSSD.

7.2.2.1 Primary Care Decontamination

In NHS Fife, general practice instruments are either single-use or are decontaminated centrally and podiatry services moved to single–use instruments in 2010, so only dental services operate LDUs.

7.2.3 Estates - Equipment Procurement

Nominated IPCNs sit on National Procurement Commodity Advisory Panels (CAPs) and on Board procurement groups as part of NHS Fife's strategy for effective and safe procurement of a wide range of patient related equipment, soft furnishings, furnishings and medical devices.

7.2.3 Estates – Built Environment

The design of the built healthcare environment plays a fundamental role in infection prevention and control. The increasing threat of antimicrobial resistant organisms and other emerging pathogens in healthcare may present new and more difficult challenges in future healthcare facility design and planning efforts.

HAI-SCRIBE (Healthcare Associated Infection Systems for Controlling Risk in the Built Environment) aims to manage infection risks through the use of a prevention and control of infection questionnaire and a multi-disciplinary team of specialists with appropriate skills to ensure its implementation.

Throughout 2022, there continued to be a focus on reducing risk in the healthcare built environment - from the design, construction and adaptation phases of buildings and associated environments, to how they are occupied and maintained by the health care teams using them.

NHS Fife IPCT supported by providing specialist IPC advice to 2 capital projects:

- NTC Fife Elective Orthopedic Centre
- Lochgelly and Kincardine Health Centers

The IPCT have worked collaboratively with NHSScotland Assure Assurance, to ensure an overarching focus on IPC and infection risk during all stages of the building lifecycle review the design, construction and maintenance of major healthcare infrastructure developments within NHSScotland at key stages during the project lifecycle.

During 2022, NHS Fife created the new role of Senior IPC Nurse to provide specialist advice regarding the built environment and HAI-SCRIBE to a wide variety of staff within NHS Fife, including Executive and Non Executive Members, General Managers, Clinical Directors, Nursing and Medical staff, Project Managers, Architects and Estates Team. Funding was secured and the post successfully recruited to.

7.3 IPC Policy Guidance and Practice

7.3.1 Infection Control Manual

The NHS Scotland National Infection Prevention and Control Manual (NIPCM) first published on 13 January 2012, and was endorsed on 3 April 2017 by the Chief Medical Officer (CMO), Chief Pharmaceutical Officer (CPO), Chief Dental Officer (CDO) and Chief Executive Officer of Scottish Care.

The NIPCM provides guidance to all those involved in care provision and should be adopted for infection prevention and control practices and procedures. The national manual is mandatory for NHS Scotland. In all other care settings to support with health and social care integration the content of this manual is considered best practice.

The NIPCM currently contains guidance on; Standard Infection Control Precautions (SICPs) (Chapter 1), Transmission Based Precautions (TBPs) (Chapter 2), Healthcare Infection incidents, outbreaks and data exceedance (Chapter 3). Infection control in the built environment and decontamination (Chapter 4) was launched 2022. In addition to the core chapters, the NIPCM also contains multiple appendices and supporting materials which are constantly being updated as the evidence base evolves.

When an organisation adopts practices that differ from those recommended/stated in this national guidance, that individual organisation is responsible for ensuring safe systems of work, including the completion of a risk assessment(s) approved through local governance procedures.

The *NHS Fife Infection Control Manual* is available exclusively in electronic format on the NHS Fife StaffLink powered by Blink and NHS Fife external website.

As per **CNO (2012) 01**, Chapter 1 to 3 of the *National Infection Control Manual* are incorporated into the online NHS Fife manual with direct links. Further sections of the *National Infection Control Manual* will replace NHS Fife chapters as they are published.

Implementation of policy elements is monitored through the Infection Prevention and Control Team audit programme and Senior Charge Nurses fulfil the requirements for SICPs auditing laid down in **CNO (2012) 01** and later modified by the CNO letter of 17 May 12.

Manual sections sit under the overarching Infection Control Policy with the status of Standard Operating procedures (SOPs) which are updated on a rolling programme (every two years in line with HIS IPC Standards 2022).

7.3.2 HCAI Education, Training and Development Strategy: Mandatory and Continuing Education

The *HCAI Education, Training and Development Strategy* was developed to ensure that all staff had access to appropriate HCAI education and training. (Line managers are required to ensure all staff have HCAI objectives in their annual personal development plans).

The IPCT have strived to provide NHS Fife and Care Home staff with IPC education and training via a blended learning approach and exploring alternatives to face-to-face training. The IPCT have actively promoted the NES modules, which include eLearning- Respiratory protective equipment (RPE), presentations and webinars on COVID-19 and IPC.

IPCT have collaborated on several training presentations on topics relevant to staff, including outbreaks and terminal cleans. The presentations have been recorded with a voice over, available on StaffLink and can be accessed by all NHS Fife staff.

Throughout 2022, the IPCT have delivered education sessions via Microsoft Teams and face to face sessions when risk assessed. Sessions have included Grand Rounds and training at ward/department level.

HCAI education is a core component of corporate induction, nurse induction, junior doctors' induction, Consultant Mandatory Programme, and Core Update training programmes and is available as an e-learning module(s) on TURAS Learn. All NES developed e-learning programmes are available to staff on TURAS Learn.

7.3.3 Hand Hygiene

7.3.3.1 Trends

Publication of National Hand Hygiene Audit data ceased in Sept 2013 with Boards moving to reporting of data in their bimonthly HAIRT reports.

The IPCT carry out Hand Hygiene quality assurance audits as part of the *HCAI Prevention and Control of Infection Assurance Framework*.

7.4 Organisational Structures

7.4.1 Public Involvement

Historically a member of the public is invited to sit on the NHS Fife ICC and contribute to the outcomes of the committee, this is to be reviewed.

7.4.2 Communications

The IPCT has a *Prevention and Control of Infections Communications Plan*, which has been in place since June 2011 (updated accordingly). NHS Fife recognises the importance of having a comprehensive set of accurate, relevant and accessible information available for patients and the public. During the year, NHS Fife Communications Team has played a vital role in providing essential communications to the patients, visitors and population of Fife during the COVID-19 pandemic. Patient and public information leaflets on MRSA, *Clostridioides difficile,* Norovirus, Laundering of Patient Clothing, and Infection Control advice for Patients & Visitors have continued to be provided to wards and clinical areas. Leaflets on peripheral vascular devices, Vancomycin Resistant *Enterococcus* (VRE), Carbapenemase Producing *Enterobacteriaceae* (CPE) and MRSA screening are provided on a targeted basis to patients affected by these issues.

In addition to hard copy leaflets distributed to wards and clinics, these have been made available online to ensure that they are available for staff to use when briefing patients and visitors. Translation services are available on request.

In response to HEI requirements, and to ensure that all patients are provided with relevant HCAI information on admission, the general Infection Prevention and Control advice for Patients & Visitors leaflet is available to all clinical areas for distribution. Banner-stand posters aimed at both staff and visitors reinforce key HCAI messages.

7.5 Staff and Leadership

7.5.1 Structures and accountabilities

In October 2015, the IPCT was reorganised to comply with the *Vale of Leven Public Enquiry Report (2014)* recommendations. The IPC team returned to single system working managed by an Infection Control Manager with responsibility for a Fife wide service.

7.6 Quality Improvement

7.6.1 *Quality Improvement Programmes and partnership working with the Scottish Patient Safety Partnership (SPSP)*

During 2022, the IPCT worked collaboratively to support improvements in Urinary Catheter Care via the Urinary Catheter Improvement Group (UCIG).

UCIG update for 2022

To support a reduction in Catheter Associated Urinary Tract Infections & complications and to assist achieving the HCAI *E. coli* bacteraemia (ECB) reduction targets by 2022 & 2024, Fife established a Urinary Catheter Improvement Group (UCIG).

This multi-disciplinary and multi-agency programme works across all of Fife, both in the Acute Services Division (ASD) and the health and social care partnership (HSCP).

The aim of this work is:

- To minimise the incidence of urinary catheters
- To reduce avoidable harm from urosepsis and associated catheter trauma
- To optimise communication of care between all care disciplines & locations
- To optimise education around urinary catheter insertion & maintenance for health care workers, patients & carers
- To optimise documentation of urinary catheter care across Fife
- To improve quality & standardise pathways of urinary catheter care across the system
- To optimise the procurement of catheters & associated devices
- To ensure governance for all urinary catheters to ensure there is robust, accessible, consistently applied and measures (process and outcome) are reported reliably and consistently to provide assurance and data for improvement.

People Who Inject Drugs (PWID) SAB Project Update for 2022

A significant increase in the total number of SAB infections were identified in people who inject drugs (PWID) in 2022. 11 cases in total were identified, more than doubling the total of 5 in 2021. This worrying trend is further supported by anecdotal evidence from addictions services and third sector organisations across the country. It is reported that these services are observing worsening injection sites which may be a result of injectors using new and different combinations of drugs. The IPC aim for 2022 was to focus on supporting NHS Fife Addictions Service to complete and implement the agreed pathway for the assessment and treatment of injection site infections. This included refresher training via an online presentation accessed by individuals in the service and support with the re-implemention of the injection site assessment questionnaire.

7.7 Surveillance

7.7.1 Surgical Site Infection (SSI)

A CNO letter on 25 March 2020 advised of changes to HAI surveillance requirements with temporary changes to routine surveillance:

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

7.7.1.1 Caesarean section

Due to the COVID-19 pandemic, there has been a temporary pause on SSI surveillance, until further notice from Scottish Government. Maternity Services have continued to monitor their Caesarean Section SSI cases liaising with the IPCT.

7.7.1.2. Hip Arthroplasty

All Orthopaedic surveillance has been postponed due to the COVID19 pandemic until further notice as per CNO letter

7.7.1.3. Large Bowel

All Large Bowel surveillance has been postponed due to the COVID19 pandemic until further notice as per CNO letter

7.7.1.4.a **Standards on Reduction of Healthcare Associated Infections**:

DL (2022) 13, published on the 11th May 2022, advised reductions standards for Healthcare Associated Infections for CDI, SAB and ECB as outlined in DL (2019) 23 are to be extended by one year as a result of the COVID-19 response. Please see below for new LDP Standards.

For *E. coli* bacteraemia (ECB)

- New LDP standards are to reduce incidence of healthcare associated ECB by **25%** from 2019 to 2023, utilising 2018/19 as baseline data

Table 1: **25% reduction ECBs - 2022**

1) 25% reduction ECBs – 2022/23		
New standards for reducing all Healthcare Associated ECB by 25% by 2022/23 (from 2018/2019 baseline)		
Standards application for Fife:	**ECB Rate Baseline 2018/2019**	**ECB 25% reduction target by 2023**
ECB by rate 100,000 TBDs	**44.0** per 100,000 TBDs	**33.0** per 100,000 TBDs
ECB by Number of HCAI cases	**160**	**120**

For *Clostridioides difficile* infection (CDI)

- New LDP standards are to reduce incidence of healthcare associated CDI by **10%** from 2019 to 2023, utilising 2018/19 as baseline data

Table 2: **New standards for reducing all Healthcare Associated CDI by 10% by 2023 (from 2018/2019 baseline)**

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 2023**
CDI by rate 100,000 Total bed days	**7.2** per 100,000 TBDs	**6.5** 100,000 TBDs
CDI by Number of HCAI cases	**26**	**23**

For *Staphylococcus aureus* bacteraemia (SABs)

- New LDP standards are to reduce incidence of healthcare associated SAB by **10%** from 2019 to 2023, utilising 2018/19 as baseline data

Table 3: **New standards for reducing all Healthcare Associated SAB by 10% by 2023 (from 2018/2019 baseline)**

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 2023**
SAB by rate 100,000 Total BDs	**20.9** per 100,000 TBDs	**18.8** 100,000 TBDs
SAB by Number of HCAI cases	**76**	**68**

7.7.2 Escherichia coli Bacteraemia (ECB)

Escherichia coli (E. coli) bacteria are frequently found in the intestines of humans and animals. There are many different types of *E. coli,* and while some live in the intestine quite harmlessly, others may cause a variety of diseases. The bacterium is found in faeces and can survive in the environment. *E. coli* bacteria can cause a range of infections including urinary tract infection, cystitis (infection of the bladder), and intestinal infection. *E. coli* bacteraemia (blood stream infection) may be caused by primary infections spreading to the blood. Bloodstream infections with *E. coli* are widespread in NHS Fife and were identified in patients in hospitals, care homes, under social care and the wider community.

Nationally during 2022, there were 5,506 cases of ECB in Scotland with a rate of 77.0 per 100,000 population. There has been a 3.5% year-on-year decrease over the last 5 years, however the rate remained stable between 2021 to 2022. Healthcare associated ECB saw an 8.2% decrease in the rate between 2021 and 2022. Whereas for hospital acquired and community associated the rates remained stable between 2021 and 2022.

Locally during the surveillance period of 2022 there was a total of 280 ECB. Bloodstream infections with *E. coli* are widespread in NHS Fife and were identified in patients in hospitals care homes, community and under social care.

The ECB epidemiology in this report occurred during the SARS-CoV-2 pandemic and must be considered in this environment. During the third year of the pandemic services were disrupted and this may have influenced the number of hospital acquired ECB.

COMMENTS

- There was a 12.4% increase in the number of ECB in 2022 compared to 2021.
- The age range for an *E. coli* bloodstream infections is skewed towards the over 50s with the peak of infections occurring in the age range 80-89 years of age. This possibly reflects the age of patients with most co-morbidities.
- In both hospital acquired infections and non-hospital acquired infections the renal tract is the major source of infection with lower UTI the major entry point.
- Hospital patients account for16.4% of the total ECB. This is down from ~20% in 2021.
- In non-hospital acquired infections hepato-biliary infections are the second most common cause of an ECB followed by the “Not known” category.
- NHS Fife had higher annual rates of community associated ECB compared with the Scottish average rate.
- Catheters account for 26.27% of all healthcare associated infections.

Recommendations

- Reducing ECB to achieve the LDP will require infection prevention measures in hospitals and in the Health and Social Care Partnerships to reduce CAUTI.
- To reduce the total number of ECB and reduce hospital admissions, quality improvement programs need to focus on greater awareness and improved management of UTI, CAUTIs and hepato-biliary infections: to prevent these infections developing into bloodstream infections.
  (See Appendix 1: ECB Annual report for full details)

7.7.3. *Clostridioides difficile Infection* (CDI)

Clostridioides difficile is a bacterium found in people's intestines. Healthy people may have in gut flora, where it causes no symptoms. However, it may cause disease when the normal bacteria in the gut are disadvantaged, usually by antibiotics. When *C. difficile* is able to multiply this allows its toxins to reach levels where it attacks the intestines and causes mild to severe diarrhoea. *C. difficile* can lead to more serious infections of the intestines with severe inflammation of the bowel.

Nationally during 2022, 1,053 cases of CDI in patients aged 15 years and older were reported in Scotland. While there has been a 4.0% year-on-year decrease over the last 5 years, the rate has remained stable between 2021 and 2022. This decrease has been evidenced in Healthcare associated and hospital acquired CDI, while community associated CDI rate has remained stable between 2021 -2022.

Locally, NHS Fife & Fife Health & Social Care Partnership has seen a steady reduction in the number of CDI cases during the past 5 years. Much improvement work has taken place to ensure a better outcome for patients and service users. Surveillance focuses on looking at patient risk factors for developing CDI and ensuring appropriate feedback/information is provided to those responsible for the patients care. Antimicrobial stewardship remains an integral part, along with a continued strong focus on infection prevention and control measures.

RESULTS
Between 1st January and 31st December 2022 there were a total of 40 cumulative episodes of CDI in patients aged ≥ 15 years in Fife.
There were 16 hospital associated infection (HAI) CDI, 8 healthcare associated infections (HCAI) and 6 unknowns. Further to this, 10 CDI infections were community associated infections (CAI).
Of the 40 cases there were 4 episodes of recurrent CDI, and 1 case of previous infection. (Appendix 3: CDI Annual Report 2022).

COMMENTS

- Compared to 2021 there has been a 14.8% decrease in the total number of CDI.
- The proportion of hospital acquired CDI in 2022 was 40%
- In 2022 there were 4 recurrences of CDI and 1 case of previous infection

Management of recurrence of CDI for 2022
Patients with recurrent CDI are advised pulsed Fidaxomicin and are followed up until day 30 and day 90. The use of extended pulsed Fidaxomicin (EPFX) to address recurrences has shown a good outcome. In 2022, the sustained clinical cure rate was 72% with EPFX.
Commercial faecal transplant (FMT) is now available and NHS Fife will use this for recurrences that have failed first and second line treatments.
Bezlotoxumab is available only when FMT is contraindicated or if the patient is unable to tolerate the procedure.

Key areas to be addressed to achieve the HCAI CDI 10% reduction target by 2023
Continue stewardship advice where any inappropriate prescribing is identified. General advice against using of quinolones wherever possible is given to both GPs and hospital doctors as part of routine antibiotic advice.

Key actions for 2023
Continued surveillance and follow up of all CDI cases.

NHS fife will continue to use the EPFX regime for the high-risk groups to prevent recurrence.
Until August 2023 all cases have had sustained clinical cure with EPFX. Further cases on EPFX are due for review in October 2023 pending completion of treatment.
(Full report Appendix 3: Annual report: *Clostridioides difficile* infection **(**CDI) in NHS Fife from 1st January 2022 to 31st December 2022)

7.7.4 *Staphylococcus aureus Bacteraemia (SAB)*

Staphylococcus aureus is a bacterium that commonly exists on human skin and mucosa without causing any problems. It can also cause disease, particularly if there is an opportunity for the bacteria to enter the body, for example through broken skin or a medical procedure. If the bacteria enter the body, illnesses, which range from mild to life-threatening may then develop. These include skin and wound infections, infected eczema, abscesses or joint infections, infections of the heart valves, pneumonia and blood stream infection (bacteraemia).

Nationally during 2022, 1,590 cases of SAB were reported in Scotland, with 3.1% reported as meticillin resistant S. aureus (MRSA) bacteraemias and 96.9% as meticillin sensitive S. aureus (MSSA) bacteraemias. For both MSSA and MRSA the rate has remained stable between 2021 and 2022. The incidence rate year-on-year trend over the last 5 years of MSSA and MRSA has remained stable over this time period.

The SAB epidemiology in this report occurred during the third year of the SARS-CoV-2 pandemic and must be considered in this environment. During the third year of the pandemic the Health Board has tried to maintain elective surgical program and during October there was a move away from pandemic measures. However there were still high numbers of ward closures in both the ASD and HSCP which influenced the number of hospital admissions.

RESULTS
Locally during 2022 in NHS Fife there was a total of 92 SAB. 86 SAB were identified in the Victoria Hospital and three were acquired in Queen Margaret Hospital. Two patients had their *S. aureus* bloodstream infection identified in other HSCP hospitals. One patient under the care of Hospital at Home acquired a *S. aureus* bacteraemia.

COMMENTS

1. Compared to 2021 there has been a 15% increase in the number of SAB.
2. In 2022 there were no MRSA bacteraemia. **NHS Fife has achieved the local improvement target** set by the ICC for ≤5% of total *S. aureus* bacteraemia to be due to MRSA.
3. The proportion of hospital acquired SAB in 2022 was 35.9% which was slightly less than the 37.5% in 2021
4. The proportion of VADs resulting in a hospital acquired SAB in 2022 was 18.18%. This is the lowest proportion on record. **NHS Fife has achieved the local improvement target** set by the ICC of ≤35% of hospital acquired SAB due to VAD.
5. Three SAB were associated with PVC. **NHS Fife has achieved the local improvement target** set by the ICC.
6. When the entry point was identified, skin and soft tissue infections (SSTI) along with IVDA sites were the primary cause of non hospital acquired SAB. The number of

non-hospital SAB due to Illicit IV drug has more than doubled in 2022 to 11 from 5 episodes in 2021. This is a significant increase

7. Areas where effort needs to be focused to reduce SAB further; Medical devices including vascular access devices and non-VA medical devices, skin & soft tissue infections plus people who inject drugs.
8. SAB where the entry point is not known remain a significant problem and accounted for 19.56% percent of the total in 2022

(See Appendix 2: Annual SAB Report for full details).

- ***7.7.5 National MRSA and CPE screening programme***

The MRSA Screening Key Performance Indicator (KPI) for 2022 remains set as '*90% of all acute admissions must have CRA within 24 hrs of admission'.*

Table 6: MRSA CRA Compliance to end 2022

MRSA

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

Quarter	Q1 2022 Jan-Mar	Q2 2022 April- June	Q3 2022 Jul-Sept	Q4 2022 Oct-Dec
Fife	98%	98%	98%	100%
Scotland	81%	80%	78%	74%

Table 7: CPE CRA Compliance to end 2022

CPE (*Carbapenemase Producing Enterobacteriaceae*)

For 2022, CRA has also included screening for CPE

Quarter	Q1 2022 Jan-Mar	Q2 2022 April- June	Q3 2022 Jul-Sept	Q4 2022 Oct-Dec
Fife	100%%	98%	100%	100%
Scotland	80%	79%	78%	76%

Compliance with MRSA and CPE CRA completion fluctuates however is predominantly above the Scottish national average and continuously well above the 90% compliance target in 2022 (Table 6 & 7). With the IPC worked closely with Excellence in Care and Digital Information, developed a national tool for Multi-Drug Resistant Organisms surveillance, which is be used locally. This tool supports a consistent pathway for the clinical risk assessment of patients and patient placement.

7.7.7 Outbreaks and Incidents

7.7.7.1 Norovirus

The year of 2022 saw 5 outbreaks of Norovirus and 1 GI outbreak with pathogen unknown.

7.7.7.2 Other Outbreaks

For the year of 2022 there were 3 wards/bays closed due to Influenza, and 1 Respiratory Syncytial Virus (RSV) outbreak.

7.7.7.3 COVID-19 Clusters and Incidents related to healthcare

The IPCT provided support to clinical teams to investigate and implement control measures during the COVID-19 pandemic which saw a significant increase in incidence of COVID-19 respiratory illness. There were 129 incidents/clusters that involved patients and/or healthcare workers, this was a significant increase from the 37 outbreaks the previous year.

7.7.8 Infection Control Audits

The IPC audit programme provides assurance to the organisation that the required HAI standards are being met board wide. The focus is on intelligence led auditing which will assist in validating the ward level audit programme and ensure a consistent approach is taken.

A two-year rolling programme was initially commenced in August 2016 and again in 2018; which encompasses all divisions and a wide range of clinical areas.

The IPC nurses prioritise areas where issues with compliance have been identified through either observation or other assurance processes provided by other services within the board.

Monitoring and reporting of Estates issues is conducted by the domestic teams as part of NHS Scotland National Cleaning Standards monitoring and Quality Assurance team undertake additional audits.

Auditing of Standard Infection Control Precautions including hand hygiene is the responsibility of Senior Charge Nurses (SCNs).

7.7.9 2021 Surveillance Summary:

- Surgical Site Infection (SSI) rates pause to national programme.
- *Escherichia coli* bacteraemia (ECB), NHS Fife witnessed an increase in the total number of cases in 2022 compared to 2021. NHS Fife was above Scottish average rates for community associated ECB. Lower Urinary tract Infections (UTIs) and Catheter associated UTIs (CAUTIs) remain the prevalent source of ECBs and are therefore the two areas to address to reduce the ECB rate.
- *Clostridioides difficile* infection (CDI) rates continue at a low level, achieving rates below the national average: for HCAI Infection Rate and community associated infection rates. Pioneering work to reduce incidence of recurrent infection introduced in 2019 has continued.
- The total number of SAB rate for NHS Fife in 2022, was higher than 2021. There were no MRSA bacteraemias identified in 2022, the sixth consecutive year where the proportion of invasive MRSA has been less than 5%.

- 2022 saw 3 influenza outbreaks and 1 RSV outbreak.
- 2022 saw 5 norovirus outbreaks and 1 GI outbreak with unknown pathogen.
- COVID-19 incidents and clusters – NHS Fife reported 129 incidents to ARHAI Scotland in 2022.

8. REFERENCES

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Appendix 1:

Annual report: *E. coli* bacteraemias (ECB) in NHS Fife from 1st January 2022 to 31st December 2022
Dr Keith Morris, Microbiologist & Infection Control Doctor

INTRODUCTION
The report demonstrates the *E. coli* bacteraemia (ECB) epidemiology in 2022. The Infection Control Committee are asked to **note** this report and clinical directors and general managers should **act** on the conclusions to further reduce the number of *E. coli* bacteraemia.

Data for this report has been obtained from surveillance carried out by consultant microbiologists and the Infection Control Surveillance Audit Nurses in NHS Fife. During the surveillance period there was a total of 280 ECB. Bloodstream infections with *E. coli* are widespread in NHS Fife and were identified in patients in hospitals care homes, community and under social care.

The ECB epidemiology in this report occurred during the SARS-CoV-2 pandemic and must be considered in this environment. During the third year of the pandemic services were disrupted and this may have influenced the number of hospital acquired ECB.

RESULTS

Between 1st January and 31st December 2022 there were 280 episodes of ECB. 137 occurred in males and 143 occurred in females. Figure 1 demonstrates the trend in the number of ECB over the last seven years split by gender.

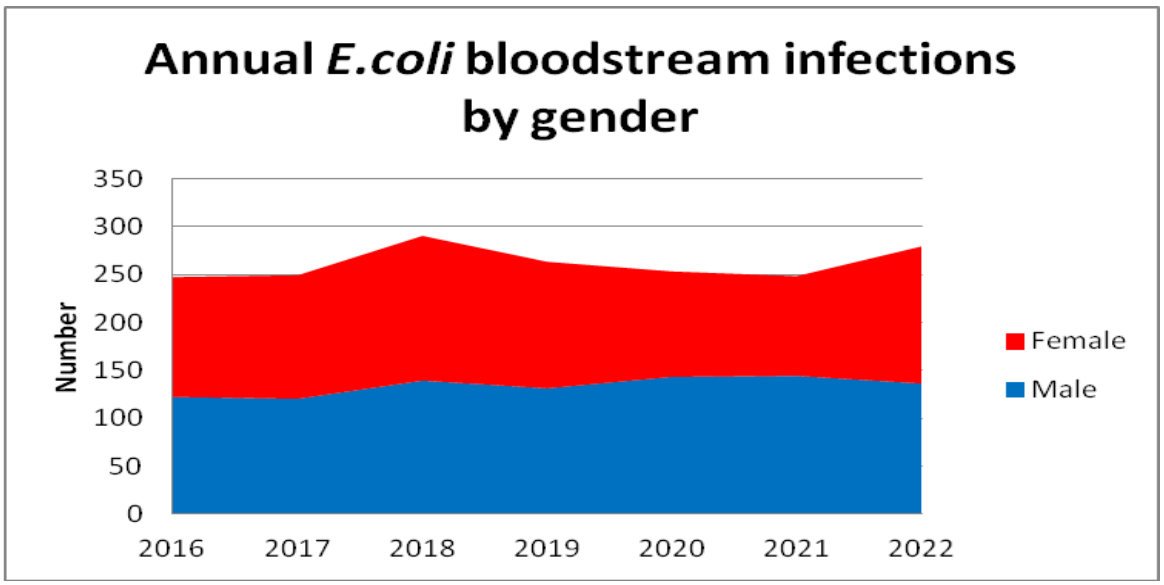


Figure 1: Trend in ECB by gender

Appendix 1 demonstrates that gender does have a role to play in the entry points for ECB. Males are more likely to have a urethral catheter as the cause of an ECB, while lower UTI as an entry point is more common in women.

Figure 2 demonstrates that the number of ECB increases with age.

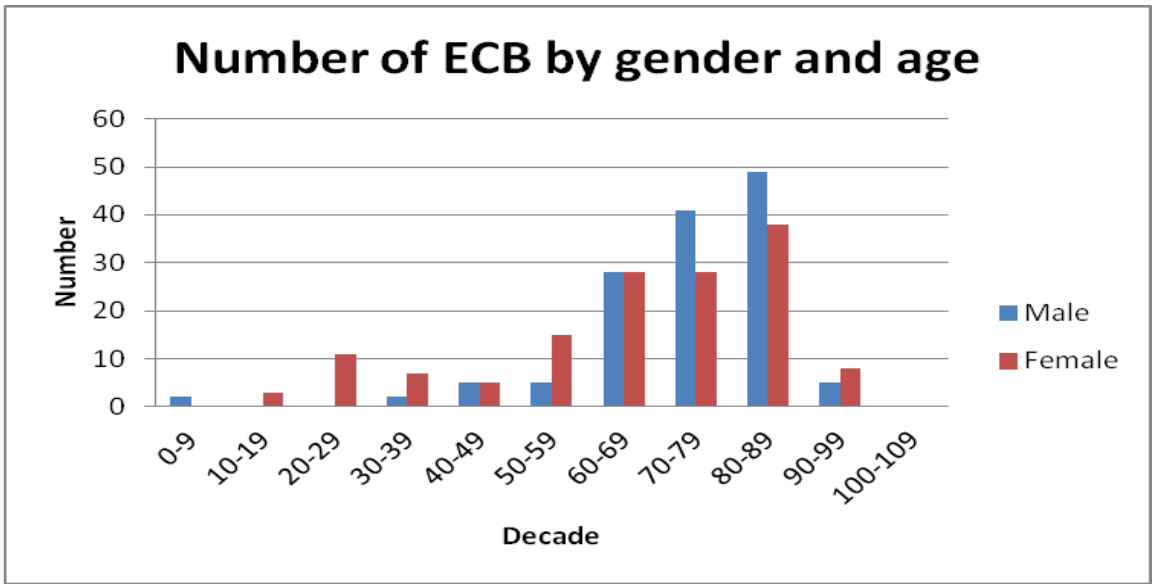


Figure 2 number of ECB by decade of life

46 (16.4%) of ECB episodes were hospital acquired and 236 (83.6%) were non hospital acquired. Non hospital ECB can be divided into Healthcare Associated Infection (HCAI) and community acquired infections.

Figure 3 demonstrates the trend between hospital acquired and non-hospital ECB over the last seven years.

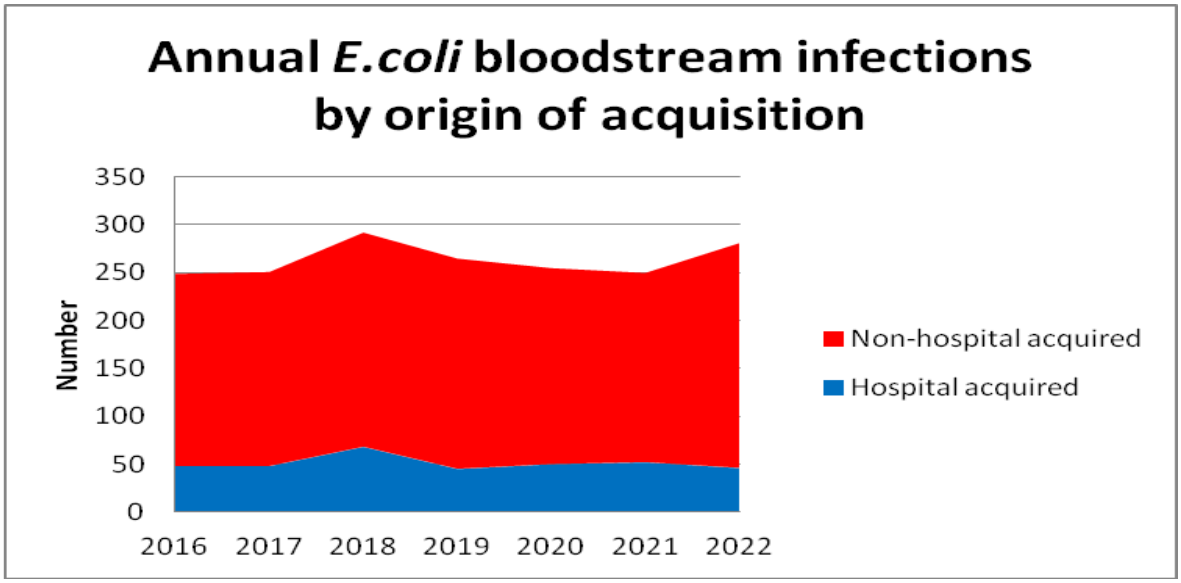


Figure 3: Annual ECB by origin of acquisition

Figure 4 presents data on the entry point of each hospital acquired ECB by system during 2022.

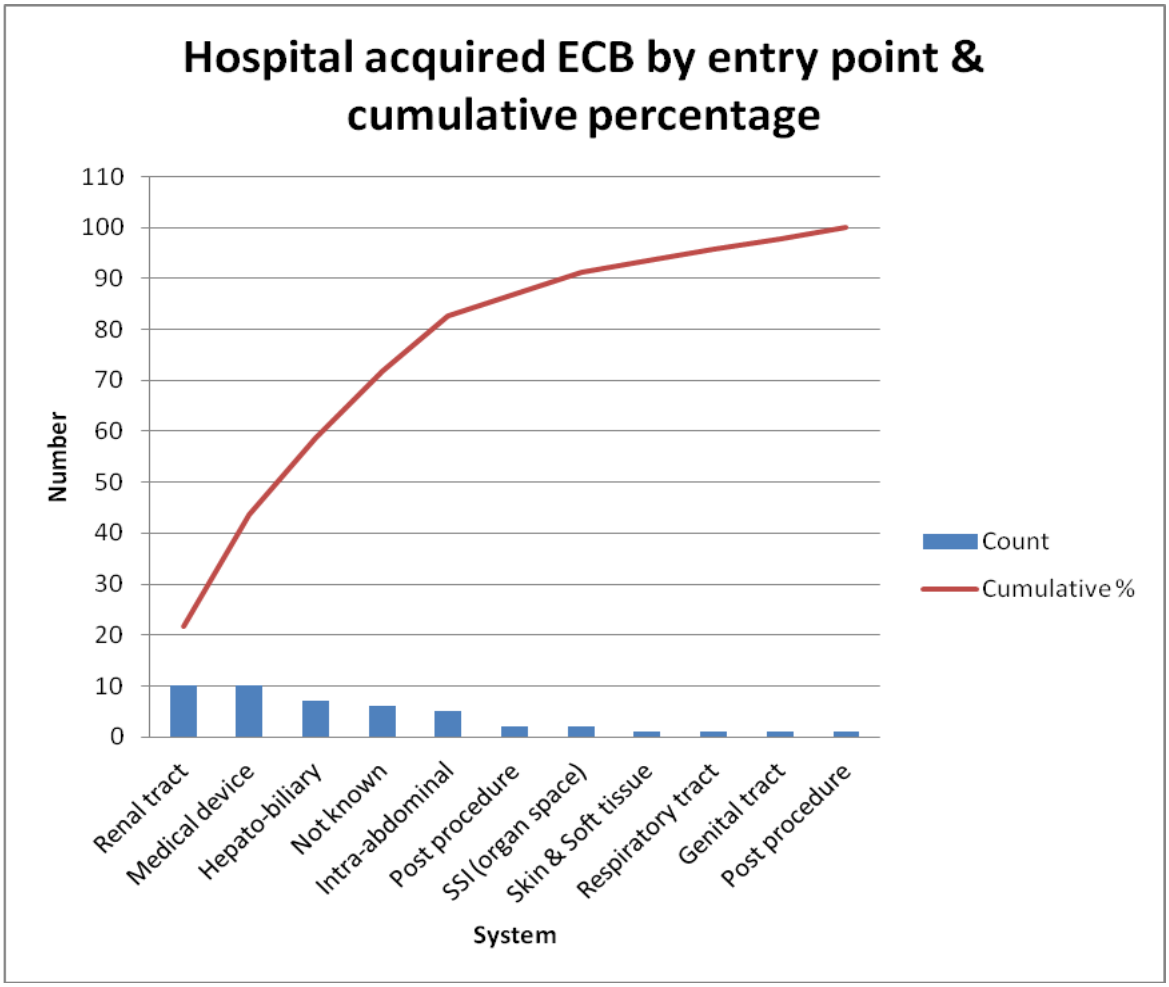


Figure 4: Pareto chart demonstrating the entry point by system of each hospital acquired ECB. More detail on the source of each ECB can be found in appendix 1.

Regarding hospital acquired infections; nine of the renal tract infection were due to cystitis and one was related to a urostomy infection. All 10 of the medical devices were due to urinary catheters.

Figure 5 presents data on the entry point of each non hospital acquired ECB episode during 2021.

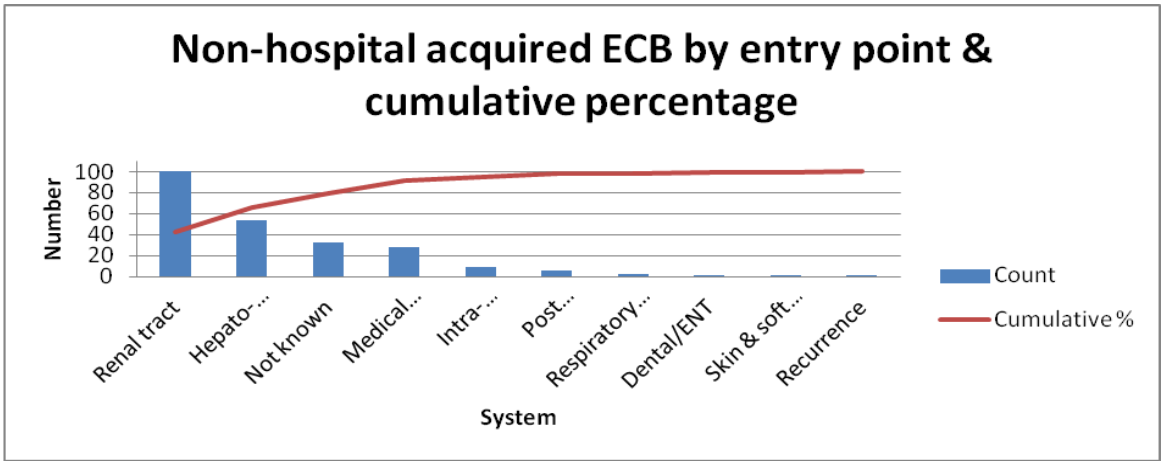


Figure 5: Pareto chart demonstrating the entry point by system of each non hospital acquired SAB.

Regarding the non-hospital acquired ECB; 64 of the renal tract infections were due to cystitis and 36 due to an upper urinary tract infection. There were 28 medical device related infections. 22 were due to urethral catheters, three were due to a nephrostomy, two were due to a supra-pubic catheter and there was one due to a sounding device.

COMMENTS

- There was a 12.4% increase in the number of ECB in 2022 compared to 2021.
- The age range for an *E. coli* bloodstream infections is skewed towards the over 50s with the peak of infections occurring in the age range 80-89 years of age. This possibly reflects the age of patients with most co-morbidities.
- In both hospital acquired infections and non-hospital acquired infections the renal tract is the major source of infection with lower UTI the major entry point.
- In non-hospital acquired infections hepato-biliary infections are the second most common cause of an ECB followed by the “Not known” category.
- Hospital patients account for16.4% of the total ECB. This is down from ~20% in 2021.
- Catheters account for 26.27% of all healthcare associated infections. Reducing ECB to achieve the LDP will require infection prevention measures in hospitals and in the Health and Social Care Partnerships to reduce CAUTI.
- To reduce the total number of ECB and reduce hospital admissions, quality improvement programs need to focus on greater awareness and improved management of UTI, CAUTIs and hepato-biliary infections: to prevent these infections developing into bloodstream infections.

NATIONAL LOCAL DELIVERY PLAN (LDP) TARGETS

The National LDP targets were redefined in October 2019 (see DL(2019) 23). The letter set out a reduction of 50% in healthcare associated E. coli bacteraemia by 2023/24, with an initial reduction of 25% by 2021/22. 2018/19 should be used as the baseline for E. coli bacteraemia reduction. In the letter healthcare associated ECB includes hospital acquired infections plus healthcare associated infection as described in the table in appendix 2.

In March 2023 a new DL was issued (DL(2023) 06) which reset the LDP as 25% reduction in healthcare associated ECB by 31st March 2024.

For the period 1st Apr 2018 to 31st Mar 2019 there were 160 healthcare associated ECB. Therefore 25% of 160 is 40. To achieve the LDP 25% reduction target there should be no more than 120 healthcare associated ECB for the period 1st Apr 2023 to 31st Mar 2024.

Appendix 1
System involved split by gender

System	Female	Male	Grand Total
Contaminant	1		1
Dental/ENT		1	1
Genital tract	1		1
Hepato-biliary	25	36	61
Intra-abdominal	7	7	14
Medical device	12	26	38
Not known	20	18	38
Other		1	1
Post procedure	2	6	8
Recurrence		1	1
Renal tract	72	38	110
Respiratory tract	2	1	3
Skin & soft tissue	1		1
SSI (organ space)		2	2
Grand Total	**143**	**137**	**280**

Appendix 2

Entry point for each ECB episode by origin

System	Community	%	Healthcare associated	%	Hospital acquired	%	Not hospital acquired, but ?HCAI or community	%	Grand Total	%
Contaminate					1	2.17			1	0.36
Dental/ENT			1	1.39		0.00			1	0.36
Genital tract					1	2.17			1	0.36
Hepato-biliary	46	28.57	8	11.11	7	15.22			61	21.79
Intra-abdominal	5	3.11	4	5.56	5	10.87			14	5.00
Medical device	7	4.35	21	29.17	10	21.74			38	13.57
Not known	21	13.04	10	13.89	6	13.04	1	100	38	13.57
Other					1	2.17			1	0.36
Post procedure			6	8.33	2	4.35			8	2.86
Recurrence			1	1.39		0.00			1	0.36
Renal tract	79	49.07	21	29.17	10	21.74			110	39.29
Respiratory tract	2	1.24			1	2.17			3	1.07
Skin & soft tissue	1	0.62				0.00			1	0.36
SSI (organ space)					2	4.35			2	0.71
Grand Total	**161**		**72**		**46**		**1**		**280**	

*The numbers in red highlight the three most common ECB by system

Appendix 2:

Annual report: *S. aureus* bacteraemias (SAB) in NHS Fife from 1st January 2022 to 31st December 2022

Dr Keith Morris, Consultant Microbiologist & Infection Control Doctor

INTRODUCTION

The report demonstrates the *S. aureus* bacteraemia (SAB) epidemiology in 2022. The Infection Control Committee are asked to **note** this report and clinical directors and general managers should **act** on the conclusions to further reduce the number of *S. aureus* bacteraemias.

Data for this report has been obtained from surveillance carried out by Dr Morris & Dr Griffith. During the surveillance period there was a total of 92 SAB. 86 SAB were identified in the Victoria Hospital and three were acquired in Queen Margaret Hospital. Two patients had their *S. aureus* bloodstream infection identified in other HSCP hospitals. One patient under the care of Hospital at Home acquired a *S. aureus* bacteraemia.

The SAB epidemiology in this report occurred during the third year of the SARS-CoV-2 pandemic and must be considered in this environment. During the third year of the pandemic the Health Board has tried to maintain elective surgical program and during October there was a move away from pandemic measures. However there were still high numbers of ward closures in both the ASD and HSCP which influenced the number of hospital admissions.

RESULTS

Between 1st January and 31st December 2022 there were 92 episodes of SAB. 92 (100%) were due to MSSA. There were no MRSA SAB. Figure 1 demonstrates the trend of SAB over the previous 15 years.

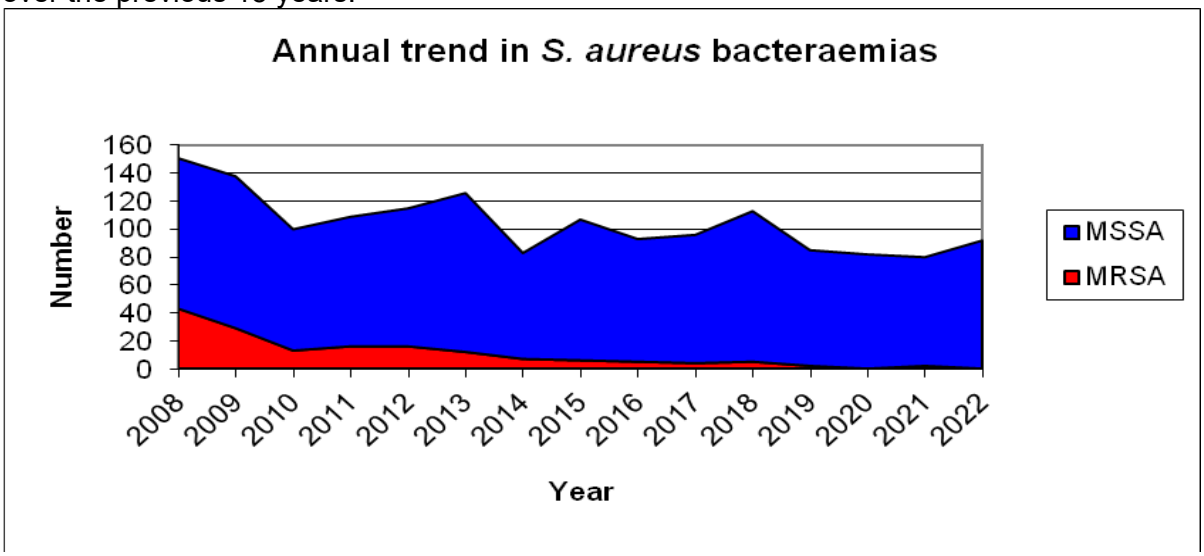


Figure 1: Trend in SAB

33 (35.9%) of SAB episodes were hospital acquired and 59 (64.1%) were non hospital acquired. Non hospital SAB can be divided into Healthcare Associated Infection (HCAI) and community acquired infections. Table 1 demonstrates the age and gender of patients with a hospital or non hospital acquired SAB

	Hospital acquired infection* (*n*=33) 35.9%	Healthcare associated infection* (*n*=16) 17.7%	Community Acquired infection* (*n*=43) 46.7%	Total SAB (*n*=92)
	n (%)	n (%)	n (%)	n (%)
Male	19 (57.6)	9 (56.3)	29 (67.4)	57 (62.0)
Female	14 (42.4)	7 (43.8)	14 (32.6)	35 (38.0)
Age: mean (Range) years	68.1 (35-92)	67.6 (24-95)	67.1 (0-92)	66.2 (0–95)
MRSA	0 (0)	0 (0.0)	0 (0.0)	0 (0.0)
MSSA	33 (100)	16 (100)	43 (0.0)	92 (0.0)

Table 1 Age, sex and susceptibility to meticillin of each SAB by origin

*The origin of a SAB is defined in the Enhanced *S. aureus* Bacteraemia Surveillance Protocol April 2016, Version 1.0

Figure 2 presents data on the entry point of each hospital acquired SAB during 2022.

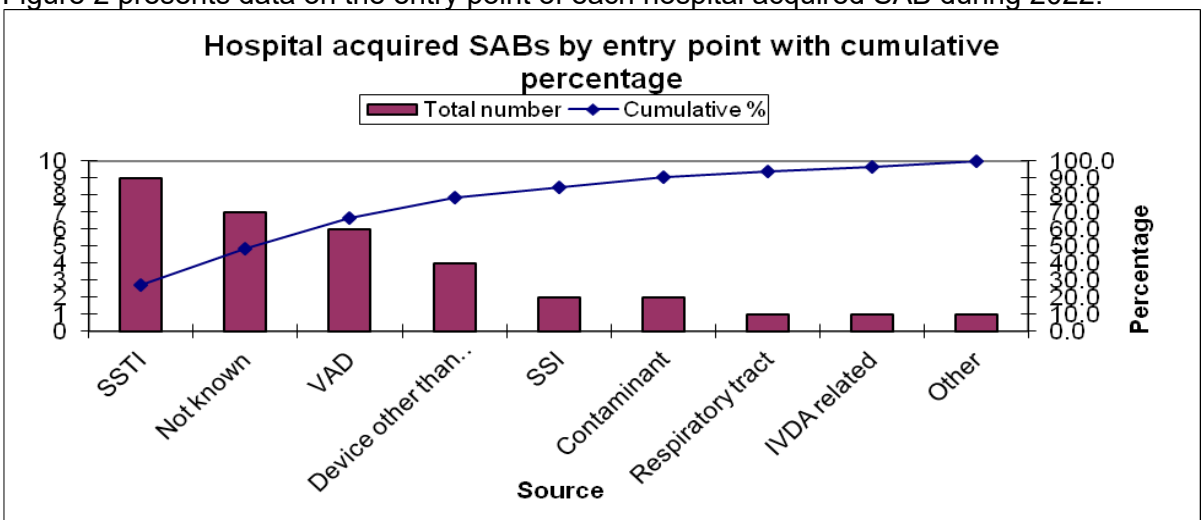


Figure 2: Pareto chart demonstrating the entry point of each hospital acquired SAB. VAD=vascular access device, Not known=entry point not identified, SSTI=soft tissue infection.

More detail on the source of each SAB can be found in appendix 1.

Figure 3 provides a breakdown of the different types of vascular access device for every hospital acquired SAB episode where a VAD was identified as the entry point for the bacteraemia.

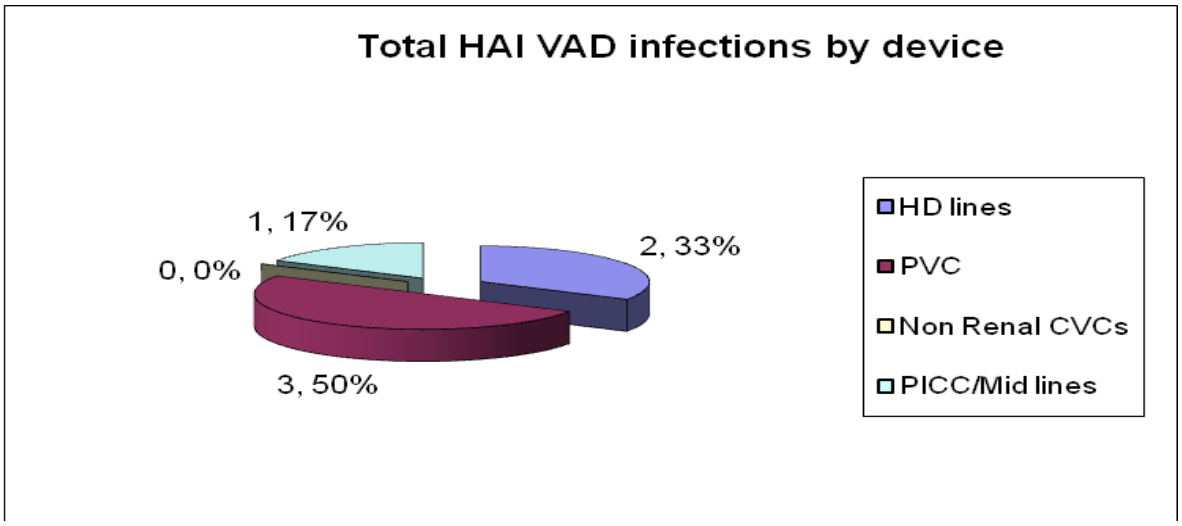


Figure 3: Types of VAD infection in 2022. PVC=peripheral vascular catheter, HD=haemodialysis, CVC-central venous catheter. PICC=peripherally inserted central catheter

Figure 4 demonstrates the trend in hospital acquired SAB over the last six years in relation to the entry point for the bacteraemia.

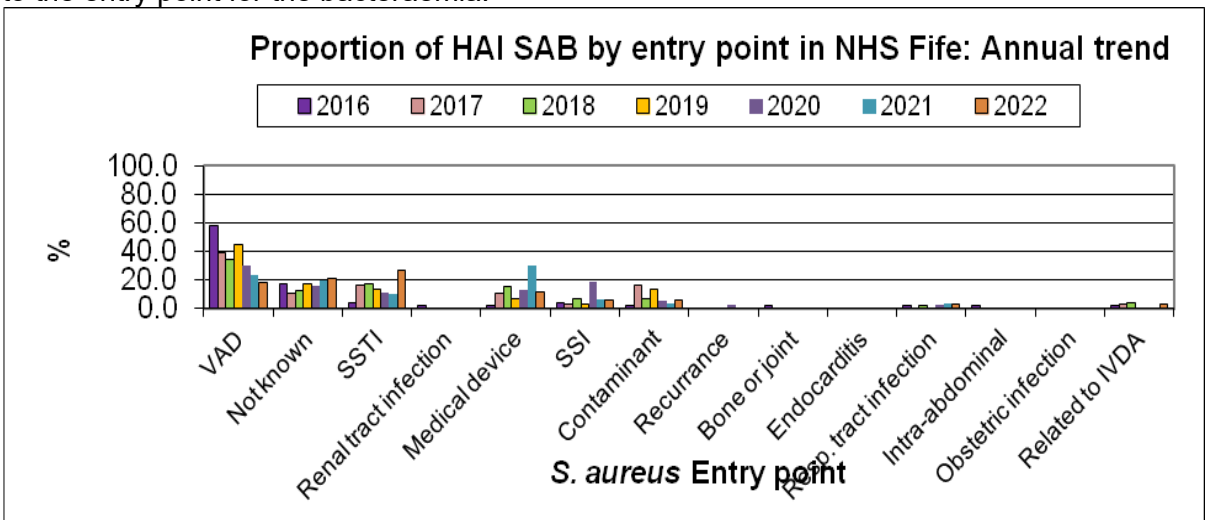


Figure 4: Trend in the entry point of hospital acquired SAB over seven years. VAD=vascular access device, Not known=entry point not identified, SSTI=soft tissue infection, SSI=surgical site infection

Figure 5 presents data on the entry point of each non hospital acquired SAB episode during 2022.

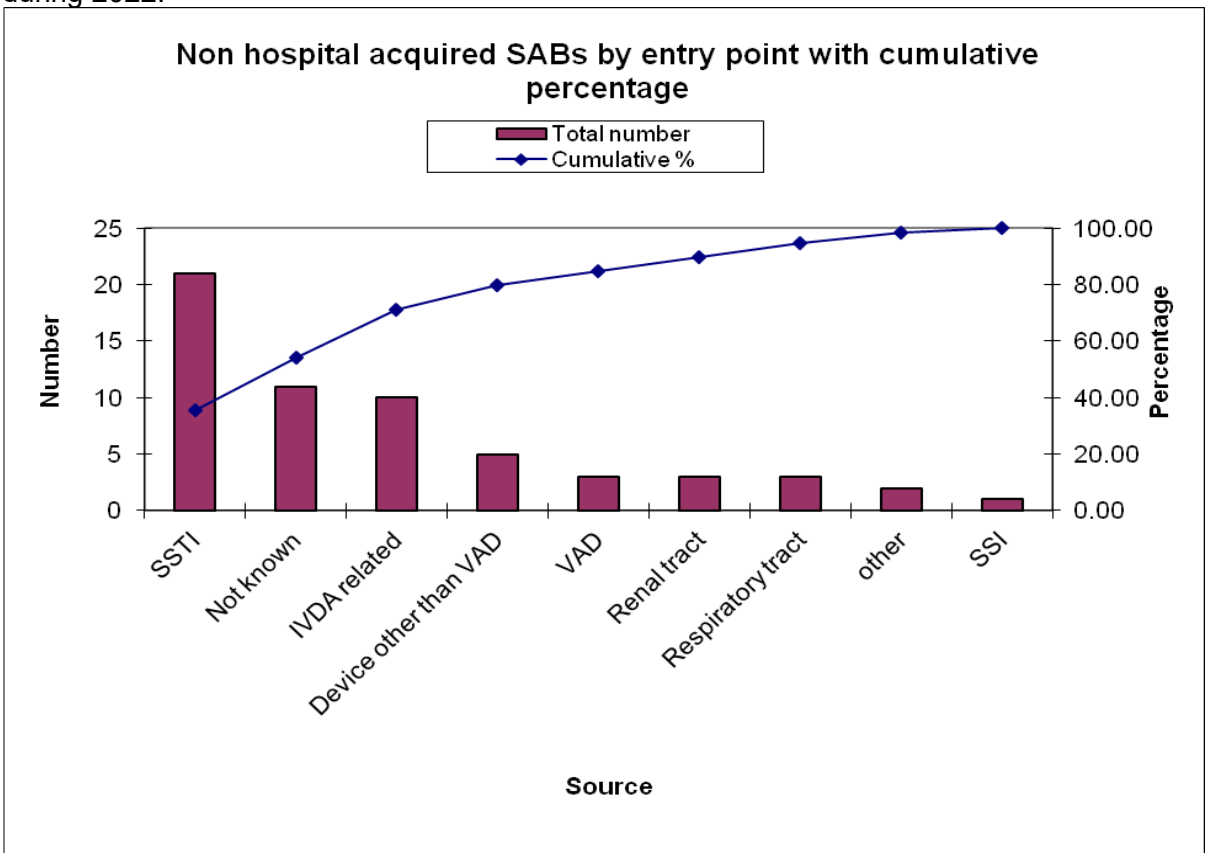


Figure 5: Pareto chart demonstrating the entry point of each non hospital acquired SAB. VAD=vascular access device, Not known=entry point not identified,.

COMMENTS

- Compared to 2021 there has been a 15% increase in the number of SAB.
- In 2022 there were no MRSA bacteraemia. **NHS Fife has achieved the local improvement target** set by the ICC for ≤5% of total *S. aureus* bacteraemia to be due to MRSA.
- The proportion of hospital acquired SAB in 2022 was 35.9% which was slightly less than the 37.5% in 2021
- The proportion of VADs resulting in a hospital acquired SAB in 2022 was 18.18%. This is the lowest proportion on record. **NHS Fife has achieved the local improvement target** set by the ICC of ≤35% of hospital acquired SAB due to VAD.
- Three SAB were associated with PVC. **NHS Fife has achieved the local improvement target** set by the ICC.
- When the entry point was identified, skin and soft tissue infections (SSTI) along with IVDA sites were the primary cause of non hospital acquired SAB. The number of non-hospital SAB due to Illicit IV drug has doubled in 2022 to 11 from 5 episodes in 2021. This is a significant increase
- Figures 2 & 5 indicate the areas where effort needs to be focused to reduce SAB further; Medical devices including vascular access devices and non-VA medical devices, skin & soft tissue infections plus people who inject drugs.

9. SAB where the entry point is not known remain a significant problem and accounted for 19.56% percent of the total in 2022

LOCAL TARGETS SET BY ICC

	Local targets first set in 2014	Review end 2021	Review end 2022
1	Meticillin resistant *S. aurues* to be ≤5% of total *S. aureus* bacteraemia.	2 (2.5%) MRSA bacteraemia **Target achieved**	No MRSA bacteraemia **Target achieved**
2	Vascular access device SAB to be ≤35% of hospital acquired SAB.	23.3% of HAI SAB due to VAD **Target achieved**	18.18% of HAI SAB due to VAD **Target achieved**
3	Total number of PVC related SABs to be halved compared with 2013. (Total in 2013 was 12)	Three PVC SAB **Target achieved**	Three PVC related SAB **Target achieved**

NATIONAL LOCAL DELIVERY PLAN (LDP) TARGETS

The National LDP targets were redefined in October 2019 (see DL(2019) 23). All Health Boards have to achieve a 10% reduction in Healthcare associated SAB by 2021/22 using 2018/19 as the base year. This requires NHS Fife to have no more than 66 Healthcare associated SABs by 2021/22. However DL(2023) 06 extended the LDP deadline to 31st March 2023.

NOTE: Healthcare associated SAB referred to in the DL (2019) 23 include hospital acquired SAB plus Healthcare associated SAB discussed defined in this report.

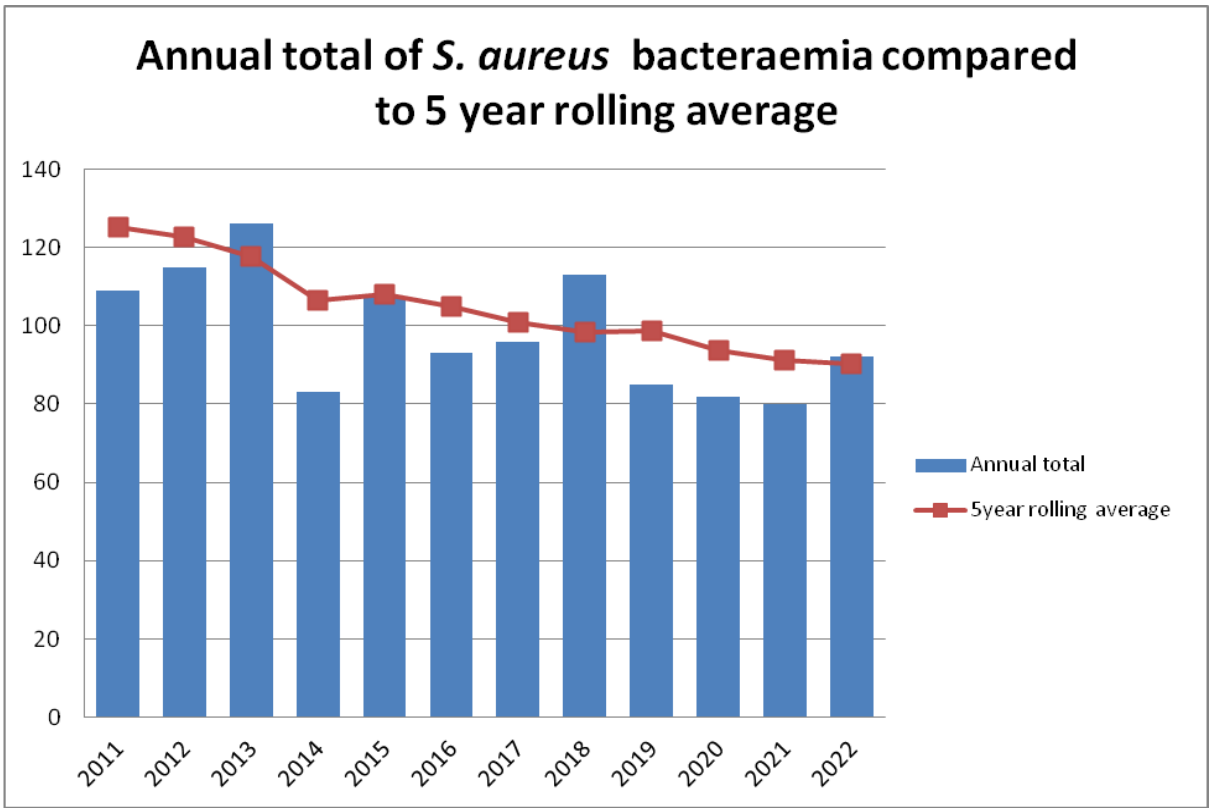
Appendix 1
Entry point for each SAB episode by origin

	Hospital acquired infection (n=33)	%	Healthcare associated infection (n=16)	%	Community acquired infection (n=43)	%	Total SABs by source (n=92)	%
Source								
Not known	7	21.2	3	18.8	8	18.6	18	19.6
Vascular access device							0	
Haemodialysis CVC	2	6.1					2	2.2
PVC	3	9.1					3	3.3
PICC/Midline	1	3.0	3	18.8			4	4.3
Portacath			1	6.3			1	1.1
Medical device other than VAD								
Urinary catheter	1	3.0	4	25.0			5	5.4
Nephrostomy	2	6.1					2	2.2
Arthroscopy	1	3.0					1	1.1
SSTI								
Skin break	5	15.2	1	6.3	9	20.9	15	16.3
Ulcer	3	9.1	2	12.5	3	7.0	8	8.7
Eczema					4	9.3	4	4.3
Cellulitis					1	2.3	1	1.1
Other	1	3.0			1	2.3	2	2.2
Surgical site infection								
Superficial					1	2.3	1	1.1
Deep	1	3.0					1	1.1
Organ or space	1	3.0					1	1.1
Bone or joint infection								
Miscellaneous								
Renal tract (UTI)					3	7.0	3	
Respiratory tract	1	3.0			3	7.0	4	4.3
Related to IV drug abuse	1	3.0			10	23.3	11	12.0
Contaminant	2	6.1					2	2.2
Other	1	3.0	1	6.3			2	2.2
Recurrence			1	6.3			1	1.1
Total	33		16		43		92	

Appendix 2
Trend data

Chart 1 demonstrates annual number of *S. aureus* blood stream infections compared to the five year rolling average. Identifies the long term trends set against the spikes and troughs of individual years. Using the 5 year rolling average a subjective judgement can be made on the Health Boards performance in any one year.

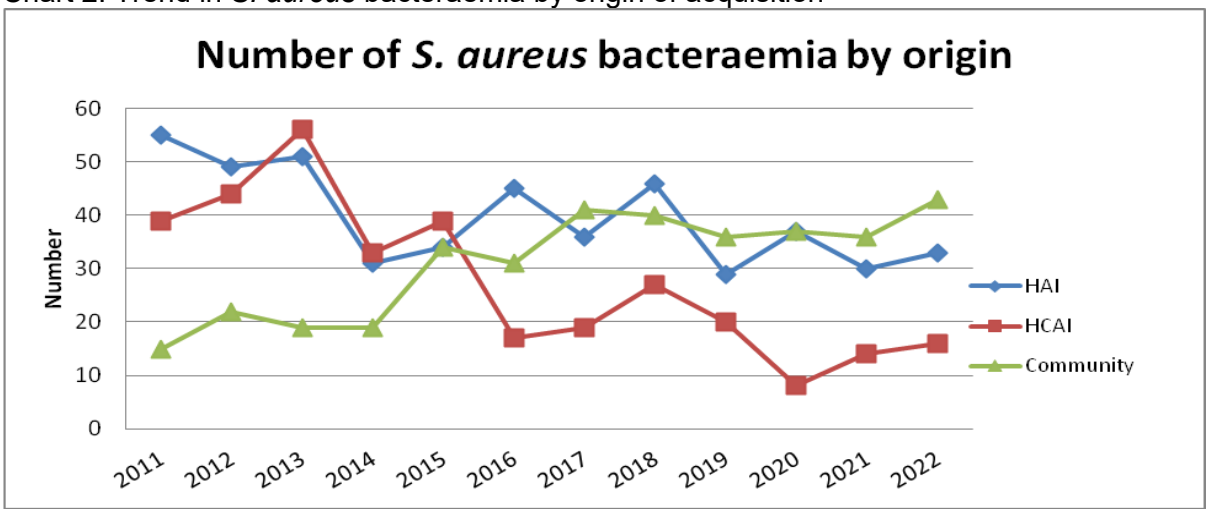
Chart 1: Fife year rolling average of SAB against annual total



Total number of SAB per annum	Performance rating
≥100	Poor
90-99	Average
80-89	Very good
70-79	Excellent

Chart 2 demonstrates the trend in *S. aureus* blood stream infection acquisition by patients and the healthcare sector which requires targeting to reduce the total annual number of *S. aureus* bacteraemia.

Chart 2: Trend in *S. aureus* bacteraemia by origin of acquisition



Appendix 3:

Annual report: *Clostridioides difficile* infection (CDI) in NHS Fife from 1st January 2022 to 31st December 2022

INTRODUCTION

The report demonstrates the *Clostridioides difficile* infection **(**CDI) epidemiology in 2022. The Infection Control Committee is asked to **note** this report and clinical directors and general managers should **act** on the conclusions to further reduce the number of CDI.

Data for this report has been obtained from surveillance carried out by the IPCT Surveillance and Audit Midwife and Dr Venkatesh. During the surveillance period there was a cumulative total of 40 CDIs.

The CDI epidemiology in this report occurred during the third year of the SARS-CoV-2 pandemic and must be considered in this environment. During the third year of the pandemic the Health Board has tried to maintain elective surgical program and during October there was a move away from pandemic measures. However there were still high numbers of ward closures in both the ASD and HSCP which influenced the number of hospital admissions.

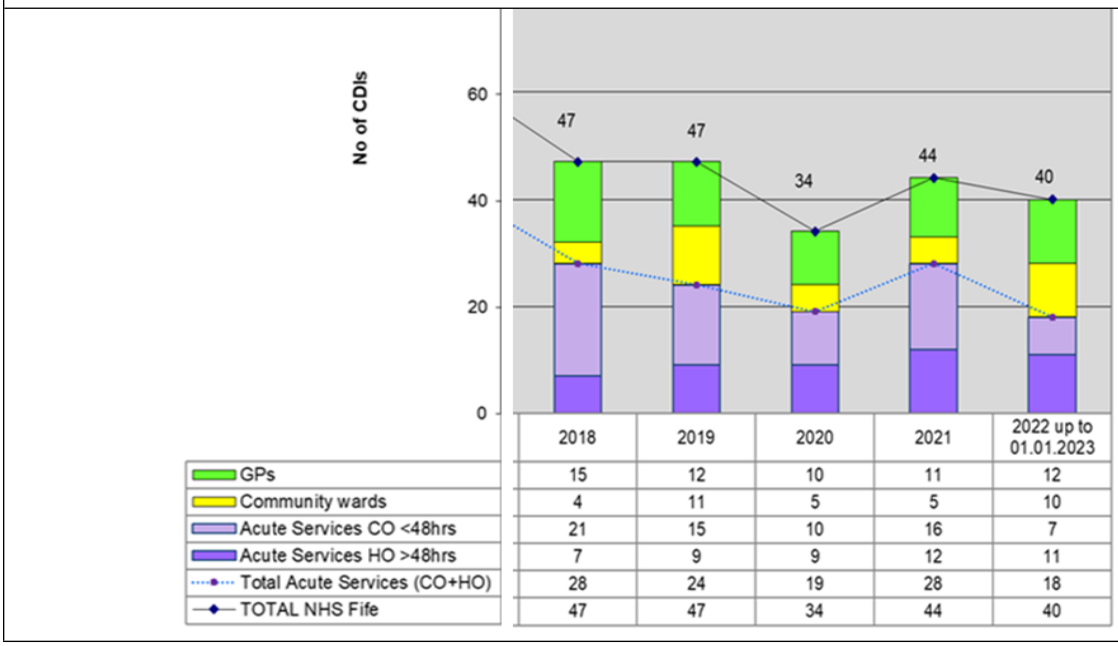
NHS Fife & Fife Health & Social Care Partnership has seen a reduction in the number of CDI cases during the past 5 years (see Figure 1). Much improvement work has taken place to ensure a better outcome for patients and service users. Surveillance focuses on looking at patient risk factors for developing CDI and ensuring appropriate feedback/information is provided to those responsible for the patients care. Antimicrobial stewardship remains an integral part, along with a continued strong focus on infection prevention and control measures.

Each improvement strategy has contributed to the overall reduction since 2018:-

- 14.8% overall reduction in total number of cases

Figure 1: CDI 2018 to 2022

NHS Fife Clostridiodies difficile Infections (CDIs) 2018-2022
By Acute Services (Split by HO/CO), Community Hospitalwards & GPs



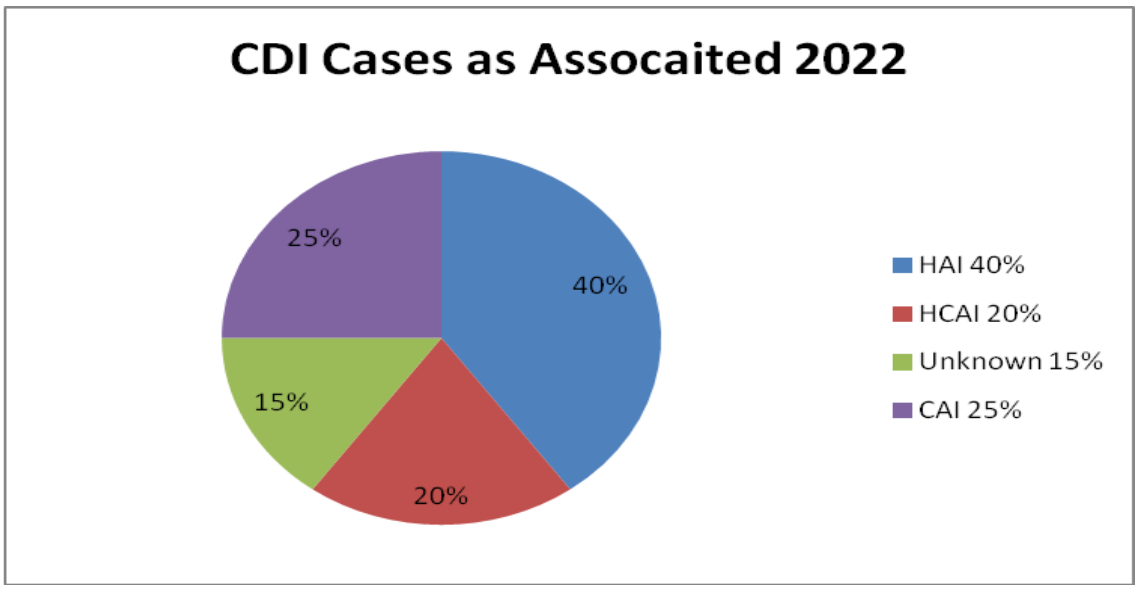
	2018	2019	2020	2021	2022 up to 01.01.2023
GPs	15	12	10	11	12
Community wards	4	11	5	5	10
Acute Services CO <48hrs	21	15	10	16	7
Acute Services HO >48hrs	7	9	9	12	11
Total Acute Services (CO+HO)	28	24	19	28	18
TOTAL NHS Fife	47	47	34	44	40

RESULTS

Between 1st January and 31st December 2022 there were 40 episodes of CDI in patients aged ≥ 15 years in Fife.

There were 16 hospital associated infection (HAI) CDI, 8 healthcare associated infections (HCAI) and 6 unknowns. Further to this, 10 CDI infections were community associated infections (CAI) (see Figure 2).

Figure 2: CDI cases as associated



Of the 16 HAIs, 12 were associated to the Victoria Hospital and 1 was acquired in each of the following community hospitals; Queen Margaret Hospital, St Andrews Hospital, Stratheden and Glenrothes hospital.

Of the 40 cases there were 4 episodes of recurrent CDI, and 1 case of previous infection (out with the case definition 8 week period), this is lower than the 5 cases of recurrent infections reported in 2021.

BREAKDOWN

16 (40%) of CDI episodes were hospital acquired and 24 (60%) were non hospital acquired. Non hospital CDI can be divided into Healthcare Associated Infection (HCAI), unknown and community acquired infections. Figure 3 Demonstrates the age and gender of patients with a hospital or non hospital acquired CDI.

Figure 3: Age, sex and infection by origin

	Hospital acquired infection* (*n*=16) 40%	Healthcare associated infection* (*n=8*) 20%	Community Acquired infection* (*n*=10) 25%	Unknown (n=6) 15%	Total CDI (*n*=40)
	n (%)	n (%)	n (%)	n (%)	n (%)
Age: (Range)	25-94	59-81	71-89	67-89	
Average age	68	69	80	78	
Single infection	15 (94%)	6 (75%)	10 (100%)	5 (83%)	36
Recurrent infection	1 (6%)	2 (25%)	0	1 (17%)	4

***The origin of a CDI is defined in the Protocol for the Scottish Surveillance Programme for Clostridium difficile Infection. User Manual 2017, Version 4.**

NATIONAL LOCAL DELIVERY PLAN (LDP) TARGETS

Standards on Reduction of Healthcare Associated Infections:
DL (2022) 13, published on the 11th May 2022, advised reductions standards for Healthcare Associated Infections for CDI, SAB and ECB as outlined in DL (2019) 23 are to be extended by one year as a result of the COVID-19 response.

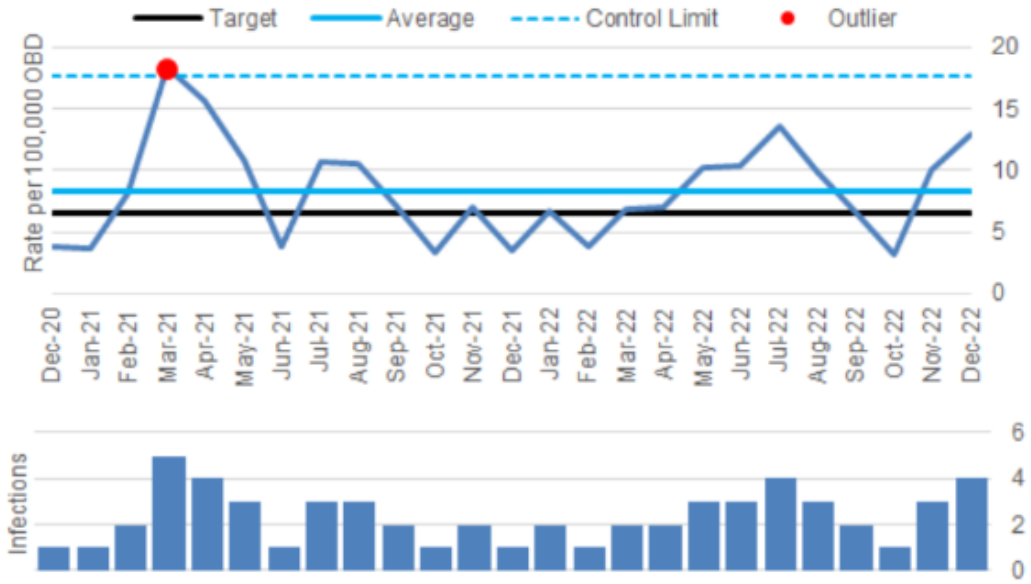
***Clostridioides difficile* Infection (CDI)**

- New LDP standards are to reduce incidence of healthcare associated CDI by 10% from 2019 to 2023, utilising 2018/19 as baseline data.
- Outcome measure - achieve 10% reduction by 2022/23 in healthcare associated infection rate - rate of 6.5 per 100,000 total bed days.

NOTE: Healthcare associated CDI referred to in the DL (2019) 23 include hospital acquired CDI **plus** healthcare associated CDI **plus** unknown CDIs as defined in this report.

Figure 4 demonstrates the challenge for NHS Fife to achieve the 10% reduction target by April 2023, with an increase in cases during the later quarter of 2022, the trajectory line was not met. It will remain an ongoing challenge for 2023, to further reduce Healthcare Associated CDIs, to meet the target reduction.

Figure 4 – NHS Fife 2021- 2022 CDI Monthly rate against the Improvement Trajectory



Each Fife CDI case is reviewed to ascertain risk factors for developing the infection. Figure 5 displays a breakdown of risk factors for HAI, HCAI, Unknown and CAI.
The highest risk factor is antibiotic therapy with 80 % of total cases.

The second highest risk factor associated with 48% of total cases was Proton Pump Inhibitors (PPI), immunosupression (25%), gastric history (15%) and lastly recurrent infections (10%).

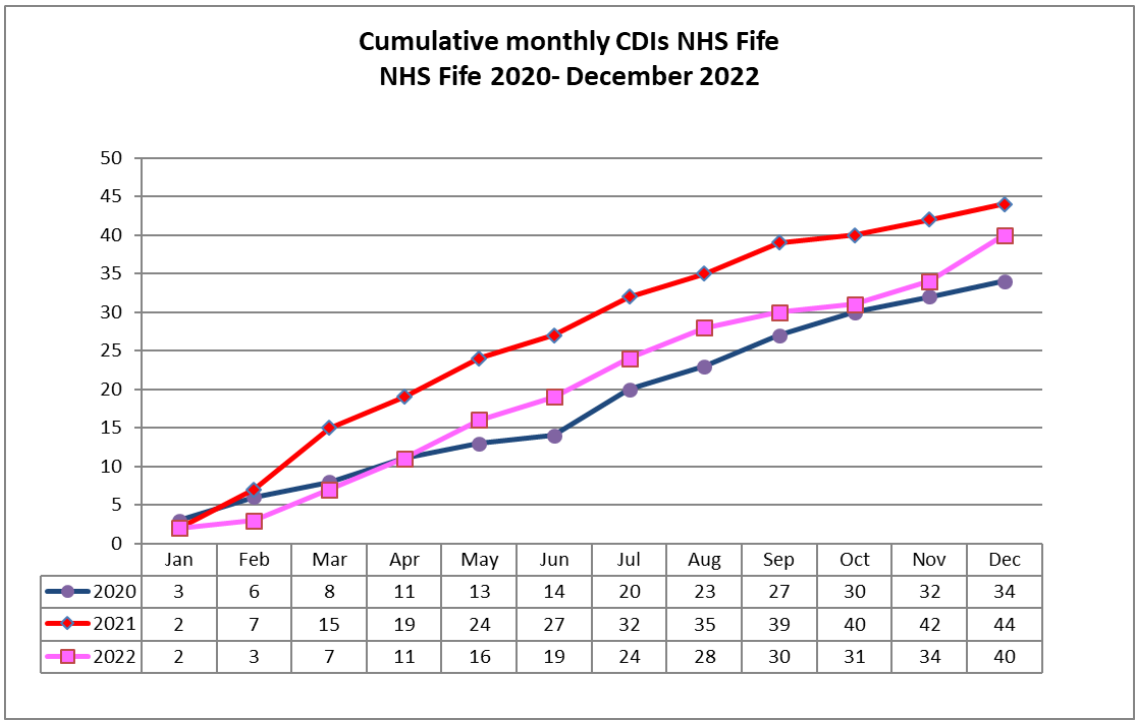
Figure 5 – CDI risk factors

	HAI (n=16)	%	HCAI (n=8)	%	Unknown (n=6)	%	CAI (n=10)	%	Total number 40	%
Antibiotic	15	94%	3	38%	6	100%	8	80%	32	80%
Gastric history	3	18%	2	25%	0	0	1	10%	6	15%
Immuno suppression	4	25%	3	38%	1	17%	2	20%	10	25%
PPI	4	25%	4	50%	5	83%	6	60%	19	48%
Recurrence	1	6%	2	25%	1	17%	0		4	10%

Trend data

Figure 6 demonstrates the annual number of *CDIs* compared to the previous 2 years. It shows that 2022 had a lower number of cases than during 2021, but a higher number from 2020.

Figure 6– CDI cumulative graph for 2020-2022 for all HCAI & CAIs



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2020	3	6	8	11	13	14	20	23	27	30	32	34
2021	2	7	15	19	24	27	32	35	39	40	42	44
2022	2	3	7	11	16	19	24	28	30	31	34	40

National context

From the ARHAI (Antimicrobial Resistance and Healthcare Associated Infection) 2022 Annual Report national comparison for overall year analysis, the annual incidence rate was 19.2 per 100,000 population. The rate has remained stable between 2021 and 2022. Fife has remained below the national comparator for each quarter in 2022.

COMMENTS

- Compared to 2021 there has been a 14.8% decrease in the total number of CDI.
- The proportion of hospital acquired CDI in 2022 was 40%
- In 2022 there were 4 recurrences of CDI and 1 case of previous infection

Dr P. Venkatesh, Consultant Microbiologist summary for 2022

Challenges identified in 2022

Recurrent CDI remains an ongoing challenge in NHS Fife.

Key areas to be addressed to achieve the HCAI CDI 10% reduction target by 2023

Continue stewardship advice where any inappropriate prescribing is identified. General advice against using of quinolones wherever possible is given to both GPs and hospital doctors as part of routine antibiotic advice.

Management of recurrence of CDI for 2022

Patients with recurrent CDI are advised pulsed Fidaxomicin and are followed up until day 30 and day 90. The use of extended pulsed Fidaxomicin (EPFX) to address recurrences have shown a good outcome. In 2022, the sustained clinical cure rate was 72% with EPFX.

Commercial faecal transplant (FMT) is now available and NHS Fife will use this for recurrences that have failed first and second line treatments.

Bezlotoxumab is available only when FMT is contraindicated or if the patient is unable to tolerate the procedure.

Key actions for 2023

Continued surveillance and follow up of all CDI cases.

NHS Fife will continue to use the EPFX regime for the high-risk groups to prevent recurrence.

Until August 2023 all cases have had sustained clinical cure with EPFX. Further cases on EPFX are due for review in October 2023 pending completion of treatment.

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**3 November 2023**
Title:	**Volunteering Annual Report 2022/23**
Responsible Executive:	**Janette Keenan, Executive Director of Nursing**
Report author	**Siobhan McIlroy, Head of Patient Experience**

1 Purpose

This report is presented for:

- Assurance

This report relates to a:

- Government policy/directive
- Local policy

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

- Person Centred

2 Report summary

2.1 Situation

This report covers the period from April 2022 to March 2023 and provides a flavour of work undertaken during this time and describes plans as the service moves forward.

2.2 Background

NHS Fife recognises the invaluable work of our volunteers. The huge commitment and dedication to our NHS, patients and public alike, are experienced every day by the work that our volunteers do in their various roles across all our sites and in each service.

NHS Fife volunteers come from various backgrounds and from across the whole of Fife.

Volunteering also offers the volunteer a new challenge, a new focus for those retired or who have an experience to share and offer others in similar situations.

2.3 Assessment

The Volunteering Service has continued to navigate the impact of COVID-19 pandemic, and associated infection control and prevention measures, whilst actively promoting, growing and developing the service. All acute and community

volunteers who wished to return have now successfully remobilised, with the exception of those volunteering with Therapets.

2.3.1 Quality/ Patient Care

Our volunteers want to make a difference to the recovery and care of everyone using health services and, as such, volunteers bring an enormous contribution to the health and wellbeing of staff and patients, enhancing everyone's experience of health every day.

2.3.2 Workforce

The team consists of two Volunteer Leads (1.8 WTE) supported by one full time administrative assistant (1.0 WTE). The service reports directly to the Head of Patient Experience (HoPE).

At the time of writing NHS Fife benefits from the support of over 80 active volunteers.

2.3.3 Financial

N/A

2.3.4 Risk Assessment/Management

The COVID-19 pandemic had a significant impact on the levels of volunteering activity. The National Group for Volunteering in NHSScotland recommended NHS Boards should consider a safe and measured return of volunteering. The NHS Fife Volunteering service has reviewed and updated all volunteering risk assessments, roles and activities accordingly to ensure a safe and effective remobilisation process.

2.3.5 Equality and Diversity, including health inequalities

Volunteers are welcomed from all walks of life and plans have been put in place to encourage young people to volunteer with NHS Fife through the Duke of Edinburgh Award Scheme. NHS Fife Volunteering Services are now a registered approved activity provider for volunteering with the Duke of Edinburgh Award. This allows young people working towards their award to undertake the volunteering element of this with NHS Fife and for our volunteering opportunities to be displayed and promoted via their website.

2.3.6 Other impact

Positive community engagement

2.3.7 Communication, involvement, engagement and consultation

NHS Fife Volunteer Leads continue to communicate regularly and offer support when required with volunteers. As part of our volunteer improvement plan, we have identified a number of ways to ensure effective and meaningful engagement and consultation with our volunteers.

2.3.8 Route to the Meeting

N/A

2.4 Recommendation

The Committee is asked to take **assurance** from the report.

3. Appendices

Appendix 1 - Volunteering Annual Report 2022/23

Report Contact:
Siobhan McIlroy
Head of Patient Experience
Siobhan.McIlroy@nhs.scot

NHS Fife

Volunteering Annual Report

2022-2023

Foreword

Volunteering is invaluable to our NHS Fife services. It enhances not only the patient's journey and experience by offering support and helping to reduce loneliness and isolation but can also offer a new focus and challenge to those who want to make a difference, sharing their experiences and sacrificing their own time for others. Volunteering creates opportunities to gain new skills, and knowledge, helping to build confidence and resilience.

The last 12 months have continued to be challenging for our volunteering services. Our Volunteering Leads have been working hard to grow and remobilise our volunteers after the COVID-19 pandemic, redefining roles, and engaging with Services to explore new, exciting, meaningful opportunities for our volunteers and patients.

Our dedicated volunteers come from various backgrounds and locations across Fife and the Volunteer Leads worked alongside our Equality and Human Rights colleagues to launch a survey that would allow a better understanding of our volunteering demographics, and areas to focus on for future recruitment and retention.

The Volunteer Leads have been focusing on re-introducing volunteers back into the Hospice at Victoria Hospital and scoping the possibility of volunteers supporting our mental health teams. The Volunteer Leads have also been supporting the recruitment of the Community Listening Volunteers who continue to deliver a vitally important service to those experiencing difficulties in their lives. They are excited to continue working alongside Spiritual Care to support and to continue to widen this service across our Fife Communities.

We were delighted to re-launch the Volunteering Strategy Group, and we have had great support with this. The group aims to ensure policies, guidelines and best practices relating to volunteers are consistently followed and implemented across NHS Fife. We want to showcase and celebrate the tremendous contributions of the volunteers, recognising and sharing their stories, efforts, and successes. We also hope to focus on and encourage the number of volunteers engaging with NHS Fife and explore how best to do this.

Although it has again been a busy year, we are delighted to continue working with our teams and volunteers and are excited to grow and develop the Volunteering service. We cannot emphasise enough the value of their commitment and contribution to NHS Fife and patients' lives. A huge, continued, heartfelt thank you to all our volunteers and teams for their dedication, support, and hard work.

Siobhan McIlroy
Head of Patient Experience

Introduction & Summary

This Annual Report for NHS Fife Volunteering Service covers the financial period between 1 April 2022 to 31 March 2023, and details the volunteering activity throughout this period.

During this time the Volunteering Service has continued to navigate the impact of the COVID-19 pandemic, and associated infection control and prevention measures, whilst actively promoting, growing and developing the service.

National Guidance & Policy

Volunteering within NHSScotland is supported by Scottish Governments, Volunteering for All, Our National Framework, April 2019. The Framework sets the direction for Scotland's approach to volunteering over the next decade by focusing first and foremost on the volunteer, rooted in our national values of kindness, dignity and respect. It highlights and recognises the changes required to break down barriers to volunteering and to create more diverse and inclusive opportunities for everyone to engage in throughout their life.

Scottish Governments Scotland's Volunteering Action Plan, June 2022, seeks to build upon the Volunteering for All Framework, and to maximise the impact of volunteering. It aims to create an environment and a community of practice in which volunteering can adapt to changing priorities and continue to thrive. It seeks to establish accountability for ensuring that the needs of volunteers are at the centre of future decision-making.

NHS Fife's current policy was last reviewed in April 2021, with the next refresh due no later than April 2024. At the time of writing it is undergoing review. Associated policy; NHS Fife Volunteer Expenses Procedure will also be reviewed upon receipt of anticipated Healthcare Improvement Scotland Volunteer Programme guidance which will advocate for boards to increase the mileage rate for volunteers, as this has not been amended by Scottish Government for over 12 years and to move to best practice of 45p per mile in line with HMRC figures. Volunteer Leads are conscious of the impact of the increased cost of living on our volunteers, and apprehensive that this may become a barrier to entry for some.

Workforce & Support to Volunteering Services

The team consists of two Volunteer Leads (1.8 WTE) supported by one full time administrative assistant (1.0 WTE). The service reports directly to the Head of Patient Experience (HoPE).

The Volunteering in NHSScotland Programme, delivered by Healthcare Improvement Scotland (HIS), drives forward the volunteering agenda in NHSScotland through effective leadership, governance, consultancy and expert advice for volunteering across NHSScotland. They have a

range of publications providing information, guidance and good practice. The programme offers a package of support to volunteer managers with peer networking sessions, practice development sessions and access to their 'volunteering helpdesk' for support, alongside a virtual Volunteering Community of Practice.

Fife Voluntary Action (FVA) are our local Third Sector Interface (TSI) who provide good practise guidance, training and networking opportunities for the volunteering team and are a means of promoting volunteer opportunities and recruitment locally.

Remobilisation and Recruitment

Remobilisation from the COVID-19 pandemic has been slow, adapting to ongoing changes; to reflect shielding, immunisation status, lateral flow testing, mask wearing and social distancing. All acute and community volunteers who wished to return have now successfully remobilised, with the exception of those volunteering with Therapets. Volunteer Leads are in communication with Canine Concern, who are the registered body who train and regulate Therapets, infection control and health and safety colleagues to navigate their safe return to community settings. The service has received requests from both patients and their families, and staff for this valuable volunteering to resume.

Volunteering within the palliative care service is yet to resume as a result of the closure and refurbishment of the Victoria Hospital based hospice, and the change of service delivery, which has seen the dedicated hospice ward at Queen Margaret Hospital close and palliative care being delivered as an outreach model.

During this period recruitment has been open with a variety of roles being promoted via corporate website, corporate social media, attendance at school career fayres and via FVA.

Volunteer Demographic

NHS Fife Volunteering Services presently has 78 volunteers across 6 sites (Victoria Hospital, Queen Margaret Hospital, Adamson Hospital, Cameron Hospital, Glenrothes Hospital and St Andrews Hospital) along with 9 public partner volunteers currently engaging with groups across NHS Fife.

We are unable to adequately monitor our equality and diversity characteristics due to the limitations of the national Volunteer Information System. As such with the current system constraints the optimum solution was to conduct an annual anonymous survey of all active volunteers, with the results representing a snapshot of the volunteers taking part at that moment in time. In March 2023 the NHS Fife Volunteer cohort (Acute services, Community hospitals and public partner volunteers) where asked to participate in an equality monitoring survey which yielded a 60% response rate. (see Appendix 1)

An inclusive volunteer service should be reflective of the community it serves. Where national census information was available for the Fife Health Board these where used for comparative purposes.

The data tells us that we are unrepresented in our volunteer cohort with males, and those in the age brackets 26-35, 36-45 and 46-55.

The Volunteer Service are working with colleagues in FVA and our Equality and Human Rights Team to understand and address these gaps.

Service Activity and Development

2022-23 quarter 4 (Jan-Mar 2023) figures

Number of new enquiries received	100
Number of application forms Returned	31
Total number of interviews held	18
Total number of orientations conducted	26
Total number of new volunteer placements	17
Total hours of volunteering delivered	2529

As part of a National reporting exercise to the Scottish Government, in the period between April 2022 and March 2023 (inclusive), NHS Fife recorded an average of 50 volunteers delivering over 8500 hours of support across Acute and Community Hospitals.

Volunteer Leads took part in “Make your mark” inclusive volunteering workshops facilitated by Adopt an Intern (AAI) Employability, an inclusive recruitment enterprise advocating good ethics and assisting businesses how to recruit more diversity to their workplace and how to enhance their inclusion practices. Resulting action plans have been produced and the actions are in progress. The volunteer showcase, as appendix 2, was one such action. The showcase feature allows perspective volunteers to see a range of volunteers across demographics and promotes the ethos that volunteering is for all and should be representative of the community we serve.

NHS Fife is an anchor institution; a large organisation connected to our local area and community. Providing volunteering opportunities for the people of Fife enhances their own health and wellbeing, and supports access to education and employment. Employability can be increased by volunteers learning new skills and building their confidence to either enter or re-enter the workforce. It can also be the first step in the career pathway for those looking to pursue careers specifically within healthcare and the NHS. The volunteer service is actively

building on this; linking with colleagues to attend high school career fayres and working with council partners engaging with employability clients.

The Volunteering Strategy Group has been re launched with the purpose to;

- ensure that volunteering national policies, guidelines and best practice are implemented across NHS Fife and followed consistently.
- influence policy and practice in order to ensure that the volunteering service is adequately resourced and supported. To identify and resolve any obstacles to this.
- champion the volunteering service at both an operational and board level, recognising and celebrating the contribution of volunteers throughout NHS Fife.
- maximise the number of volunteers engaged with NHS Fife; striving to have a volunteering cohort reflective of the communities we serve.

The current spread of the volunteering service is not Fife Wide, with a notable absence within Mental Health Services. Volunteer Leads are currently engaging in a scoping exercise to understand what meaningful volunteer support would like within mental health services.

Volunteers & NHS Fife Community Listening Service

Our Community Listening Volunteers continue to provide an important service to the population of Fife. In the last year they have provided a pivotal service that has allowed that active listening and therapeutic service to help many people who were experiencing difficulty in their lives. This is very much a community assets based type of approach. The result is that individuals are supported to make sense of their circumstances during periods of transition and change; helping them to recognise and use their own and communal assets with a view to proactively developing their wellbeing. The recently published Scottish Government framework on Spiritual Care recognises the significant contribution that the community listening service makes and recommends that it is widened across the community.

From the 1st Apr 2022 to the 31st Mar 2023, CCL received 318 new referrals and provided 1153 listening sessions.

We currently have 16 active listeners providing CCL in 15 GP Practices and to the Improving Cancer Journey Project. During 2023, a number of new volunteers undertook the National Formation Course which has resulted in an increase of 7 volunteers being identified for NHS Fife. It is our hope that these new volunteers will be appointed in the last quarter of 2023. As articulated within the new National Framework, the value of CCL has never been more recognised and is seen as being pivotal to the wellbeing of many patients across the Health and Social Care Partnership. There is a need for further growth and development, and this will be actively considered in the next year or so.

Celebrating Volunteering

Annually NHS Fife take part in recognising and celebrating our volunteers across National Volunteers Week, 1-7 June. Due to the pandemic we were unable to gather volunteers to

mark the occasion, however this was acknowledged through thank you cards and a series of social media posts highlighting and thanking our volunteers.

Fortunately local policy permitted us to gather the volunteers for a Christmas celebration which was well attended and well received.

In November 2022 a memorial presentation of artwork took place in tribute to Helen Hagan. Helen volunteered as a play volunteer in the Children's Unit at the Victoria Hospital, Kirkcaldy, for over 30 years, with her volunteering beginning back in 1988. Helen provided vital support to the play staff by providing and supervising play opportunities within the play rooms.

The presentation was made to Helen's daughter, Mary Sparling, by NHS Fife Chief Executive Carol Potter and NHS Fife Chair Tricia Marwick. The painting was donated by the artist, John Gifford. The scene is of Dysart Harbor which was of personal significance to Helen.

"Sandra is an incredible volunteer; I can really see the impact she is trying to make with the patients in ward 7... I really appreciate her advice and guidance...I would love to shadow her again"

"It's been brilliant, first-hand experience"

(Volunteer reflection on volunteer experience in the ward, VHK)

"You made such a difference when you volunteered with us and the patients and staff adored you. You have been a pleasure to have in the ward"

(SCN reflection to volunteer at the end of their volunteering, Cameron Hospital)

"I attended the Queen Margaret Hospital in Dunfermline...at the front door I was met with professionalism... the friendly meeter and greeter at the door made me feel as though I was entering a top hotel"

(Patient Feedback via Care Opinion)

"I always consider it a privilege to be a member of your team"

(St.Andrews)

"All the staff welcomed me and helped me to get to know the place and helped me to get to know the patients.All the patients were super kind and I enjoyed talking to them all...overall an amazing first day and I can't wait to go back"

(volunteer reflection, Glenrothes)

"Today was a really good volunteering day. A very nice elderly woman was deposited in a wheelchair near the hospital entrance after her clinic appointment. She asked me if I could help her on her phone to get a taxi. I did, there was to be a 20 minute wait and she decided she'd like a cup of tea while waiting. I wheeled her to Costa, returned her to wait on the taxi making sure she was ok and not in a draught, etc. She kept saying how helpful I'd been... how nice everyone was in the clinic too and how happy she'd been with all the people she'd met. A very happy customer! "

(meet & greet volunteer, VHK)

Moving Forward 2023-24

Strategy – A strategy and associated action plan is required to mobilise and realise our Volunteer Policy and reflect the aims of Volunteering for All, Our National Framework.

Developing roles – Working with colleagues and volunteer candidates to develop volunteer roles that are meaningful and purposeful, and allow people to get involved and stay involved. Increasing volunteering participation for all and to addressing inequalities is vital to continuing to expand opportunities for more people to volunteer. Without taking action to engage and support people of all ages and backgrounds to volunteer, communities will lose out on their talents.

Associated Documents/Links

- Volunteering in NHSScotland Programme Annual Report 2022-23;
  Volunteering in NHS Scotland Annual Report 2022-23 | HIS Engage
- NHS Fife Volunteering Policy;
  Volunteering Policy | NHS Fife
- Volunteering for All: National Framework;
  Volunteering for All: national framework - gov.scot (www.gov.scot)
- Scotland's Volunteering Action Plan;
  Volunteering action plan - gov.scot (www.gov.scot)

Appendices

Appendix 1

March 2023 Equality Monitoring Report.do

Appendix 2

Volunteer stories | NHS Fife

Volunteer Name: Suleman Khan
Volunteering Role: Ward-based/ Meet & Greet
Place of Volunteering: Ward 1 & Reception QMH

How long have you been volunteering/when did you start volunteering:
Started May 2022

Why did you get involved with volunteering?

I wanted to get involved in volunteering with NHS Fife to acquire hospital work experience to support my medical school applications. I also used the experiences to determine if healthcare is the industry I want to work in. Offering some form of help to the NHS, especially considering the strain its under, was also a big part of why I wanted to volunteer.

What do you get out of/enjoy about volunteering?

I have learnt quite a lot about myself and what a career in healthcare involves through my time as a volunteer. From the importance of strong communication skills, empathy and teamwork on patient outcomes, to what I would find to be the less glamorous parts of working in a hospital. Despite the challenges, the reward of being trusted to help individuals in my community during a vulnerable and scary time for them makes the work worth it.

Do you have any reflections you would share about your volunteering experience, and would you recommend volunteering to others?

The NHS Fife volunteering team is a fantastic and supportive bunch, so whether you want to offer a helping hand to your local hospital or build essential experiences to support your future aspirations then give them an email.

Volunteer name: Jack Wilson
Volunteering role: Response Volunteer
Place of volunteering: Ward 1, Glenrothes Hospital

How long have you been volunteering/when did you start volunteering?
Started in November 2022.

Why did you get involved with volunteering?
I had experience of the NHS and healthcare through family dealings, and I wanted to get experience volunteering in this.

What do you get out of/enjoy about volunteering?
I enjoy trying to make a difference to our patients' hospital stay and finding out a bit about each of the patients and what really matters to them.

Do you have any reflections you would share about your volunteering experience, and would you recommend volunteering to others?
If it is something you think you would enjoy definitely go for it! It is a great experience being a part of the ward and a part of the patients' hospital stay.

AREA CLINICAL FORUM

(Meeting on 5 October 2023)

No issues were raised for escalation to the Clinical Governance Committee.

Area Clinical Forum

Fife NHS Board

Unconfirmed

MINUTES OF THE NHS FIFE AREA CLINICAL FORUM HELD ON THURSDAY 5 OCTOBER 2023 AT 2PM VIA MS TEAMS

Present:
Ailie Mackay, Speech and Language Therapy SLT Operational Lead (Vice Chair)
Robyn Gunn, Head of Laboratory Services
Chris McKenna, Medical Director
Susannah Mitchell, General Practitioner
Nicola Robertson, Associate Director of Nursing

In Attendance:
Sharon Crabb, Public Health Service Manager *(item 5.1 only)*
Fiona Forrest, Deputy Director of Pharmacy *(deputising for Ben Hannan)*
Lynne Johnston, Service Manager *(item 5.2 only)*
Hazel Thomson, Board Committee Support Officer (Minutes)

1. Apologies for Absence

The Chair welcomed everyone to the meeting.

Apologies were received from Aileen Lawrie (Chair), Jackie Fearn (Consultant Clinical Psychologist), Donna Galloway (Women Children & Clinical Services General Manager), Ben Hannan (Director of Pharmacy & Medicines), Emma O'Keefe (Consultant in Dental Public Health), Janette Keenan (Director of Nursing) and Amanda Wong (Director of Allied Health Professions).

2. Declarations of Members Interests

There were no declarations of interest from those present.

3. Minutes of the Previous Meeting held on 3 August 2023

The minutes of the previous meeting were **agreed** as an accurate record.

4. Matters Arising and Action List

The Forum **noted** the updates on the action list.

5. PRESENTATION

5.1 Anchor Institutions Strategy

S Crabb, Public Health Service Manager presented on the Anchor Institutions Strategy, and welcomed questions.

The Associate Director of Nursing updated the Forum on the work that is being undertaken in relation to increasing our nursing workforce. She also advised that we are in the early stages of looking at a magnet programme for Fife for nursing. In addition, the importance of infrastructure in terms of greenspace was highlighted. The Associate Director of Nursing agreed to arrange for a nursing representative to join the Anchor Institutions Group.

Action: Associate Director of Nursing

The Deputy Director of Pharmacy reported that there are pharmacy representatives who are exploring opportunities to utilise community pharmacies with a view of embedding them as Anchor Institutions within the community. It was also reported that a modern apprenticeship is being developed for medicines management support workers, and that more widely, work is being undertaken to raise the profile of pharmacy as a profession.

The Vice Chair provided an update on Allied Health Professionals (AHP), noting that they are looking at how they can deliver to the AHP public health framework. It was also advised that AHP foundation apprenticeships are being undertaken.

It was agreed that Forum members provide the presentation, and the questions within the presentation, at their subcommittees and/or groups, and feedback to the Public Health Service Manager who will include within the Anchor Institutions Strategy.

Action: Members

5.2 Scottish Government Women's Plan

L Johnston, Service Manager joined the meeting and presented on the Scottish Government Women's Plan.

The General Practitioner highlighted that the plan has resulted in a large increase of consultations within General Practice in relation to menopause, and that there has been limited support from secondary care. Discussion took place on the challenges in terms of capacity. The Service Manager agreed to feedback to the team, and the Deputy Director of Pharmacy agreed to link in with the Pharmacy team around the share care protocol.

Action: Service Manager/ Deputy Director of Pharmacy

Following a question from the Deputy Director of Pharmacy, the Service Manager advised that individual subgroups collate data in relation to outputs, activity & evaluations, and she agreed to provide this detail in the next update to the Forum.

Action: Service Manager

6. QUALITY / PERFORMANCE

6.1 Winter System Review Update

This item was deferred to the next meeting.

6.2 Escalations and Updates from Subgroups to the Area Clinical Forum

The Vice Chair opened up discussion around escalations and updates from subgroups to the Area Clinical Forum.

The Head of Laboratory Services highlighted the Audiology External Independent Review, and suggested inviting the Head of Audiology to present to the Forum. The Medical Director explained that the review is wider that audiology, and suggested bringing our response and action plan to the Forum, before it goes to the Clinical Governance Committee for assurance.

Action: Medical Director/Head of Laboratory Services

The Vice Chair advised that an ACF Development Session will take place in February 2024, with a focus on raising the profile of the ACF.

7. GOVERNANCE MATTERS

7.1 Rehabilitation Oversight Group Terms of Reference

This item was deferred to the next meeting.

7.2 Delivery of Annual Workplan 2023/24

The Forum **noted** the tracked workplan.

7.3 Proposed Meeting Dates 2024/25

The Forum **agreed** the proposed meeting dates for 2024/25.

8. UPDATE FROM EXTERNAL GROUPS

8.1 Area Clinical Forum Chairs Group for Scotland Update

This item was deferred to the next meeting.

9. LINKED MINUTES

9.1 Allied Health Professions Clinical Advisory Forum held on 2 August 2023 (unconfirmed)

9.2 GP Sub Committee held on 20 June 2023 (confirmed) & 15 August 2023 (confirmed)

9.3 Area Medical Committee held on 8 August 2023 (unconfirmed)

9.4 Area Pharmaceutical Committee held on 27 February 2023 (confirmed) & 24 April 2023 (unconfirmed)

The Forum **noted** the linked minutes.

10. ESCALATION OF ISSUES TO THE CLINICAL GOVERNANCE COMMITTEE

There were no matters to escalate to the Clinical Governance Committee.

11. ANY OTHER BUSINESS

11.1 Healthcare Science

It was agreed that the Head of Laboratory Services would present on Healthcare Science at a future meeting, to provide members with a deeper insight of that area.

Action: Head of Laboratory Services/ Board Committee Support Officer

12. DATE OF NEXT MEETING

The next meeting will take place on **Thursday 7 December 2023 from 2pm – 3.30pm** in the Boardroom, Staff Club, VHK.

AREA MEDICAL COMMITTEE

(Meeting on 8 August 2023)

No issues were raised for escalation to the Clinical Governance Committee.

Area Medical Committee

CONFIRMED NOTES OF THE AREA MEDICAL COMMITTEE (AMC) HELD ON TUESDAY 08 AUGUST 2023 VIA MS TEAMS

Present:

Chris McKenna (Chair)	Medical Director
Helen Hellewell	Deputy Medical Director, H&SCP
Fiona Henderson	Fife LMC Honorary Secretary
Iain MacLeod	Deputy Medical Director, ASD
Joy Tomlinson	Director of Public Health
Morwenna Wood	Associate Medical Director, Medical Education

In Attendance:

Catriona Dziech (Notes)	Executive Assistant to Medical Director

1 APOLOGIES FOR ABSENCE

Apologies were received from Ian Fairbairn, John Morrice, Satheesh Yalamarthi, Claire McIntosh, Glynn McCrickard

Calendar invite was declined by Phil Duthie, Robert Thompson, Sally McCormack, Susanna Galea-Singer

2 DECLARATIONS OF MEMBERS' INTERESTS

There were no declarations of interest.

3 MINUTES OF PREVIOUS MEETING HELD ON 27 JUNE 2023

The notes of the meeting held on 27 June 2023 were approved.

4 MATTERS ARISING

i) Update from Realistic Medicine (RM) Team

The Realistic Medicine Team will attend AMC on 12 December 2023 to provide an update.

Dr McKenna advised the RM Team are holding a Workshop on 20 September 2023 between 9.30am and 12.30pm in the Main Hall at Lynebank. Shirley-Anne Savage is currently working on the invitation list. Dr Hellewell agreed to seek wider representation from Primary Care.

Action: HH

5 STANDING ITEMS

i) Financial Position – Including *(IPQR)*

Dr McKenna advised the financial position remains unchanged. As reported at the previous meeting NHS Fife had been allocated more NRAC share. There will be discussion at EDG on 09 August 2023 about where

savings could be achieved. Maxine Michie would be invited to attend the next meeting on 10 October 2023 to give a fuller finance run down.

Action: CMcK

ii) Adverse Events Update – considered at the Clinical Governance Oversight Group

The notes of the Clinical Governance Oversight Group are included within these papers. There are no significant issues to highlight. Dr McKenna advised consideration is going to be given again to the sign off process for SAERs. A process had been put in place previously to clear backlog, but it was now a good time to move back to a more blended approach to sign off. It is hoped this discussion will take place before the end of the month.

Joy Tomlinson advised she has spoken with Nicola Robertson regarding the organisational learning group and how they might help with some of the cross-cutting themes that come through events. One theme being positive learning from communication issues when communication has been done well and making sure it is done well again in the future and where there has been challenges.

Joy Tomlinson said she had also shared with Nicola Robertson two public health related learning situations. Nicola Robertson has agreed to take both examples to the next meeting of the Group to consider how these organisational elements can be shared.

Dr McKenna highlighted the internal Auditors were clear there has been a lot of focus on the group to try to corral learning and then feed it back into the organisation for improvement.

Dr MacLeod said the group has struggled to find where it fits into the system, and it is trying to pick out relevant issues to move forward. There have been many meetings, without much progress but there is potential and willingness to share information. A trawl of SAER and LAER reports has been undertaken but no consistent themes were identified. Dr MacLeod will be meeting with Nicola Robertson to progress further and share learning points and find a forum to communicate.

Following discussion the Committee agreed at the end of every adverse event, it is key to have the opportunity to communicate and share learning across the organisation with all those involved.

As a way forward it may be helpful to reinstate EC4H courses for staff in Fife. Dr McKenna agreed to ask Kim Steele for an update as to whether we can deliver EC4H or if there were any barriers for delivering EC4H across the organisation.

Action: CMcK

Professor Wood said the other hope over the next few years would be to have simulation areas on three sites in Fife not just at QMH but also at Cameron and VHK to achieve learning. Professor Wood welcomed ideas from members.

Action: All

Dr McKenna suggested another way to communicate to the wider organisation would be through a Grand Round type event where feedback from SAERs could be discussed. Professor Wood suggested having a 10 / 15 minute slot for four similar themed SAERS focussing on learning. Dr McKenna agreed to discuss this with Martin Clark.

Action: CMcK

Dr MacLeod suggested another route would be one similar to the Medicines Management Team who issue a weekly email shot of "Lessons of the Week"

iii) Medical Staff Committee

Dr McKenna advised there is no update, and any suggestions welcome on how to move this forward.

It was noted there is a danger of medical staff using social media as a means of communicating with each other so there needs to be a functional Medical group, so things are not aired on social media. Although not the right format this could be via What's App Groups. Dr McKenna agreed to give this some further thought.

The Committee noted the function of the Medical Staff Committee is to provide professional medical oversight through to the Area Medical Committee.

Joy Tomlinson said there was a similar issue in Ayrshire in trying to get people enthused to attend meetings as there was no sense of the added value of the Committee. It was suggested if there was clear commission from the AMC for them to consider and raise specific issues this may encourage attendance.

It was suggested the main barriers to attendance could also be considered and thought given to holding the meeting in the evening at a set time each month. This may include a meeting attendance fee or time back arrangement as it is recognised that is not within daily limits of work. It should also be considered that the meeting could take place on Teams.

Dr McKenna agreed to considered using the Strategy as an opportunity to take the conversation back to the consultants and ask them to be part of how it progresses.

Action: CMcK

Dr McKenna also agreed to speak to Phil Walmsley about his role as Chair of the Medical Staffing Committee.

Action: CMcK

iv) Update from GP Sub Committee

Dr Henderson advised there was no update at this time.

v) Realistic Medicine

No update at this time.

vi) Medical Workforce

Dr McKenna advised he is holding a Senior Medical Leadership away afternoon on 26 September 2023 with one of the main topics being medical workforce strategies.

Dr McKenna advised there has been a good conversation with the Medical Director for NHS Professionals who run the Gateway programme about what they might be able to do for other groups of doctors, perhaps senior doctors, that we might be able to coach and teach and support to Caesar, to grow our own consultant workforce.

There are sixteen new doctors in our system who are hopefully settling into their job in Fife with local Teams supporting them to become integrated. This should mean we are not having to spend money on agency locums. It is hoped investment in these doctors result in them wanting to stay on in the region to the training programmes or indeed come back as GPs or consultants of the future.

Dr McKenna advised he is considering the feasibility of Fife becoming a pilot site for a training programme for Sports and Exercise Medicine. Hopefully this would come into effect from August 2024. There is a strong connection to Public Health and the ambitions set out in our Population Health and Wellbeing Strategy. NES are looking to Fife as a place where they can do business.

Professor Wood agreed to do a short 10-minute presentation on 26 September 2023 explaining Gateway doctors.

Action: MW

Professor Wood advised Gateway doctors are recruited through an organisation in England called NHS Professionals. They have various types of doctors, but the ones we have here now are Gateway Foundation doctors. Some of them want to be GPs so are being sent to the Community Hospital in their F2 year. It was agreed Professor Wood and Dr Hellewell would meet to consider identifying GP practices willing to take F2 doctors within their Practice.

Action: MW/HH

There are also the more senior refugee doctors. Currently the only ones in Fife are from Myanmar. NHS Fife had asked for physicians in the making because this is where there were gaps in money, but they would potentially be surgeons in the making. Professor Wood suggested it may be worth having a conversation about how we benefit more widely.

There is also work ongoing with the Royal College of Physicians where they are recruiting in India on an MTI basis but at a lower level, because previously they had been recruiting at a consultant or sub consultant level. A project is now underway looking at recruiting people who come for two years to pass their MRCP paces.

Professor Wood said there are other opportunities so it would be useful to discuss with the wider group at some point. Dr McKenna said the issues Professor Wood was raising fall into the strategic planning for the workforce currently and for the future. One of the outcomes of the Away Day on 26 September 2023 is to set out ideas on paper to produce a report.

Joy Tomlinson highlighted there is a UK wide workforce planning event taking place for Health Protection to which she has been invited to attend as chair of the Scottish Health Protection Network and to a meeting with the Four Nations on the 11 September 2023. Gaps have been identified, particularly in Health Protection Groups but there no increase in the number of trainees that are required. Donna is also leading a separate piece of work around the wider public health workforce working with Karen Wilson and Donna Milner from NES. This is at the stage of undertaking surveys and looking at our forwards national planning so that would be quite useful to link in with.

Joy Tomlinson agreed to attend the Away Day at Carnegie Library on 26 September 2023.

vii) Education & Training

Professor Wood advised the Scottish Government have agreed a new five year medical school at St Andrews University, where Fife will be the chief clinical partner. The first entry of students will be coming September 2023 and will undertake the traditional St Andrews BSc. This will be reconsidered to make it more fit for purpose and more curriculum aligned. The first cohort of students will come out to clinical practice in January 2026, which is the second-half of their third year.

SCOTCOM will have bases in Queen Margaret and Cameron Hospital and staff of all descriptions will need to be recruited. Professor Wood asked Members to contact her as early as possibly with any ideas. SCOTCOM should lead to significant expansion of facilities especially in relation to

having a SIM centre. It will not be the same as the QMH SIM centre but lower tech and more community focused and more utilised by Community Healthcare workers.

Work will also be undertaken to try and do more this year and subsequent years for postgraduate trainees in the way of simulation and getting more coordinated and organised for simulation.

Dr McKenna said this was massive development for NHS Fife. A Governance Structure is being agreed to oversee SCOTCOM in Board and in connection with St Andrews.

It was noted the full cohort is just under 200 per annum with the St Andrews intake being 55.

Professor Wood advised there are real opportunities to build medical education in the community through this course despite struggles with capacity to teach.

Professor Wood advised GCMs, GPs who teach SCOTGEM course, have been recruited. Eight candidates were interviewed and three have been recruited as permanent members of staff, all new to GP Practices in Fife.

Iain MacLeod advised he had received an enquiry from a Neurologist in Edinburgh who Fife would like to recruit who wishes to engage in some form of academia and sought advice from Professor Wood on how to start the process. Professor Wood advised this would need to be given some thought as there is a danger of upsetting existing activity. It was agreed this was not for discussion at AMC but could be discussed at a more informal group or Development Session with Dr MacLeod and Dr Hellewell on how Professor Wood could take this forward.

Action: MW, HH, IMcL

6 STRATEGIC ITEMS

i) GMS Implementation

Dr Henderson advised from a GP Sub perspective there was incredible frustration over the whole issue. There is nothing positive to say about the current situation in terms of where the staffing sits at, where the transitional agreement sits at and what the service provision looks like, and how practises are not benefitting from the contract.

Despite everybody's best efforts, it has not moved forward as it should, and general practice continues to get worse week on week with more talk of practices being handed back to the Board. This remains an on-going crisis.

Although not related to GMS Professor Wood said she thought politicians are really interested in medical workforce and concerned about lack of

applicants to medical schools and people dropping out throughout the training process. Directors of Medical Education across Scotland asked to meet with the civil servants to tell them what could be done to make it better. Having given a response there remains a mismatch between the problem and solution.

Professor Wood said thought needs to be given on how the get a medical staffing voice and how this can be replicated across Scotland, so politicians are forced to listen.

7 ITEMS FOR INFORMATION

i) Notes of the GP Sub Committee:
No notes for consideration.

ii) Notes of the Clinical Governance Oversight Group:
No notes for consideration.

iii) **Notes of NHS Fife Area Drugs & Therapeutics Committee: 26 April 2023**
Noted

8 AOCB

9 DATE OF NEXT MEETING
Tuesday 10 October 2023 at 2pm via MS Teams

AREA RADIATION PROTECTION COMMITTEE

(Meeting on 10 May 2023)

No issues were raised for escalation to the Clinical Governance Committee.

Area Radiation Protection Committee

RADIATION PROTECTON MEETING

Via Teams

Wednesday, 10th May 2023

9.30am – 10.17am

Present:

Dr Chris McKenna (Chair)
Nicola MacDonald, RPA, Head of Radiation Protection
Donna Galloway, General Manager
Gail Taylor, Superintendent Radiographer
Lesley Henderson, Superintendent Radiographer
Simon Willis, RPA, RWA
Claire Parry, Principal Physicist (RP)
Debbie Sliders, Public Dental Service
Laura Cluny, Principal Physicist (NM/RP)

Absent/Apologies:

Theatre staff
Jane Anderson, Radiology Services Manager

ACTION:

MRI Scanning / Pacemakers –
Compliance ongoing. Business case to be carried into the next financial year.

Radon Assessment for underground workers –
Laura Cluny hopes to have results by the next meeting.
Paul Bishop in Estates is leading on this.

Two sealed disks, sources for dose calibrator QC –
Laura Cluny advised the VHK had been done, but QMH was still outstanding.
Chris McKenna advised that if it's a funding issue with Planned Care, speak to Murray Cross.

Review of Supply of Dose Monitoring Badges -
Nicola MacDonald advised we are still trying to progress. Landauer lost a whole shipment of badges, which has never happened before. There are a number of other issues being investigated.

Lessons Learned -
Fife Orthopaedic Centre – Nicola MacDonald advised that nothing formerly had been written up but learning has been shared with colleagues across Scotland.
It was suggested to take this item off the Actions for this Committee.

MRI healthy volunteers
Protocols to be set up. Lesley Henderson advised some had been done for training purposes, including herself being a volunteer. Need to speak to Jane Anderson re this matter. Item to be taken off this Action Plan.

New Regulations, looking at AORD compliance –
Nicola MacDonald advised Medical Physics and Estates to be involved. A new member of staff had been appointed and had already commenced some investigations. This work will be on-going, any issues will come back to this committee.

AGENDA ITEMS:

HSC Consent Update
ECP Analysis –
Simon Willis advised the application fee would be between £1,000 and £5,000, not yet fixed. The application would be done electronically. No specific time, could be within the next 5 years.
We will have 3 months notice. It won't happen before October this year. Physicists will lead on this with support from Richard and Sally.

Classification of Nuclear Medicine Staff Update
Laura Cluny advised this is now underway, in line with expectation from HSE that virtually all staff working in Nuclear Medicine should be classified. Process already begun in Lothian, but need to have further discussion with Fife. A guidance document is nearly completed.

Breast Theatres at QMH – do not need to be classified.
Gail Taylor advised there are less than a dozen staff members working in Nuclear Medicine.

Annual Compliance Reports
Gail Taylor read out a report for Radiology. Key notes are:

- All VHK Radiation Protection Supervisors had been reviewed.
- Two RPS had attended training at the Western General Hospital.
- Radiology Referrals have escalated.
- Radiology Risk Assessments updated.
- Pregnant staff – this needs to be updated.
- The Team had been praised for the level of investigation.
- Local rules will take place 2022/2023

Debbie Sliders advised that another RPS had been trained for PDS. There had been 2 radiation incidents, which had been student errors. 2 OPGs need to be replaced as were causing too many incidents. Otherwise all is going well. A new Clinical Director had been appointed, unsure if had yet take up the post.

Jodie McGoldrick, Nurse in Charge of Theatres: No issues, other than there was more medical staff issues rather than nursing issues. Need to train some more RPS and set up IR(ME)R training. Nicola MacDonald to meet with Clinical Director.

Staff Dose Report:
Clare Parry advised this was very well controlled in NHS Fife and gave some figures.
Will move to quarterly badge monitoring, but not for Nuclear Medicine or Interventional staff.
This will be from July.

Radiation Incident Report
Nicola MacDonald advised there had been 150 incidents in 2022, only 6 involved staff, and 5 of the patient incidents were externally notifiable. A member of staff had been in the CT room when the scan had started.

Staff should be encouraged to DATIX.
Local rules need to be clear for Theatre staff.
Overall the numbers are very low.

Environmental Dose Monitoring
Simon Willis advised this is carried out every 3 years.
There is a Report in the Teams folder for reference.
6 surveys have been carried out at QMH and 2 at VHK
Shielding checks had been done across 10 rooms, no issues found.
C-arm doses, all positive.
Public Dental Service is done monthly. All going well.
Nicola MacDonald advised dental badges to be done quarterly.

Any Escalations:
Nicola MacDonald advised that both her and Clare Parry had reviewed the RP Policy on 9th May 2023. Laser and MR to be taken out. There will be 3 stand alone Policies, these will be progressed once the NHSL ones have been ratified.

Any Other Business
None

Next Meeting
Dr Chris McKenna advised the next meeting will take place on Tuesday, 14th November 2023.

CANCER GOVERNANCE & STRATEGY GROUP

(Meeting on 17 August 2023)

Report on the National Cancer Strategy Alignment to go the Clinical Governance Committee to provide assurance.

Cancer Framework Annual Delivery Plan Year 2 to go to the Clinical Governance Committee.

Cancer Governance & Strategy Group

NHS FIFE CANCER GOVERNANCE & STRATEGY GROUP (CGSG)

Unconfirmed Note of the Meeting Held at 09:30 on Thursday 17th August 2023 via Microsoft Teams

Present:	**Designation:**
Nick Haldane (NH)	Lead Cancer GP
Murdina MacDonald (MM)	Lead Cancer Nurse
Rishma Maini (RM)	Consultant - Public Health
Linda McGourty (LMcG)	GP
Chris McKenna (CM) Chair	Medical Director
Kathy Nicoll (KN)	Cancer Transformation Manager
Frances Quirk (FQ)	Assistant Director Research, Development & Innovation
Nicola Robertson (NR)	Director of Nursing, Coroporate
Shirley-Anne Savage (SAS)	Associate Director of Quality and Clinical Governance
Sarah Scobie (SS)	Consultant – Clinical Oncologist
Fiona Towns (FT)	Patient Representative
Amanda Wong (AW)	Associate Director of Allied Health Professions
Apologies:	**Designation:**
Paul Bishop (PB)	Head of Estates
Nicky Connor (NC)	Director Health and Social Care
Izzy Corbain (IC)	Patient Representative
Claire Dobson (CD)	Director of Acute Services
Fiona Forrest (FF)	Deputy Director of Pharmacy
Susan Fraser (SF)	Associate Director of Planning & Performance
Alistair Graham (AG)	Associate Director Digital and Information
Ben Hannan (BH)	Director of Pharmacy & Medicines
Janette Keenan (JK)	Director of Nursing
Neil McCormick (NM)	Director of Property and Asset Management
Margo McGurk (MMcG)	Director of Finance and Strategy
Emma O'Keefe (EO'K)	Consultant – Dental Public Health
John Robertson (JR)	Lead Cancer Clinician - Surgery
In Attendance:	**Designation**
Kerri Davidson (KD)	Consultant - Haematology
Stephanie Guillaumier (SG)	Consultant – Urology Planned Care
Rebecca Hands (RH)	Clinical Governance Administrator (minute taker)
Ian Mitchell (IM)	Consultant – Urology Planned Care

		Action
	Welcome	
	CM welcomed everyone to the meeting. CM welcomed Fiona Towns to the meeting as the new patient rep.	
1.	**Apologies for absence**	
	Apologies for absence were **noted** from the above named members.	

		Action
2.	**Unconfirmed Note of the previous NHS Fife Cancer Governance & Strategy Group Meeting of 31 May 2023 via Microsoft Teams**	
	The Unconfirmed Note of 31 May 2023 was **accepted** as an accurate record.	
3.	**Action Log**	
	041122#6 – Meeting to be rescheduled. 300323#2 – To be carried forward to the next meeting. 310523#1 – SAS, KN and Mims attend this group. This action can be closed. 310523#2 – To be carried forward to the next meeting. 310523#3 – KN provided a paper on this and it has been shared with the group. This action can be closed.	
4.	**GOVERNANCE**	
4.1	**Acute Cancer Services Delivery Group Update**	
	This will be carried forward to the next meeting.	
4.2	**Cancer Risks**	
	This will be carried forward to the next meeting.	
4.3	**Cancer Framework Risks**	
	SAS advised that herself and KN have met on a few occasions to discuss these. They have also met with the risk team to get some guidance on how to present those risks. There is currently risks under the headings of: • Cancer Workforce • Financial Delivery • Digital and Information • Edinburgh Cancer Centre (ECC) • Property and Estate They are currently querying a couple of them which was around Digital and Information, and ECC; however, the lead cancer team thought that they were relevant risks. SAS advised they are almost at the stage of sharing and for comments. KN advised these risks will go to the Cancer Leadership Team then will come to this group.	
5.	**STRATEGY/PLANNING**	
5.1	**National Cancer Strategy Alignment**	

		Action
	KN advised the group the 10 year cancer strategy has been published along with a 3 year action plan. The strategy has been reviewed alongside our Cancer Framework to ensure alignment and to identify any gaps. 11 ambitions have been identified in the strategy which aligns well with the commitments in the Cancer Framework. KN shared a table with the group which shows our commitments. The aim of the 3 year action plan is to recover and stabilise systems. In relation to the action plan, KN is currently going through the actions to see if there is anything we have not yet considered. On first look we seem to be doing what we need to do. The only action we had not included was around genomics. A lot of the actions are not at Board level. KN has had a discussion with Nicola McCloskey-Sellar and she advised that they were looking at the actions from a regional perspective. The Scottish government are in the process of developing a monitoring and evaluation framework to cover the duration of the strategy CM asked the group if this should go to the Clinical Governance Committee. KN advised she keeps this up-to-date so is able to provide a report to any group. CM advised a report will be taken to the Clinical Governance Committee.	**KN**
5.2	**Cancer Framework Annual Delivery Plan Year 2 Update**	
	SAS advised the Year 2 Cancer Framework has been drafted using actions and objectives outlined in the NHS Fife Annual Delivery Plan and the NHS Fife Medium Term plan, and has been carried forward from the Year 1 Cancer Framework action plan. SAS asked the group to review their area and update or add any objectives as required which are expected to be completed by March 2024. Other next steps taken will be to begin engagement with teams through the Cancer Leadership Team and through MS Forms to ensure we reach as many people as possible. CM advised this paper should also go to the Clinical Governance Committee.	**KN**
5.3	**Framework for Effective Cancer Management**	
	KN advised the next Framework for Effective Cancer Management update for the Scottish Government is due in September. The update goes through the Acute Cancer Services Delivery Group and the Cancer Leadership Team and is signed off by both CM and CD. To date we have completed 65% of the actions (34). There are 15 in	

		Action
	progress and 2 not started, these are referral audits. We received a paper recently called Revive your Cancer Performance Management: lessons learned from engagement with NHS Lothian. A SBAR was written by KN to assure focus on the framework for effective cancer management and that they had considered the recommendations in this paper. This was also tabled at the Acute Cancer Services Delivery Group and the Cancer Leadership Team. Actions have been identified for 2023-24 which are documented within our Annual Delivery Plan and Medium Term Plan. There were some things mentioned in the paper which are not identified as actions for us but may wish to consider: • Share articles of interest in local newsletters/briefings • Share any comments, quotes, from senior managers, CE and Executive Teams • Continue to raise awareness of cancer through monthly newsletter • Awareness of cancer audit team members and roles with a specific focus on cancer audit team – help other staff understand how things work at a local level • Review and assess the need for additional updates/education - NHS Lothian carried out a series of workshops with trackers and other staff • Sharing relevant information and information • What does our weekly timetable of events look like • Where to reports go KN asked if these should be considered at this group or at the Acute Cancer Services Delivery Group. MM advised it is for this group to consider and there is something that should be done about promoting the wider work. MM noted it may be worthwhile considering doing quarterly bite size messages. MM also noted it will be worthwhile to promote through StaffLink and to present at the Grand Round twice a year. KN advised they will take this through the Cancer Leadership Team to discuss how this will be done.	
5.4	**Projects Update**	
	Community Pharmacy This will be carried forward to the next meeting. *RCDS Expansion* MM advised CM that they are hoping to send over a paper on this shortly. MM noted that they are now expanding to colorectal and they have had 59 referrals through the service. There are a few teething problems,	

		Action
	however, it is going well. The RCDS is sustaining activity and diverts 1200 referrals per annum from general surgery. The first 6 months of expansion into the GI cancers has resulted in diverting approximately 400 patients. It is anticipated we will divert 800 referrals from the colorectal service the first six months of operation. Evidence from RCDS care opinion indicates higher levels of patient satisfaction. Service delivery outcome findings are that patients were impressed with the speed of investigations, results and tailored communication approach, with staff taking the time to assess and understand their individual health and social background in depth. *Single Point of Contact Update* KN advised the group that recently quite a lot of work has happened to improve the Single Point of Contact Hub (SPOCH). • Optimal Lung Cancer Pathway Integration – SPOCH will support radiology to ensure reduce waits to CT by: o Arranging U&E if not done/up to date o Contacting the patient to advise of CT date, specific instructions and what to expect o To facilitate vetting post CT one day reporting by updating TRAK advising when CT report available o Advise patient of 1st OPA and what to expect – The aim of this is to reduce waits to 1st OPA by way of a rapid access CT with one day turnaround and expedited 1st OPA • RCDS – Colorectal – We have now gone live with the RCDS Colorectal pathway – SPOCH will be responsible for management of the negative qFIT pathway and follow up, which will ultimately include arranging PIR and ACRT as appropriate – SPOCH will make the first outpatient appointment and introduce the service where the patient is for a consultant review – Letters done for colorectal qFIT which will be put in TRAK • Other improvements – We are looking at 'closing the loop' for 'good news' results for both lung and colorectal – We will also aim to implement the Regrading Framework as part of the vetting process – Queuebuster will be implemented, with an expected go live in September – As part of the lung cancer expansion we will be looking at the	

		Action
	SPOCH team taking updates on patient symptoms and performance status prior to 1st OPA to aid planning *Pathways Review* • Prostate Improvement Pathway – The nurse-led pathway for patients referred with a PSA <10 went live to date. There is close collaboration with the consultants to ensure robust vetting is taking place – It is expected that patients will receive their 1st OPA within a week (current wait is 2 weeks) – This pathway will integrate with SPOCH and any information has been tailored to suit the appointment type allocated at vetting – We are also exploring how the tracker can provide early support to further reduce waits in the pathway – Aim to significantly reduce the waits in the pathway from referral to MDT – The updated protocol for GPs for optimum prostate referral is now available in SCI gateway – We continue to work with the prostate team to improve the post MDT part of the pathway, however, capacity constraints will continue to make this challenging. Meantime we will aim to ensure any processes post MDT are as slick as possible to minimise any wasted days • Optimal Lung Cancer Pathway – Part of the optimal lung cancer pathway work has focussed on expanding into SPOCH to improve initiation of the pathway – When the group was set up baseline measures were done, measuring waits between steps in the pathway and CWT performance – Once pathway improvements are embedded we will review the baseline measures and performance to evaluate improvement, this should be around December time. – As well as the integration into SPOCH some other improvement have been made: o GP can request a same/next day CXR for patients with suspected lung cancer o Bronchoscopy and Outpatient clinics have changed days which has reduced the wait to MDT (average of 11 days and is now average 6.5 days) o All patients are referred to Maggies for Universal Prehabilitation as part of the lung pathway – MM is doing some work in collaboration with Edinburgh who introduced this a while ago and have had some very positive outcomes. o A bundle checklist has been agreed for surgical patients which have been posted around the clinics. – There are issues within the pathway which are outside our	

		Action
	control which impact on the pathway such as waits to PET and molecular testing. There is mention of enhancing diagnostics (including PET) and more complex molecular testing features in the national strategy; however, there is nothing specific identified in the action plan.	
6.	**FUNDING**	
6.1	**Funding Update**	
	KN advised of the following funding: • Cancer Waiting Times - £685,234 + £91,000 - Funding has now been released. Non recurring until March 2024. Thereafter, it is expected that funding will be released on a recurring basis from April 2024. • AO/SACT - £103,000 recurring. Nicola McCloskey-Sellar is chasing Scottish Government for the expected £3m recurring of which we should expect our NRAC share for 2023-24 in addition to this. • RCDS/RCDS Expansion - £339,581 - This has been released and is non recurring until March 2024. • SPOCH - £107,354 - This has been released. This should be recurring funding; however, it is allocated on an annual basis. • DCE Community Pharmacy - A project proposal was put forward but more detail is required. No further update received. • DCE Optimal lung cancer pathway - £171,353 - This has been released and is non recurring until March 2024. • CRUK Prostate - £213,000 - This has been confirmed and released. The funding is for 2 years from June 2023. • Macmillan posts - Project Manager is in post – awaiting update on allocation. Patient experience person is expected to be in post in September. CM advised a lot of the CWT money was put towards projects in urology as it was seen to be one of our most challenging areas. CM asked how are we holding ourselves to account for the use of the money. CM asked how are we assessing the outcomes of patients and value for money for the investment we are getting. KN advised there was a considerable amount of money put towards urology from the CWT specific funding about extra waiting lists for surgery for the end of the pathway for robotic prostatectomy. KN advised we have £1.9m worth of bids coming in this year. KN advised what she is aiming to do this year is to go to the Patientrack meetings to try and ascertain how that money is being spent on a more regular basis. KN advised she always keeps a regular update on that it is being spent and if there is any slippage but not necessarily effectiveness. KN agreed with CM that they do need to do this more robustly. CM advised this is a discussion for out with the meeting.	

		Action
6.2	**RCDS Plan Beyond 2024**	
	MM advised the paper that is being prepared will include this. Work is ongoing to demonstrate cost savings as total service model needs to be taken into account. They need to undertake costing exercises taking cognisance of the onward referral and the request for repeat CT scan on radiologist recommendation. Work is still required to confirm the economic evaluation and costing to sustain current activity. Although RCDS is a cost effective model it can be very difficult to show cost saving as other work moves into the vacated space.	
6.3	**Patient Involvement**	
	MM advised NHS Fife was appointed fixed term funding from Macmillan Cancer Support for the appointment of a Macmillan Project Patient Involvement Coordinator to fund the establishment of a Macmillan Oncology Improvement Project. This grant is for a fixed period of 24 months. The funding for this post was secured at the end of the 2021 alongside the funding for the Project Manager post. They initially appointed into the Project Manager pathway in the spring 2022, however, they had some human resources challenges; therefore they put a pause on the recruitment of the patient involvement post. The Project Manager post was re-advertised early 2023 and they recruited into the post 4 months ago. They are now looking to recruit the band 5 Patient Involvement post to support the cancer nursing specialists' services to embed the care experience improvement model into practice. Macmillan cancer support Awarded £165,998 for both posts. CM will go through the paper and will discuss with MM offline.	
7.	**QUALITY/PERFORMANCE**	
7.1	**Cancer Waiting Times Q1 2023**	
	KN advised the Q1 2023 publication was published in June 2023. Performance deteriorated for the 62 day standard. 62 day - 69.4% (a decrease from 72.6% last quarter). There was a total 76 breaches with 54 (71%) of them being in urology. We did not meet the 31 day standard again achieving 92.7%. There were 28 breaches. 85% of the breaches were in urology (24 breaches) The tolerance of breaches is 13 for 62 day and 19 for 31 day. Adjusted waits are now published. These are not related to the 62 or 31 day	

		Action
	standard and can be accessed via the Public Health Scotland website. Q2 submission is due and draft figures show: • 62 day - 78.4% (52 breaches, 31 of which urology) • 31 day - 96.6% (12 breaches, all urology)	
7.2	**Effective Breach Analysis SOP**	
	KN advised the group the Effective Breach Analysis SOP was published earlier in the year. As a recap, the aim of this is to ensure effective escalation to avoid breach and ensure effective breach analysis and action where breaches occur. Through the Acute Cancer Services Delivery Group an action plan has been agreed with almost half of the actions having already been completed. There are still some actions which we need to work through namely: • Agree how the template to support breach analysis should be rolled out to ensure actions are put in place where themes emerge. • Update MDTs proformas to include any upstaging of cancer where there has been a delay. • Agree a programme of attendance of services at the Acute Cancer Service Delivery Group to update on performance, challenges and actions to improve. A meeting has been arranged with CD, BH and Sally McCormack to review outstanding actions.	
7.3	**Regrading Guidance**	
	KN advised the group they will be aware that the regrading guidance was published in May 2023. In Fife approximately 16% of referrals are downgraded or sent back to the referrer from an urgent suspected cancer referral and almost 8% are upgraded. This practice varies across specialties. There is variation in practice around informing the GP. Some services such as dermatology and breast have a robust process to advise the GP of a downgrade or advise it is being rejected and why. The aim of this guidance is to ensure consistency across all specialties. An action plan has been drafted and presented to the Acute Cancer Services group and the Cancer Leadership Team. The next steps are to widely circulate the recommendations. It has been agreed that regrading will be implemented as part of the improvement work in lung, colorectal and as part of the prostate nurse led pathway.	
7.4	**Quality Performance Indicators**	

		Action
7.4.1	**Testicular 2021-22**	
	SG went through the papers that were shared with the group. Case ascertainment for NHS Fife is 100% In NHS Fife 13 patients (11 previous cohort) were diagnosed with Testicular Cancer NHS Fife met 8 of the 10 QPIs (including sub-QPIs) for Testicular cancer. QPIs not met: • **QPI 3 - Patients with testicular cancer should have primary orchidectomy within 3 weeks of ultrasonographic diagnosis (USS).** The QPI target was not met showing a shortfall of 18.1% (3 cases) 1 had sperm banking in Tayside. 2 had pathway delays due to service pressure and capacity • **QPI 6-: Patients with stage I seminoma receiving adjuvant single dose Carboplatin should receive within 8 weeks of orchidectomy** The QPI target was not met showing a shortfall of 28.3% (1 case) delayed due to patient holidays, in turn delaying chemotherapy. There were no actions identified for NHS Fife.	
7.4.2	**Bladder 2021-22**	
	IM went through the papers that were shared with the group. Case ascertainment for NHS Fife was 226%. NHS Fife met 8 of the 15 (including sub QPIs) QPIs reported for this cohort of bladder cancer patients. QPIs not met: • **QPI 2: Quality of TURBT at initial resection** – detailed description with tumour location size, number and appearance (6 cases); where the resection is documented as complete or not (4 cases); where detrusor muscle is sampled within the specimen (7 cases). • **QPI 4: Early TURBT** – all T1 or high grade Ta* (*where multifocal or >3cm) NMIBC to have re-resection within 42 days from TURBT1 (25 cases); high grade NMIBC with no detrusor muscle at TURBT1 to have re-resection in 42 days (9 cases); NMIBC where resection was incomplete at TURBT1 to have re-resection in 42 days (3 cases). • **QPI 6: Lymph Node Yield** – pelvic lymph node dissection (>10 nodes) to at least level 2 undertaken at radical	

		Action
	cystectomy (6 cases). There were 3 actions identified for NHS Fife as follows: • **QPI 2(iii) [SCAN wide action]** Clinically deemed high grade or high risk procedures should be booked in for dedicated Bladder cancer surgeons only to perform. • **QPIs 4(i)-(iii) [SCAN wide action]** Identify where main delays are for re-resections to bring repeat procedures in line with the six week QPI target. • **QPI 6 [Fife specific action]** Fife service to document the level of lymph node dissection clearly in the operation notes.	
7.4.3	**Lymphoma 2019-20 & 2020-21**	
	KD went through the papers that were shared with the group. *2019-20* Case ascertainment for NHS Fife is 99.7% NHS Fife met 3 of the 9 (including sub-QPIs) QPIs for Lymphoma. QPIs not met: • **QPI 2 Treatment Response:** The target was not met with a shortfall of 1.1% (2 cases). Both cases exceeded the 91 day target, one by 2 days and the other by 21 days (this was a clinical need as patient too unwell to attend CT). • **QPI 4 Cytogenetic Testing:** The target was not met showing a shortfall of 13.8% (5 cases). 3 did not have MYC test requested because the patients were unfit for chemotherapy. 1 had tissue sent to lab for processing but results were not reported and 1 had insufficient tissue for MYC test to be performed. • **QPI 5 MDT Discussion:** The target was not met showing a shortfall of 5% (9 cases). All were initially diagnosed by other specialities before referral to Haematology. • **QPI 12 Treatment Response in Hodgkin Lymphoma:** Part 1 - The target was not met with a shortfall of 30% (1 case). A CTCAP was performed after 2 cycles instead of a PET CT. The scan was discussed at the regional MDM to inform further management. Part 2 - The target was not met with a shortfall of 80% (1 case) where the report was available 6 days after the PETCT was performed. • **QPI 14 Clinical Trials:** Fife – 0% recruitment.	

		Action
	There were no actions identified for NHS Fife. *2020-21* NHS Fife met 5 of the 9 (including sub-QPIs) QPIs for Lymphoma. QPIs not met: • **QPI 2 Treatment Response:** The target with a shortfall of 27.5% (9 patients). The post imaging date was changed at patient request for 1 patient. 4 patients were treated with adjuvant radiotherapy and had post treatment CT of chest abdomen and pelvis (CTCAP) at 94 days to 98 days after completing radiotherapy. 1 patient had atypical disease location and had MRI as end of treatment imaging. 3 patients had completed their treatment at time of submission but have not yet completed the time period required to get their post treatment imaging. • **QPI 4 Cytogenetic Testing (within 3 weeks of treatment):** The target with a shortfall of 40% (1 case), where the MYC test result was delayed. This did not alter management and the patient received appropriate treatment. • **QPI 12 Treatment Response in Hodgkin Lymphoma:** Part 1 - All 4 patients had interim PET 2 scans. 1 patient did not attend PET appointment and would have met QPI if had attended on original date. 2 patients had early PET prior to day 9, cycle 3 chemotherapy not delayed. 1 patient had PET at correct time but cycle 3 then subsequently delayed for alternative clinical reason. Part 2 - There were no eligible patients in Fife. • **QPI 14 Clinical Trials:** Fife – 0% recruitment**.**	
7.4.4	**Acute Leukaemia 2020-21 & 2021-22**	
	KD went through the papers that were shared with the group. *2020-2021* Case ascertainment for NHS Fife is 110%. NHS Fife met 3 of the 6 (including sub QPIs) QPIs for Acute Leukaemia. QPIs Not Met: • **QPI 3 Proportion of Patients Discussed at MDT**: Fife did not meet the target with a shortfall of 26.8% (7 cases). 5 patients with AML were considered too frail to undergo bone marrow sampling and the result would not have changed supportive care management. 1 patient was discussed in detail informally with consultant in another board and was managed appropriately. 1 patient had bone marrow sampled	

		Action
	but inclusion for discussion at the Haematology MDM was overlooked, however on review, the patient was managed appropriately with best supportive care. • **QPI 8 Clinical Trials with Curative Intent:** Fife did not meet the target. (0/3 patients eligible). 2 patients were eligible for AML 19 but received DA + GO as per working group guidance. 1 patient was not eligible for the trial although they met inclusion criteria for this QPI. • **QPI 14 Clinical Trials QPI:** Fife – 0%: Trial activity was halted during Covid-19 pandemic There was one action identified for NHS Fife: • All patients should be registered at MDM, including where management would not change. *2021-22* Case ascertainment for NHS Fife is 95% In NHS Fife 19 (22 previous cohort) were diagnosed with Acute Leukaemia. NHS Fife met 7 of the 13 (including sub-QPIs) QPIs for Acute Leukaemia. 3 of the QPIs were not assessed as no patients met the criteria. QPIs Not Met: - • **QPI 3 Proportion of Patients Discussed at MDT**: Fife did not meet the target with a shortfall of 0.3% (1 case) who was being treated for MDS which then transformed to AML. This QPI was an action point in 2020-21 and now shows a 26.5% increase in attainment. • **QPI 10(ii) Intensive Chemotherapy in Older Adults:** Fife did not make the target with a shortfall of 12.5% (4 cases). 3 patients did not have trial status recorded locally. • **QPI 12 Palliative Treatment**: Fife did not make the target with a shortfall of 40% (3 cases). They were not considered clinically well enough to receive palliative SACT and were treated appropriately with best supportive care. **There was one action identified for NHS Fife:** • Ensure that trial status is recorded at MDM.	
8.	**CANCER RESEARCH**	
8.1	**Cancer Research Update**	
	FQ advised that they currently have 27 studies in the cancer portfolio.	

		Action
	Since the last meeting they have had 11 new patients recruited across 3 studies; 2 colorectal cancer and 1 breast cancer. The studies in set up are 2 breast cancer studies and a lung cancer study.	
9.	**REALISTIC MEDICINE**	
9.1	**Realistic Medicine Update**	
	LMcG advised that there is a desire to use the principals of realistic medicine to ensure that they are delivering value based care. CM advised the group there is a realistic medicine workshop that is being held on the 20th of September at Lynebank.	
10.	**LINKED COMMITTEE MINUTES**	
10.1	**Cancer Managers' Forum (28/04/2023)**	
	This was noted by the group.	
10.2	**Acute Cancer Services Delivery Group (03/05/2023)**	
	This was noted by the group.	
10.3	**Cancer Leadership Team (23/05/2023)**	
	This was noted by the group.	
10.4	**Rapid Cancer Diagnostic Service Oversight Group (31/03/2023 & 27/06/2023)**	
	This was noted by the group.	
10.5	**SCAN Regional Cancer Strategy Group (09/03/2023)**	
	This was noted by the group.	
10.6	**South East Region Cancer Innovation Programme Governance Group (04/05/2023)**	
	This was noted by the group.	
10.7	**Cancer Performance and Delivery Board (11/05/2023 & 08/06/2023)**	
	This was noted by the group.	
10.8	**Cancer Waiting Times Data and Definitions Group (21/04/2023)**	
	This was noted by the group.	
10.9	**Earlier Cancer Diagnosis Programme Board (31/05/2023)**	
	This was noted by the group.	
10.10	**SCAN Regional Cancer Planning Group (12/05/2023)**	
	This was noted by the group.	
11.	**Items to Note**	
	No items to note	

		Action
12.	**ISSUES TO BE ESCALATED TO EDG/CLINICAL GOVERNANCE COMMITTEE**	
	Report on the National Cancer Strategy Alignment to go the Clinical Governance Committee to provide assurance. Cancer Framework Annual Delivery Plan Year 2 to go to the Clinical Governance Committee. CM advised an update on RCDS may need to go to the Clinical Governance Committee before it comes to this group due to meeting dates.	**KN** **KN**
13.	**ANY OTHER BUSINESS**	
	No any other business.	
14.	**Date of Next Meeting**	
	The next meeting will be on Thursday 02 November 2023, 14:00-16:00 via MS Teams	

CLINICAL GOVERNANCE OVERSIGHT GROUP (Meeting on 22 August 2023)
No issues were raised for escalation to the Clinical Governance Committee.

Clinical Governance Oversight Group

AREA DRUG & THERAPEUTICS COMMITTEE (Meeting on 16 August 2023)
No issues were raised for escalation to the Clinical Governance Committee.

Area Drug & Therapeutics Committee

UNCONFIRMED

MINUTES OF THE MEETING OF THE FIFE DRUGS AND THERAPEUTICS COMMITTEE HELD ON WEDNESDAY 16 AUGUST 2023 AT 2.00PM VIA MICROSOFT TEAMS

Present: Mr Ben Hannan (Chair)
Ms Claire Fernie
Dr Iain Gourley
Dr Claudia Grimmer
Dr Helen Hellewell
Dr Sally McCormack
Mr Fraser Notman
Ms Olivia Robertson
Ms Andrea Smith
Ms Amanda Wong
Ms Doreen Young

In attendance: Ms Geraldine Smith (items 6.3, 7.1, 7.4, 7.5)
Ryan Headspeath (item 7.6)
Mr Duncan Wilson (item 11)
Ms Sandra MacDonald, Administration Officer (minutes)

ACTION

1 WELCOME AND APOLOGIES FOR ABSENCE

Mr Hannan welcomed everyone to the August meeting of the ADTC.

Apologies for absence were noted for Claire Dobson, Dr David Griffith, Maxine Michie, Dr John Morris, Nicola Robertson (Doreen Young representing), Rose Robertson, Satheesh Yalamarthi.

2 MINUTES OF PREVIOUS MEETING ON 21 JUNE 2023

The minutes of the meeting held on 21 June 2023 were accepted as a true record.

3 ACTION POINT LOG

The action list was discussed and actions updated/completed as agreed.

Communications Process for Guidance approved through the MSDTC

Mr Notman provided an update on discussions between Pharmacy and the Communications team. The plan going forward is to centralise all medicines guidance documents into one location on Stafflink and reduce the number of people who have administrative access to upload guidance documents. Work to identify guidance documents currently available on Stafflink or held by individual Specialties/departments is progressing. A project plan to be brought to the next ADTC meeting. **FN/AM**

Collaboration Between the Antimicrobial Stewardship Teams
Action completed.

Pharmacy First Approved List
Mr Notman provided feedback from the consensus meeting to discuss suggestions for amendments to the Pharmacy First approved list. The final list will be approved in the coming months. Action closed.

4 ANY OTHER MATTERS ARISING FROM THE MINUTES

There were no other matters arising from the minutes.

5 DECLARATION OF INTERESTS

There were no declarations of interests.

6 ADTC SUB-GROUP UPDATE REPORTS

6.1 East Region Formulary Committee

Mr Notman introduced the update report from the East Region Formulary (ERF) Committee and highlighted key points.

All adult chapters of the ERF have been reviewed and approved. Review of the paediatric chapters is progressing. The Cardiovascular, Gastrointestinal and Respiratory paediatric chapters have been approved by the ERFC and will be added to the ERF website. The next paediatric chapter scheduled for review is the Central Nervous System.

The successes of the ERFC were noted, including the transition to the full adult regional formulary and cross-region collaboration promoted by the work carried out on the ERF. Challenges were highlighted around communicating the application process to ensure consistency of approach. The application process is being reviewed and an easy to read flow-chart developed.

The ADTC noted the update from the ERF Committee and the good progress made.

6.2 MSDTC

Dr McCormack introduced the update report on behalf of the MSDTC and highlighted key points.

Business as usual is continuing and the group is functioning well. Submissions continue to be received in the appropriate format. A change in professional secretary was noted (now Alice Mathew, Senior Pharmacist Senior Pharmacist Medicines Utilisation and Therapeutics). Membership has also been reviewed to ensure wider clinical perspective and four new members have joined the committee (Interim head of Nursing Emergency Care, Head

of Nursing Planned Care, Nurse Consultant, Consultant in Addictions Psychiatry).

The ADTC noted the update on behalf of the MSDTC and the workplan for the next 6 months.

6.3 Medical Gas Committee

Ms G Smith introduced the update report on behalf of the Medical Gas Committee and highlighted key points.

The ADTC noted the work undertaken by a multidisciplinary team including Estates, Medical and Pharmacy representatives to remove the nitrous oxide manifolds at Queen Margaret Hospital and Phase 1 and 2 at the Victoria Hospital. Plans are in place for the Victoria Hospital Phase 3 nitrous oxide manifold to be decommissioned by the end of October 23.

It was noted that all actions in response to the National Patient Safety Alert on the use of oxygen where patients do not have access to medical gas pipeline systems have been completed.

An issue relating to insufficient trainers to deliver training to Porter Staff on medical gas handling and storage was highlighted. It was noted that a train the trainer session has been organised for September 2023.

The ADTC noted that Ms Smith was stepping down as Chair of the Medical Gas Committee and Claire Steele, Head of Pharmacy - Medicines Supply and Quality will take over as Chair from 1 September 2023. The ADTC thanked Ms Smith for her work on behalf of the Medical Gas Committee.

The ADTC noted the update report on behalf of the Medical Gas Committee.

7 SBARs/Updates

7.1 Annual Medicines Safety Report

Ms G Smith introduced the Medicines Safety in NHS Fife: Review and Improvement report and briefed the ADTC on the background to this.

The purpose of the report is to provide assurance on the current position with regard to medicines safety in Fife and detail the programme of work to be undertaken over the coming year.

The report outlines the overarching focus on medicines safety and links with the Board's work on High-Risk Pain Medicines as well as other key clinical areas identified for targeted improvement: anticoagulants, insulin, lithium and sodium valproate. The report details recommendations around identified themes and trends, programmes of work already taken forward including implementation of the weekly Medication Safety Minute and provides a summary of the actions to be taken forward within the next 12 months.

The ADTC welcomed the report and was supportive of the level of detail and format. The ADTC proposed further refinement around the classification of missing medication and details of communication methods (in addition to BLINK) for cascading information. Ms Smith and Mr Hannan to consider circulation to other appropriate groups prior to Clinical Governance Committee in November. **GS/BH**

7.2 Valproate Audit and Improvement Plan

Mr Notman introduced the report - Valproate - Medicines Safety Programme. The report provides an update on the current position and actions taken since the previous report presented to the ADTC in June 2023.

The ADTC noted the progress made, including a reduction in the number of women and girls of childbearing potential prescribed Valproate medicines in Fife and an improvement in the numbers of patients meeting all four audit standards of the Valproate Pregnancy Prevention Programme.

A discussion followed around patients who are not willing to accept highly effective contraception and the importance of a robust communication/ documentation process for discussions between the specialist and the patient.

The ADTC was supportive of establishment of a multidisciplinary group to oversee implementation of the Valproate Pregnancy Prevention Programme. The multidisciplinary group should also consider what assurance would look like beyond the audit data and be reactive to any future national guidance.

The ADTC thanked all those involved in the work around the valproate audit and improvement plan and noted assurance by the progress made and the plan for moving forward. To be brought back to the ADTC in 6 months. Any issues to be escalated at an earlier stage. **FN**

7.3 Prescribing in Renal Impairment (DOACS)

Mr Notman introduced the SBAR - DOACS - Medicines Safety Programme and briefed the ADTC on the background to this.

The paper provides an update on progress to date with undertaking reviews of dosing of Direct Oral Anticoagulants (DOACS) in patients with renal impairment.

Due to the large number of patients prescribed a DOAC in Primary Care, it was decided that the first cohort of patients to be reviewed would be those patients prescribed a DOAC with a coding for chronic kidney disease. The paper outlines the progress made to date and the proposals for actions going forward to review the remaining patients with CKD currently prescribed a DOAC in primary care to ensure that they are prescribed the correct dosage in relation to their renal function; review processes for initiation and monitoring of DOACs within acute and community hospitals; engage with GP Cluster Quality Leads to develop safe systems of prescribing and monitoring of DOACs on an ongoing basis; and engage with the Vascular MCN to review

current NHS Fife DOAC guidance. The proposed timeline for completion of actions is March 2024.

The ADTC was supportive of the proposed actions for going forward. A detailed plan to be brought back to the next meeting. **FN**

7.4 Provision of Medicines on Discharge

Ms G Smith introduced the Provision of Medicines on Discharge Audit report and briefed the ADTC on the background to this.

An audit on the provision of medicines on discharge in NHS Fife was undertaken in November/December 2022 as part of the Safe and Secure Use of Medicines Policy and Procedure (SSUMPP) Audit and Assurance Programme. The purpose of this audit was to seek assurance that the correct processes are followed when medicines are required to be provided to patients to facilitate their discharge from hospital.

It was noted that during the audit period over 95 discharges were observed and 88.5% were compliant with the correct discharge process. Any non-compliance observed was addressed at the time.

The ADTC noted the good compliance with the discharge process and the recommendations for communication of the audit results/raising awareness of the correct process to follow when patients are provided medicines on discharge. Action plans and recommendations to be monitored through the Safe and Secure Use of Medicines Group and escalated to the ADTC in the event of any concerns. **GS**

7.5 Medical Gas Stores and Ward Audit

Ms G Smith introduced the Medical Gases Stores and Ward Audit reports and briefed the ADTC on the background to the audit.

The audit is undertaken on an annual basis across stores, wards and all departments holding medical gases to assess compliance with legal and best practice requirements. All outstanding actions from Pharmacy have been completed and an action plan developed in order to support staff in areas where any non-compliance has been identified. The Medical Gas Committee has reviewed the report in detail and will monitor action plans to ensure that all outstanding actions are completed. The detail of the audit report will also be shared with the Heads of Nursing.

The ADTC noted the Medical Gases Stores and Ward Audit reports for awareness and assurance with regard to the management of medical gas cylinders and pipeline equipment within NHS Fife. An update from the Medical Gas Committee to be provided to the ADTC in 6 months' time.

7.6 Shared Care Agreements

7.6.1 Apomorphine

Mr Headspeath introduced the revised Shared Care Agreement for Apomorphine and highlighted key changes.

The ADTC noted the key changes including updating of contact points. A potential issue with capacity of the sharps bins was highlighted. A statement has been added to the Shared Care Agreement to request that General Practices prescribe 1L sharps bins for needle and line disposal to facilitate supply by Community Pharmacy.

It was also noted that the Shared Care Agreement includes a link to the NHS Fife Policy and Procedures for the Shared Care of Medicines. It was agreed that pending approval of the revised Policy the previous version should be referenced.

The ADTC approved the proposed revisions to the Shared Care Agreement for Apomorphine. To be taken to the LMC for consideration.

7.6.2 Darbepoetin Alfa (Aranesp®)

Mr Headspeath introduced the revised Shared Care Agreement for Darbepoetin Alfa and highlighted key updates to the formatting and contact points.

There was a discussion around potential additional monitoring requirements in Primary Care. It was noted that monitoring would be undertaken in Primary Care once the patient is stable. Specialists would be contacted for advice in the event of an issue. It was noted that implications for additional blood pressure monitoring would be minimal as this could be undertaken at routine blood test appointments. Dr Hellewell to feed blood pressure monitoring requirements into ongoing discussions around the local enhanced service. **HH**

The ADTC approved the proposed revisions to the Shared Care Agreement for Darbepoetin Alfa. To be taken to the LMC for consideration.

8 Risks Due for Review in Datix

Mr Notman took the ADTC through the risks scheduled for review. It was noted that the template has been updated to include initial, current, likelihood, probability and target RAG status.

Risk 1347 – Shared Care Protocols
The ADTC was content with the detail of risk 1347. Refinements to the risk to capture assurance around the actions taken to minimise the probability of the first two points in the risk description were agreed; the overall risk for shared care to remain. It was proposed that a new risk should be written. **FN**

9 ADTC-COLLABORATIVE/SCOTTISH GOVERNMENT COMMUNICATION

9.1 ADTCC July Newsletter

The ADTC noted the ADTCC July Newsletter.

10 EFFECTIVE PRESCRIBING

10.1 Pharmacy First Approved List

Discussed under item 3 Action Point Log.

10.2 NCMAG Quarterly Update

The ADTC noted the NCMAG quarterly update.

10.3 NCMAG 109 - Pemetrexed plus cisplatin

The ADTC noted the NCMAG 109 Pemetrexed plus cisplatin Advice Document.

10.4 NCMAG 110 - Abiraterone

The ADTC noted the NCMAG 110 Abiraterone Acetate Advice Document.

10.5 Early Access to Medicine Scheme

- **Dostarlimab**

The ADTC noted the Early Access to Medicine Scheme Operational Guidance for Dostarlimab for use in first-line treatment of primary advanced or recurrent endometrial cancer.

- **Glofitamab**

The ADTC noted the Early Access to Medicine Scheme Operational Guidance for Glofitamab for the treatment of adult patients with relapsed or refractory diffuse large B-cell lymphoma (DLBCL), after two or more lines of systemic therapy.

11 HEPMA Update

Mr Wilson provided a verbal update on the current contractual position and progress with electronic prescribing and the implementation of HEPMA.

The forthcoming expiry of the contract with Microguide was also noted. Work to move to the Scottish Antimicrobial Companion App is progressing.

12 PACS/SMC Non Submissions

12.1 Latest Submissions

The table detailing the latest PACS2/SMC non submissions was noted.

13 POINTS FOR RAISING AT CLINICAL GOVERNANCE COMMITTEE

There were no items identified as requiring escalation at this stage to the Clinical Governance Committee. The Annual Medicines Safety Report to be submitted to the Clinical Governance Committee after refinement.

14 ANY OTHER COMPETENT BUSINESS

There was no other business.

Other Information

a **Minutes of Diabetes MCN Prescribing Group 30 May 2023**. For information.

b **Minutes of Heart Disease MCN Prescribing Sub-Group -** next meeting 24 August 2023.

c **Minutes of Respiratory MCN Prescribing Sub-Group 14 June 2023**. For information.

d **Date of Next Meeting**
The next meeting is to be held on **Wednesday 25 October 2023 at 2.00pm via MS Teams**. Papers for next meeting/apologies for absence to be submitted by 11 October.

IJB QUALITY & COMMUNITIES COMMITTEE

(Meeting on 30 June 2023)

No issues were raised for escalation to the Clinical Governance Committee.

IJB Quality & Communities Committee

Fife Health & Social Care Partnership

Supporting the people of Fife together

CONFIRMED MINUTE OF THE QUALITY & COMMUNITIES COMMITTEE
FRIDAY 30 JUNE 2023, 1000hrs - MS TEAMS

Present:	Sinead Braiden, NHS Board Member (Chair) (SB) Councillor Rosemary Liewald Councillor Lynn Mowatt Ian Dall, Service User Rep, Chair of the PEN (ID) Morna Fleming, Carer's Representative (MF) Kenny Murphy, Third Sector Representative (KM) Paul Dundas, Independent Sector Lead (PD)
Attending:	Dr Helen Hellewell, Deputy Medical Director (HH) Nicky Connor, Director of Health & Social Care (NC) Lynn Barker, Director of Nursing (LB) Lynne Garvey, Head of Community Care Services (LG) Lisa Cooper, Head of Primary Care and Preventative Care Services (LC) Rona Laskowski, Head of Complex and Critical Care Services (RL) Jennifer Rezendes, Principal Social Work Officer (JR) Simon Fevre, Staff Side Representative (SF) Scott McCallum, Service Manager, Corporate Parenting (SMcC) Alan Adamson, Service Manager, Quality Assurance (AA) Avril Sweeney, Manager, Risk Compliance (AS) Heather Bett, Senior Manager, Children Services, Sexual Health & BBV and Rheumatology (HB) Lesley Gauld, Team Manager, Strategic Planning (LGal) Ruth Bennett, Health Promotion Manager (RB) Tracy Harley, Service Manager Participation and Engagement (TH)
In Attendance:	Jennifer Cushnie, PA to Deputy Medical Director (Minutes)
Apologies for Absence:	Councillor Sam Steele Councillor Margaret Kennedy Cllr Graeme Downie Alistair Grant Dr Chris McKenna, Medical Director Ben Hannan, Director of Pharmacy and Medicines Roy Lawrence, Principal Lead for Organisational Development & Culture Christine Moir, Head of Education and Children's Services (Children and Families/CJSW and CSWO) Catherine Gilvear, Quality Clinical & Care Governance Lead (CG)

No	Item	Action
1	**CHAIRPERSON'S WELCOME AND OPENING REMARKS** The Chair welcomed everyone to the HSCP Quality & Communities Committee. SB extended her sincere thanks to all HSCP staff who continue to work above and beyond in what continues to be an extremely challenging working environment.	
2	**DECLARATION OF MEMBERS' INTEREST** No declarations of interest were received.	
3	**APOLOGIES FOR ABSENCE** Apologies were noted as above.	
4	**MINUTES OF PREVIOUS MEETINGS HELD ON 16 MAY 2023** The previous minutes from the Q&CC meeting on 16 May 2023 were reviewed and no alternations or corrections were requested. The minutes were taken as an accurate record of the meeting.	
5	**ACTION LOG**	
6	**GOVERNANCE**	
	6.1 Lived Experience – Methilhaven Care Village The slideshow of photographs showing the Methilhaven Care Village as it evolved was presented by Nicky Connor. NC, who has spent time at the Village, the first of its' kind in Scotland, described the excellent facilities comprising a care home, sheltered housing, supported living and a nursery, all on one site. NC spoke very highly of the staff working within the facility with forward thinking and enthusiastic attitude. All IJB Members will be invited to the formal opening taking place in September. The presentation was brought to Committee for **Information.** SB thanked NC for the presentations and hoped the news of the ground-breaking project would be shared widely. Cllr Liewald seconded SB's comments.	
	6.2 Quality Matters Assurance LB introduced the Quality Matters Assurance Paper, brought to Committee for Assurance.	

	LB advised QMAG meets minimally six times per year and is clinical and professionally led by herself with support from the Deputy Medical Director and Chief Social Work Officer. The purpose of the group is to seek assurance from each portfolio that clinical and care governance is discharged effectively within the Partnership, whilst meeting the statutory duty for the quality of care. LB stated, the matters discussed at Fife HSCP QMAG on 21st April are summarised and these items were brought to the Group for learning, advice, assurance, review of risks and escalation. KM queried where legal responsibility lies. NC confirmed responsibility sits with the Chief Executives of FC and NHS Fife re statutory duties they hold for the quality of services delivered. She stated, the IJB is required to have a level of oversight and advised, by November 2023, a Clinical & Care Governance Framework with strengthened performance reporting will be in place. Currently, an overview of the work taking place is being brought, to show how the work connects with both Partners and how it supports responsibilities held by the IJB. KM would like the documentation to be made available to give confidence progression is being made as should be. LC felt confident HH, LB and JR will take this on board and will achieve the correct balance through the Framework.	
	6.3 External Inspection Report - deferred	
	6.4 Adult and Child Protection IJB Risk 10 Assurance JR introduced the report which is seeking assurance around the NHS overarching governance for Adult Support and Protection. She advised, the content of the paper gives an in- depth detail of the governance and JR talked through the various tiers and the branches coming from each. The report has come through QMAG and is brought to Q&CC for assurance. SB ask if Committee can take assurance a multi-agency response is being used. JR advised the report gives assurance there are systems in place to enable this. ASPC improvement plan and ASPC conveners report which comes to IJB annually giving assurance, however, did not have specific date. The Committee confirmed they were assured the correct governance structures are in place for Adult and Child Protection.	
	6.5 Home First Strategy	

	LG brought the Home First Strategy for discussion and decision to progress to IJB. LB outlined the route the Strategy has taken thus far, and where it will progress to following Q&CC. LB advised the Strategy outlines the strategic direction for the Home First model and sets out the transformational initiatives which are relevant to the three elements of the strategy. These are prevention and early intervention, person centred at the heart of all care decisions, and a whole systems approach. She spoke of feedback around early intervention and prevention featured at the start of the Strategy and changes were made. LB highlighted the main aims of the Strategy, including the vision of enable everyone in Fife being able to live longer healthier lives at home or in a homely setting. The sub-groups which enable the programme were outlined. Cllr Liewald was very supportive of the Strategy and reported very good feedback she has received. MF felt the Strategy is well-written and had various questions which she will email separately to LB. She did wish to raise the subject of Carers in this context, as they may be willing to take on more responsibility than is necessarily good for them. She spoke of IT, FC and NHS systems speaking to one another, as this is not easy currently. LB welcomed all comments and advised there has been a huge amount of consultation which has included Carers, has not been drawn through into SBAR, she will ensure this is corrected. ID felt the Strategy begins well, however, too much emphasis is placed on preventing hospital admission and releasing from hospital quickly, he felt more balance is required. ID referred to the diagram on eligibility criteria and asked at what stage intervention is made. He also queried KPIs, reference to Mental Health and the Risk Register. It was agreed, LG will pick up these points directly with ID offline as it was felt he may not have the most recent version of the Strategy. KM was happy to see the Strategy has a good level of detail. He also queried the KPIs. LG explained how the KPIs are calculated and the relevance of noting, future reports which come back will be performance related. LG will pick up out with the meeting. PD thanked LG for the Strategy which he is fully supportive of and felt to be comprehensive with considerable detail. He raised the subject of Care@Home staff currently being unable to administer medications at level 3. He felt to meet the early intervention/ prevention aim, this is imperative. He spoke of a special interest group looking at this and felt it should be included on the Risk	**LG**

		Register. He would welcome off-line conversation. LG was in agreement. SB asked if the Home First Strategy was specifically for Older People. LG advised the majority will be over 65yo, although does include all adults - does not include children and/or young people. Where mental health fits in and decision making around release from hospital was discussed. ID raised concerns around lack of evidence re early intervention. LG assured steps have been taken since previous feedback from ID. She advised interface care, supporting people within the community, will be more strongly detailed within the report.	**LG**
	6.6	**Care Inspection, Care at Home Fife** LG advised, the report comes to Committee for Noting. She stated the Care at Home Service has been inspected and the report highlights the rates awarded, the recommendations and the action plan to meet the recommendations. She advised, the Care at Home Service was previously inspected in Jan 2020, when all 3 parts were graded with 4's. She was delighted to say, despite the Pandemic having a significant impact, particularly within Workforce, a grade of 4 has been maintained. LG personally met with the Inspectors and she was told Fife is one of the few Care at Home Services which has received grades of 4. Lots of different actions were recommended and an action plan has been agreed. PD thanked LG for the report and spoke of the difficult period which had been experienced throughout the Pandemic, and with a high turnover of staff and felt it was an encouraging report to read.	
	6.7	**Carer's Strategy 2023-2026** NC presented the report for consideration and support to progress to IJB. She advised the Strategy looks at HSCP's responsibilities to the Carer's Scotland Act and requirement to publish a local carer's strategy at least every 3 years. Extensive engagement and consultation has taken place at the end of 2022/early 2023. NC detailed the various means of engaging with Carers and Carers organisations. A Strategic needs assessment underpins the Strategy and NC gave detail. Progress investments made were outlined along with forward planning for the next two years were explained. NC advised the Strategy is aligned to both National and Local Strategies and spoke of workforce development and spoke of recognising the critical importance of supporting carers. She highlighted the main points from the SBAR and advised the Strategy has been endorsed by the Joint Carer's Strategy Group. NC welcomed any comments, particularly from MF. MF advised she has points she will discuss off-line. She wanted to say, reaching out to unpaid carers was important work, carer's	**MF/FMcK**

	strategy funding has gone into additional social workers posts, adult carer support plans and young people statements wants to see a measurable outcome. NC will feed back to FMcK and ensure all points are taken forward. SB queried some of the figures, stated as doubling but no further detail. NC will feedback. ID felt communication is the key to identifying more carers and should be given high priority. Cllr Liewald was happy to see the very good work with The Wells reported with drop-ins increasing. She suggested The Wells could offer a good opportunity for conversations to take place helping to identify carers. There was discussion around advertising of the support available. TH spoke of the work the PA Team are doing around chemists, GP surgeries and on the street.	**NC** **NC**
	6.8 Fife Primary Care Strategy LC introduced the Primary Care Strategy, which was commissioned jointly by the Director of HSCP and NHS Fife Medical Director focussing on medium to long term plans to support high quality accessible care to the population of Fife for PC Services. This is one of the 9 key enabling strategies, underpinning the Partnerships Strategic Plan to support the vision for people of Fife to live independent healthier lives. LC gave an overview of the Services provided and outlined the main themes within the Strategy. The five priorities and principles within the Strategy were described. LC spoke of the significant participation and engagement work carried out to shape the Strategy ensuring the focus is on what matters to the population of Fife. The governance structure in place will give oversight, once there is a move to implementation, and formal reporting will come forward to give assurance of the Implementation Plan and Delivery Plan achieving the ambition of the Strategy. MF felt the document was very readable and queried the reason for Dental Service child registrations dropping, also Community Pharmacy, she believed some big chains are blocking new Community Pharmacies being opened and queried the reason. LC welcomed feedback advised the meeting a Summary version of the Report is to be released for easier reading. She is aware of child registration reduction and gave assurance work will be targetted looking at this. Re-established the oral health improvement programmes, one of which is the Childsmile programme, ensuring an early intervention approach. LC spoke of the complexities of Pharmacy registration which is directed through National legislation structures. Currently Fife are	

		on a journey working around these. She advise a Pharmacy Application Committee convened within Fife to manage Pharmacy applications There was discussion around the legislation relating to Community Dentistry and Pharmacy. In particular, ID felt legislation to be flawed. NC advised of work being carried out through LC's Team in partnership with NHS Fife, looking at internal processes around PPC. Internal improvements identified which can be made, engaged with Ben Hannan and Alistair Grant. NC gave assurance being looked at despite challenges around legislation. LC agreed, Dentistry access is very challenging and stated her Team are looking at novel and new approaches to support and improve work with independent contractors and Dentists. KM felt the participation and engagement results showed poor engagement from people of Fife. He suggested new methods of engagement should be considered, encouraging greater involvement. He commented he felt the Strategy, in places, appeared to cross over to operational plans for implementation. NC wished to clarify the method of participation and engagement which included a higher number of individuals and explained the background. She spoke of the 9 underpinning Strategies of the Partnership's Strategic Plan and work which will take place to ensure these are connecting as intended with an annual delivery plan which connects the key priorities, informing performance reporting each year. SB thanked everyone for their comments. She acknowledged concerns around Dentistry and Pharmacy. Information regarding public engagement work should be corrected to reflect the true engagement which took place. SB advised the committee were content to progress the Primary Care Strategy to the IJB.	**LC**
	6.9	**Child Protection Annual Report 2022/2023** HB introduced the report which she advised, ties in with the presentation given by JR around IJB Risk 10. The report covers the period 2022/23 and gives assurance appropriate child protection arrangements are in place. HB described the teams and the work being undertaken. She stated the report gives assurance the children of Fife are protected from harm and any concerns relating to their welfare are identified and addressed in a timely manner. The key drivers, leadership, accountability and governance arrangements and	

	processes were outlined. Also, activities taking place throughout 2022/23, including successes and challenges. HB spoke of progressing into 2023/24 and the work planned, she mentioned the Child Protection Guidance published in 2021, which is to be implement by April 2024. She outlined the work carried out by the small team across a range of areas and the development, education and training within the team. She advised the Team are looking to expand to include a Learning & Development Officer and a Clinical Effectiveness Co-ordinator from beginning of August. HB outlined the role of the new team members. Cllr Liewald thanked HB for a detailed report and welcomed the Team expanding and felt there is now a much-improved service available. SB agreed with Cllr Liewald's statement.	
	6.10 Participation & Engagement Strategy / Updated Planning with People Guidance 2023 TH introduced the report on behalf of Fiona McKay for assurance. The P&E Strategy, which is based on the Scottish Government Planning with People Guidance 2021, was endorsed by the IJB at the end of 2021. This Guidance was since reviewed to support a Human Rights based approach and to align with the care improvements and recommendations of the Independent Review of Adult Social Care. The P&E Strategy is brought back to Committee to give assurance it continues to be in alignment with the Planning with People Guidance. TH advised work is ongoing and the Strategy is live. She spoke of the Carers Forum which is currently being built upon. KM was supportive of the Strategy, although felt there was a lot of demand placed on the Team and asked how to proactively engage more people and gave examples of poor engagement. This question was discussed at some length. Virtual engagement and face-face within the Community is taking place and stated the goal of the Strategy is to engage more members of the population. Fully compliant with the Health Improvement Scotland Quality Framework, expected to develop and grow. ID stated himself and MF have been fully involved, with some way to go. He felt additional funding would be beneficial. Cllr Liewald encouraged the P&E Team to utilise Councillors to promote P&E work where appropriate.	
	6.11 Corporate Parenting Board – 6 Month Update SMcC introduced the report on behalf of C Moir. The 6 Month Update was brought to Committee for assurance. He advised the	

	Board meets quarterly and is attended by a wide range of Senior Officers across the Partnership. SMcC outlined the remit of the Board which is to improve outcomes and life chances for children and young people with Care Experience. Four priority areas which have been further developed during the previous 6 months, include 'Belonging to Fife' which SMcC explained, improving school attendance, supporting and improving young people's mental health and developing lived experience groups. SMcC gave details relating to the work. Cllr Liewald spoke highly of the work taking place. ID reiterated Cllr Liewald's comments and spoke of a positive experience story and thanked SMcC for the work he and the Team are carrying out.	
	6.12 Annual Performance Report 2022-2023 AA presented the report on behalf of Fiona McKay, brought for consideration and recommendation for progression to IJB. AA highlighted the main points from the report. He advised further detail will come to the Strategic Planning Group in July and will then be progressed to IJB. AA stated, the Annual Report must be published by the end of July and to ensure the report goes through the Committee process on a timely basis to seek approval, indicators have not been provided. He advised, indicators will be provided by 4th July and will be included when the report goes to the IJB. MF thanked AA for the report which she felt was very readable. She asked if abbreviations could be more clearly explained.	**AA**
	6.13 Quality & Communities Strategic Risk Register AS presented the Strategic Risk Register on behalf of Audrey Valente for awareness and discussion. The Register sets out the IJB Strategic Risks which may pose a threat to the Partnership in achieving its objectives in relation to quality & care governance and quality of care. AS advised, the Register was last presented to Committee in November 2022 and is scheduled to come to Committee on a 6-monthly basis. AS advised the Risks continue to be managed by the Risk owners and were last reviewed in May '23. The Risks are presented in order of residual risk score, this takes into account the current level of management actions and internal control in place. AS highlighted the risks which have a high residual risk score and advised there are a number of risks at an operational level which are monitored at the QMAG meeting and managed by Service Managers. If a risk raises concern, it will be escalated to SLT and to a strategic level if necessary. She spoke of work ongoing	

	developing a deep dive review process for Strategic Risks, piloted by Finance, Performance & Scrutiny and agreed at Audit & Assurance Committee. These deep dive review reports will be brought back to Q&CC going forward. The Committee were assured quality & communities risks are being managed.	**AS**
	6.14 Risk Appetite Statement AS again brought the report for discussion and recommendation to the IJB. She advised this follows on from a lot of work which took place Dec '22 and at the IJB Development Sessions in Feb '23. The report has been previously recommended to IJB at Audit & Assurance in July '23 and will go to Finance, Performance & Scrutiny w/c 03.07. AS gave an overview of the report and explained the risk process, including how tolerance levels are applied. It is the intention to apply the risk appetite to all IJB Strategic Risks and to use it when considering risks related to decisions being taken by the IJB around Strategy, development, budget, etc. Cllr Liewald commented the Development Session was very enlightening and gave good understanding of the process. The Committee were content to approve the Risk Appetite Statement to progress to IJB.	
	6.12 Health Promotion Service Annual Report 2022/23 LC welcomed Ruth Bennett to present the report to Committee. RB introduced the report which had been requested by the PHWBC for information. RB outlined the main topics of the report which included the role of the Service, key National and Local strategic drivers, commitment to early intervention and prevention with a focus on up-stream determinants of health and the report sets out the range of the work undertaken and the Services provided with examples to illustrate how the Health Promotion Service works to achieve this. The report also provides examples to illustrate the response made to recover and remobilisation from the Pandemic. Examples showing how the team have contributed to working across H&SC portfolio and gave examples of these. And also contributed to HSCP & NHS Fife commitment to anchor institutions, giving examples. MF felt specific reference to carers is missing, particularly in relation to recovery from the Pandemic where carers took on extra responsibility as people did not want others coming into their homes and this has not changed due to various reasons. MF would like to see in the Equality & Diversity para 335 some specific mention of carers and the effects on them during and post Pandemic. RB thanked MF for her comments.	

	Cllr Liewald thanked LC and RB for the report and stated she was particularly pleased with Food for Fife Strategy, there is also a community growing project with community orchards being developed where members of the community grow their own. In the Cowdenbeath area, this is expanding with plots of land being identified for use. She asked if this work can be included within the report. Many benefits, including mental health. RB will ensure comments are fed back. LC welcomed the feedback and she referred to MF's comments around carers. LC wanted to give assurance, as the Service moves forward, in the development of the prevention and early intervention strategy, carers and what matters to carers, will be threaded through the Strategy.	
7.0	**EXECUTIVE LEAD REPORTS & MINUTES FROM LINKED COMMITTEES**	
	7.1 Quality Matters Assurance Group Confirmed Minute from 21.04.23 **No comments.**	
	7.2 Strategic Planning Group Unconfirmed Minute from 17.05.23 **No comments.**	
	7.3 Clinical Governance Oversight Group Confirmed Minute from 18.04.23 **No comments.**	
	7.4 Equality & Human Rights Strategy Group No new minute available.	
	7.5 Fife Drugs and Therapeutics Committee Confirmed Minute from 26.04.23 **No comments.**	
8.0	**ITEMS FOR NOTING** **No comments.**	
9.0	**ITEMS FOR ESCALATION** Methilhaven Care Village.	
10.0	**AOCB** No further business raised.	
11.0	**DATE OF NEXT MEETING** Thursday 07 September 2023 – 1400-1700hrs	

QUALITY & COMMUNITIES COMMITTEE

(Meeting on 7 September 2023)

No issues were raised for escalation to the Clinical Governance Committee.

IJB Quality & Communities Committee

Fife Health & Social Care Partnership

Supporting the people of Fife together

UNCONFIRMED MINUTE OF THE QUALITY & COMMUNITIES COMMITTEE THURSDAY 07 SEPTEMBER 2023, 1000hrs - MS TEAMS

Present:	Sinead Braiden, NHS Board Member (Chair) (SB) Councillor Rosemary Liewald Councillor Lynn Mowatt Councillor Sam Steele Ian Dall, Service User Rep, Chair of the PEN (ID) Morna Fleming, Carer's Representative (MF) Colin Grieve, Non-Executive Board Member (CG) Kenny Murphy, Third Sector Representative (KM)
Attending:	Dr Helen Hellewell, Deputy Medical Director (HH) Nicky Connor, Director of Health & Social Care (NC) Amanda Wong, Director of Allied Health Professionals (AW) Lynn Barker, Director of Nursing (LB) Catherine Gilvear, Quality Clinical & Care Governance Lead (CG) Lynne Garvey, Head of Community Care Services (LG) Lisa Cooper, Head of Primary Care and Preventative Care Services (LC) Rona Laskowski, Head of Complex and Critical Care Services (RL) Jennifer Rezendes, Principal Social Work Officer (JR) Simon Fevre, Staff Side Representative (SF) Avril Sweeney, Manager, Risk Compliance (AS) Leesa Radcliffe, Clinical Services Manager (LR)
In Attendance:	Jennifer Cushnie, PA to Deputy Medical Director (Minutes)
Apologies for Absence:	Councillor Margaret Kennedy Cllr Graeme Downie Ben Hannan, Director of Pharmacy and Medicines Roy Lawrence, Principal Lead for Organisational Development & Culture Christine Moir, Head of Education and Children's Services (Children and Families/CJSW and CSWO) Paul Dundas, Independent Sector Lead (PD)

No	Item	Action
1	**CHAIRPERSON'S WELCOME AND OPENING REMARKS** The Chair welcomed everyone to the HSCP Quality & Communities Committee. SB extended a warm welcome to new Member, Colin Grieve, Non-Executive NHS Board Member. SB thanked HSCP staff	

	who continue to work above and beyond in what continues to be an extremely challenging working environment.	
2	**ACTIVE OR EMERGING ISSUES**	
	Helen Hellewell advised 'Active and Emerging Issues' has been newly introduced to the Committee's Agenda. This items will be verbal and will bring forward any relevant issues which are important for the Committee to know, for which there has not been time to prepare Papers. HH wanted to make the Committee aware of the re-phasing of the Covid 19 and Flu Vaccination Programme. She explained this is due to the new strain of Covid 19 and the Government has instructed all Boards to protect those most vulnerable, in the first instance. This involves bringing forward vaccinations for Care Home residents, those over 75 and those with weak immune systems. Care Home delivery has been brought forward to 18 September and over 75 yo's / weak immune systems to the beginning of October. HH spoke of extensive, on-going comms which are being actioned. She explained a slight hold up with the self-booking on-line system, which will continue to be monitored. A paper will be brought to a future meeting for further assurance. No questions were raised.	**H Hellewell**
3	**DECLARATION OF MEMBERS' INTEREST** No declarations of interest were received.	
4	**APOLOGIES FOR ABSENCE** Apologies were noted as above.	
5	**MINUTES OF PREVIOUS MEETINGS HELD ON 30 JUNE 2023** The previous minutes from the Q&CC meeting on 30 June 2023 were reviewed and no alterations or corrections were requested. The minutes were taken as an accurate record of the meeting.	
6	**ACTION LOG**	
	The Action Log from the meeting held on **30 June 2023** was approved as accurate and updates noted.	
7	**GOVERNANCE**	
7.1	**Quality Matters Assurance** The report was brought for assurance by HH on behalf of Lynn Barker. HH gave an overview of the current clinical and care governance arrangements, systems and processes which are in place across the Partnership and outlined the matters discussed at Fife HSCP QMAG. HH advised, increased emphasis will be placed on social work and social care aspects at future meetings and a draft of the Clinical & Care Governance Framework will be brought to the next Q&CC meeting. HH added, the QMAG meetings currently fall out of sync with the Q&CC meetings, however, in the new year, these shall be aligned to bring more recent reports. Questions were invited.	**L Barker / H Hellewell**

	MF queried mental health incidents and asked for an explanation for the upward trend of occurrences. HH told of continuous monitoring which takes place and explained the complexities of the trends. CG advised, additional information is collected and is looked at in different ways, ensuring all necessary mitigations are in place and deeper dives carried out where appropriate. Cllr Liewald thanked HH for the paper and queried the statement "we now have monthly unit manager quality assurance meetings for HSCP care homes, chaired by the Care Home Manager and Care Home Lead Nurse". NC advised this refers to the National Direction to have a care home assurance group in place, which includes all the care homes in Fife, not only managed care homes. LG gave further detail around these meetings.	
7.2	**Community OT Service Waiting Times** LG introduced the report which was brought to Committee for discussion and to emphasise the increased demand in the service and where resource is to be focused. LG introduced Leesa Radcliffe, Clinical Services Manager who was available to answer any questions at the end of the presentation. LG described the ongoing work within the COT service and outlined mitigations in place and how waiting times are managed. The Committee were asked to consider proposals to make further changes to the way the COT Service operates with LG giving detail. She finished by stating it was acknowledged the waiting times are sub-optimal and recognised the impact this is having on service users. The paper was brought to committee to ask for recognition the Service does regard the waiting times as unacceptable and are working to ensure these are reduced. KM felt there was insufficient trend data to show the scale of the challenge. He acknowledged there was a lot in the report which was good common sense, however, would welcome a later paper to give assurance around quality of care. He also queried some of the waiting time data relating to those 'at greater risk' and 'moderate risk'. LG advised the trend data was omitted by herself, she will circulate. She explained some figures include people awaiting housing. LR advised, on occasion, major adaptions are required to be made by housing services. Whilst the person is awaiting the work's completion, the individual remains on the waiting list, thus increasing waiting times. MF asked what support is given for people in urgent need of assistance, should targets be missed? LG stated, all 'critical' needs will be met, those deemed 'moderate' will be regularly monitored and other supports put in place, ie Third Sector Organisations, District Nurses and other Partners and Services ensuring the individual is safe. MF queried the length of time until the Carer's Strategy Funded OT post is filled. LR advised, the post is actively being recruited to currently.	

	SF felt it would be useful to see which other Services need to be involved, ie Housing. He also queried why there was no mention of increasing staffing, the complexities of which were discussed and raised in the recent staff questionnaire. LG advised lack of funding was the main reason and spoke of the imminent development session which will be looking at addressing some of the problems which came through the questionnaire. The re-hab model in the community is hoping to reach out to many more people, currently being addressed, although not directly by employing Community OT Council staff. ID was not supportive of the paper and felt it did not give assurance. He told of people who have not contacted the service, as they felt there was no help there, instead bought their own equipment/home improvements. He felt the situation is going to become worse and queried why implications for Fife Council/NHS had been marked 'not applicable'. He advised urgent attention is required. LG felt radical steps are being taken and are outlined in the report. She suggested PMO support may be helpful to rapidly improve the situation with a plan. She advised Fife are one of three Partnerships in Scotland who are assessing and considering 'moderate risk and below'. She felt the Service is very committed to progress improvement. She will take ID's suggestion to put a rapid PMO approach into further improvements. Cllr Liewald had concerns around what HSCP trying to do and the connection with other services. She felt once assessment is carried out, services are not connecting, there are time delays and suitability of equipment is a concern, she felt this should be investigated. It may be a restructuring is required and Cllr Liewald voiced her serious concerns. LG noted the concerns and stated, for the moderate cohort, the service is now working with The Wells, which may release capacity to address 'most urgent'. LR spoke of meetings and engagement with Housing, Contractors and Community Occupational Therapy. Cllr Mowatt gave a positive lived experience story, indicating the system is working in some cases. SB asked if a PMO approach can be taken and NC agreed, there will be a meeting with the Team. She thanked LG and LR who reflected openness and transparency and welcomed frank feedback. Further consideration will be given and an update will come back to Committee.	**N Connor, L Garvey, L Radcliffe**
7.3	**Deep Dive Review for IJB Risk 26 Primary Care Services** LC brought the report for Discussion and Assurance. She introduced Avril Sweeney who was present to assist with questions. LC stated, the Deep Dive Review for the Primary Care Services is number 26 on the IJB Risk Register and seeks to demonstrate how the risk is being managed and sets out relevant assurances.	

	LC explained the Appendices of the report. Appendix 1 details the work which has taken place to truly understand the Risk and Appendix 2 outlines the questions which support the process, giving focus as the Deep Dive is taken. She drew attention to the description of the risk and the external and internal factors which impact the risk level. She also outlined the SMART controls in place with timescales and details of mitigating actions. By implementation of the Primary Care Strategy, it is hoped the risk factor will in time move from 16 to 8. LC spoke of the level of assurance which is felt to be 'reasonable' around the mitigating actions and control measures in place. She drew attention to external factors which are expected to evolve and change whilst moving to implementation of the Strategy. Questions were invited. There was considerable discussion around the Risk, concerns included funding and staffing. LC fully acknowledged the concerns, however, through innovative thinking, upskilling of the present workforce, along with the local ambition to deliver the PC Strategy and Workforce Strategy, she felt change is already happening. KM was keen to see evidence. NC thanked KM for his comments and explained the reason and process for a deeper dive, which will come through the Audit & Assurance Committee. She stated feedback will go back and she invited KM to email Avril Sweeney with any suggestions of how this balance can be reached, stressing feedback is welcomed and continuous improvement is aimed for. Cllr Liewald felt comms to general public making it clear exactly the services which are provided is vital. LC agreed with Cllr Liewald's comments and advised correct comms is one of the key elements of the Strategy, as well as National comms. NC asked for feedback – she queried if the concept of bringing a deeper dive of any risks which sit with Q&CC was a helpful exercise, SB stated it was very helpful.	
7.4	**MWC Overview** This report is deferred to 02 November meeting.	
7.5	**Mental Health Estates Initial Agreement** This report is deferred to 02 November meeting.	
8	**LIVED EXPERIENCE – will come forward to 02 November 2023 meeting.**	

9	**STRATEGIC PLANNING & DELIVERY**	
9.1	**IJB/HSCP Resilience Assurance Annual Report** This report was brought to Committee by LG for Assurance and Discussion. LG stated, the Civil Contingencies Act was amended in March 2021 to include the IJB as Category 1 Responders under the Act. LG gave an outline of the Assurance Framework and the work which has taken place. She stated the framework provides assurance the Partnership effectively prepares for, responds to and recovers from, civil emergencies which impact on Fife's Communities and the delivery of Health and Social Care Services. LG expanded on several points from the report. Feedback was welcomed. NC thanked LG, AS and all of the team who have worked to enable the creation of the framework which recognises and values the responsibilities held by NHS, FC and also the IJB. She spoke of the massive piece of work which has taken place to reach this stage. KM felt the Framework to be comprehensive and spoke of the importance of protecting the most vulnerable of Fife residents. He questioned the cyber resilience of the IT Systems within NHS Fife and FC and asked if it is a priority to protect data and systems which enable services within communities to continue, should there be an attack. LG advised she had attended a presentation on this topic. AS explained, cyber-attacks are a high risk which are actively monitored for and spoke of preventative systems which are in place. She advised, there is a priority list of systems to be protected, of which health and social care are high. Care at Home being particularly vulnerable with a technology team to establish workarounds, should an attack occur. Cllr Liewald spoke of an incident which occurred in her Ward in 2020 where many homes were flooded. She felt if HSCP had been part of the First Response team, they would have been able to help a great deal more than what was done at the time. Therefore, she was very supportive and welcomed the Resilience Framework. MF questioned the recording of incidents and when FC and NHS Fife will be using the same IT systems. NC completely agreed and advocates for joined up IT systems at a national level, filtering down. She will continue to champion for shared IT systems. CG commended the very detailed report. Embedding this into the organisation will be the next stage to implement and ensure everyone understand it. Cllr Steele was particularly pleased to see the incident debrief and lessons learned which can often be missed. LG agreed this was an important part of the report.	

9.2	**Winter Planning 2023/2024 (incorporating Winter Reflections 2022/23)** This report is brought to Committee by LG for Discussion and Assurance. She advised, the report gives an update on actions agreed last winter and describes work being undertaken to prepare for winter 2023/24. LG highlighted pressures, which have not subsided since 2020. As far back as data shows, 2022/23 having been the most pressurised winter to date. Demand for services was significant and she commended the teams on continuing to flex and be agile to meet demands. LG explained the new actions which have been introduced to help meet demand, including Predicted Day of Discharge and Front Door Teams. Performance data was outlined and graphs explained, with Fife seeing an all-time high in weekly discharge figures. Comparisons with national averages was given. LG stated, Scottish Government have developed ten recovery drivers which have been incorporated into Fife's Annual Deliver Plan for 2023/24, two of which are covered in the report – more care to be delivered in the community and improved access to urgent and unscheduled care. LG described the additional actions being taken in preparing for winter 2023/24, including reducing admissions due to long term conditions and telecare service redesign for social care. LG spoke of quality of care being at the forefront of all decisions made, working with planned day of discharge which is done with the patient, carer/family, 'what matters to you' is the fundamental question asked at the patients' admission. Funding and workforce were also outlined. MF commented she was pleased to see learning from recent years. She asked LG if she was confident care packages will be available on the planned date of discharge, LG explained, weekly meetings are held reviewing every patient in hospital with a delay code, to ensure care packages are in place. Needs are usually met, with only ~ 5 or under, where care packages cannot be arranged for various reasons. ID queried if there remains a problem in NEF to secure care packages and care home placements. LG advised, there is a good improvement in care packages and care homes. SB was impressed with the work which has been taking place and congratulated everyone involved. She would be interested to know more about the assessment and rehab centre model, which will be brought to Committee by Lisa Cooper at a future meeting. NC suggested team members from the Community Care Services be invited to the next IJB Development Session to discuss some of the innovative models which are being taken forward.	**V Salmond**
10	**LEGISLATIVE REQUIREMENTS & ANNUAL REPORTS**	
10.1	**Duty of Candour 2021/22 FC and NHS** The reports were introduced to Committee by AS, for FC and HH for NHS. They were brought for Assurance. As part of the Duty of	

	Candour provision in the Health (Scotland) Act 2016, details of when and how duty of candour has been applied are recorded. HH advised the reports demonstrate obligations are being fulfilled with the Partners correctly through their system. Annually, the Health Board publishes a Duty of Candour report. HH explained Incidents are identified through the Adverse Event Process where there is a need to be transparent with a patient and their carer/ family if care has not gone so well. HH highlighted the various themes which come through the reports, mainly falling into 3 themes – tissue viability, theatre & surgery incidents and then a smaller number of smaller incidents. All learning from Duty of Candour reports is shared with services. Patients and carers/family receiving an apology in a timely manner is improving and will continue to be worked on. AS advised of a similar situation for FC, for SW and SC services of which HSCP is a part, also including children's services, housing services, criminal justice services also. The report highlighted a number of instances where Duty of Candour has been identified and the learning obtained from it. No questions were asked.	
10.2	**Fife Alcohol and Drug Partnership Annual Report 2022-23** SB advised the report has been to IJB and is brought to Q&CC for completeness. FMcK introduced Lynda Reid-Fowler, Policy Co-ordinator, Fife Alcohol & Drug Partnership to help answer any questions. FMcK advised the report comes in two parts, firstly the Annual Report 2022/23 and secondly the Government Return, for across the whole of Scotland - a Return which HSCP are required to complete. FMcK told of work the Partnership have been involved with for the MAT Standards (medication assisted treatment) introduced by SG in 2021. She advised, within the MAT Standards, there are many requirements which must be met and told of a recent event at Rothes Halls around designing the Strategy for 2023-26. The event was well attended with lived experience service-users who have come through the programme. Feedback received indicated it had been both emotional and uplifting. FMcK was heartened to hear funding being invested is making a real difference. The number of deaths through alcohol has dropped, although is still high throughout Scotland. She stated the focus will increase on alcohol, alongside drug issues, throughout 23-26. FMcK spoke of rapid re-housing projects which are currently awaiting funding. The ADP Strategy will come through committees once complete. Questions were invited. Cllr Liewald commented she was heartened by the work taking place across the alcohol and drug partnership. She felt, the programmes have given her a great deal of insight into the excellent work which is taking place. She acknowledged much needed work relating to alcohol abuse, is taking place. She mentioned Art Therapy and a connection with DAPL.	

	ID was encouraged to see the success of peer support and peer programmes and was fully supportive of greater emphasis being placed on alcohol abuse. Legislation around alcohol pricing and its complexities were discussed.	
10.3	**Security Data Breach Incident** This report is brought to Committee for assurance by HH on behalf of Lynn Barker. HH conveyed thanks to the Chair for accepting a late paper. HH gave a summary of a data breach incident at a Community Hospital recently, whereby a member of the public impersonated a member of Bank Staff. Before being discovered, the individual had received a sheet which detailed patients on the ward. HH outlined the steps taken to investigate and to ensure there will be no re-occurrence, including significant policies put into place. The incident was reported to the Information Commissioner and it is likely a reprimand will be issued to NHS Fife, which will be published on the ICO website. NHS Fife will be required to evidence steps taken to ensure there is no re-occurrence of the breach. ID queried the CCTV being switched off. NC advised, this was human error and there has been a review across the organisation to ensure there is learning from the incident.	
11	**LOCALITIES**	
12	**OTHER**	
13	**EXECUTIVE LEAD REPORTS & MINUTES FROM LINKED COMMITTEES**	
	13.1 Quality Matters Assurance Group Confirmed Minute from 16.06.23 **13.2 Strategic Planning Group** Unconfirmed Minute from 11.07.23 **13.3 Clinical Governance Oversight Group** Unconfirmed Minute from 20.06.23 **13.4 Equality & Human Rights Strategy Group** No minute available. **13.5 Fife Drugs and Therapeutics Committee** Unconfirmed Minute from 21.06.23	
14	**ITEMS FOR NOTING**	
15	**ITEMS FOR ESCALATION** Community OT Service Waiting Times - SB asked if a PMO approach can be taken and NC will have a meeting with the Team. An update will come back to Committee.	

16	**AOCB**	
17	**DATE OF NEXT MEETING**	
	Thursday 02 November 2023 – 1400-1700hrs **(Please note change of start time from 1000hrs)**	

HEALTH & SAFETY SUBCOMMITTEE

(Meeting on 8 September 2023)

No issues were raised for escalation to the Clinical Governance Committee.

Health & Safety Subcommittee

Minute of the H&S Sub-Committee Meeting
Friday 8 September 2023 at 12.30 pm on Teams

Present
Neil McCormick (Chair), Director of Property & Asset Management (NMcC)
Rona Laskowski, Head of Complex Critical Care Services, Fife HSCP (RL)
Janette Keenan, Director of Nursing (JK)
David Miller, Director of Workforce (DM)

In Attendance
Billy Nixon, H&S Manager (BN)
Anne-Marie Marshall, Manual Handling Team Lead (A-MM)
Paul Bishop, Head of Estates (PB)
Ian Campbell, Interim Head of Spiritual Care (IC)

The order of the minute may not reflect that of the discussion
The meeting was recorded on Teams for transcribing after the meeting

No.		Action
1	**Welcome & Apologies** NMcC welcomed the group to the meeting. Apologies were received from Chris McKenna and Conn Gillespie. Action - NMcC and DM **agreed** to meet with Staff Side in terms of increasing attendance and resilience within health and safety representation at the Health & Safety (H&S) Sub-Committee and also at HSCP H&S meetings.	**NMcC/DM**
2	**Minute/Matters Arising**: The Minute of 9 June 2023 was approved as an accurate record. Matters Arising Matters Arising from the previous minute were included in the Agenda and discussed at today's meeting.	
3	**Governance Arrangements**: There were no Governance Arrangements to report.	

4	**Operational Updates** 4.1(a) H&S Incident Report (Jun-Aug 2023) The H&S Incident Report for the period June to August 2023 was distributed and **noted** by the Sub-Committee. Incidents Summary: Musculoskeletal (staff): 5 reported incidents in the quarter 15 incidents in the period April to August 2023 Riddor (all) 7 reported incidents in the quarter 17 incidents in the period April to August 2023 Self-Harm (patients) 63 reported incidents in the quarter 162 incidents in the period April to August 2023 Sharps (staff): 35 incidents reported in the quarter 57 incidents in the period April to August 2023 Slips, Trips & Falls (staff) 12 incidents reported in the quarter 21 incidents in the period April to August 2023 Violence & Aggression (staff) 334 incidents reported in the quarter 850 incidents in the period April to August 2023 NMcC added that often regular violence and aggression racially and sexually motivated incidents occur on more than one occasion with certain individuals, a subject that has been raised at recent Staff Governance meetings. He advised that our Violence & Aggression Advisor has been actively approaching individuals to offer support. IC advised that the Spiritual Care Team has been involved with the A&E Team in relation to violence and aggression incidents. He enquired as to whether there was a particular hotspot within Acute. NMcC **proposed** that IC be introduced to Bill Coyne, V&A Advisor. IC **agreed** to contact BN to arrange to meet Bill Coyne. 4.1(b) Consideration for Violence & Aggression Training be Mandatory across Fife	

	In terms of the high number of violence and aggression incidents being recorded, BN advised the Sub-Committee that he is collaborating with his team to consider that Violence and Aggression training be made mandatory across Fife. BN will prepare an SBAR for discussion at EDG. The Sub-Committee **agreed** to this way forward. NMcC **agreed** to take the report forward to EDG for approval. 4.1(c) Incidents Dashboard - Month-on-month Trends DM **supported** the content of the Incident Report and suggested that it would be interesting to see in the Incident Dashboard how incidents from the previous quarter compare in terms of trends. The Sub-Committee **agreed** that BN take forward trend analysis details on future Incident Dashboards Action - BN **agreed** to include this information on the next Incident Report (Sept to Dec 2023). 4.1(d) Escalation of the Quarterly H&S Incident Report NMcC proposed that it would be useful to have the quarterly Incident Report added as an item for noting at either Staff Governance Committee or the Area Partnership forum to widen health and safety activity reporting across Fife. The Sub-Committee **agreed** to the proposal. Action - DM will take forward the proposal and provide an **update** on progress at the next meeting. 4.1(e) Fire Extinguishers in Mental Health Settings A discussion took place around the access to and safety surrounding fire extinguishers in mental health settings. This followed a report of a fire extinguisher being used as a weapon towards staff, which raised the one question of whether we can prevent or reduce similar incidents happening in the future. The Sub-Committee **supported** A-MM progressing with this with a view to advising the H&S Sub-Committee of any updates. 4.2 Moving & Handling Report (June 2019 - June 2023) BN advised the Sub-Committee that the Manual Handling Training uptake is at 80% which is a good result. The Manual Handling Analysis Report was distributed and **noted** by the Sub-Committee.	**BN** **DM**

	A-MM gave a detailed discussion and comparison on manual handling course delivery and attendance figures for the period June 2019 to June 2023. Thanks were extended by the Sub-Committee to the Moving & Handling Team for the great work they are carrying out. NMcC added that following the Covid-19 Pandemic and the difficulties faced during this time, NMcC commended the Health & Safety team overall for their commitment and hard work in achieving the great results we see today. 4.3 Sharps Review Update Sharps incidents were discussed at item 4.1. The Sharps Review Update will remain a standard agenda item on the H&S Sub-Committee agenda. 4.4 Face Fit Testing Update BN advised that the requirement for Face Fit Testing has reduced following the Covid-19 Pandemic, however the scheduled machine test continues on a monthly basis for those who fail the local test. Action - BN and JK **agreed** to liaise regarding the co-ordination of Face Fit Testing in terms of a possible Central Database and **agreed** to provide an update at the next H&S Sub-Committee meeting on 8 December 2023. 4.5 Learning & Development - all H&S /Manual Handling Training Packages Update A-MM **advised** that scheduled courses continue to be well attended. There have been several over subscriptions, however, these continue to be monitored and extra training sessions are provided to encompass them. 4.6 Anti-Ligature Discussion RL advised the group that there is a schedule of refurbishment being developed which involved the HSCP Clinical team and the NHS Fife Estates team. At present, the teams are preparing for the decant of patients and staff from Ward 3, QMH in preparation for the schedule of works to begin as soon as possible and from there, the teams will continue to work through the refurbishment. Investment funding will be provided over the next 3 years from both the HSCP and NHS Fife. She added that the works have also been supported by the Fife Health Charity which is a welcome addition.	**Andrea for the Agenda** **BN/JK**

	On a softer side, investment has been made in a café at Stratheden and bids are being received for improvements to outdoor space which will complement the statutory works. A Short Life Working Group is in the process of being set up and is being co-ordinated by the Business Manager of the HSCP. Work continues with the proposed development of a Ligature Policy and literature has been gathered from Boards across the country will be considered when compiling a local policy. This will apply not only to the HSCP but Board wide including community hospitals and several of our Acute hospital wards. Representation is therefore sought from these areas to join and be part of the Short Life Working Group. The Sub-Committee **agreed** that the upgrade works are welcomed which will create a better overall environment for our mental health patients, staff, and visitors. JN advised that positive valuable feedback was received following a visit from the Mental Welfare Commission on 7 September 2023 including improved changes to the nursing team and the environment. RL extended thanks on behalf of the Sub-Committee to the staff team and everyone else who helped achieved the positive result.	
5	**NHS Fife Enforcement Activity** BN **advised** that there was no enforcement activity to report within NHS Fife or any other Boards at this time.	
6	**Policies & Procedures** There were no Policies and Procedures updates to report.	
7	**Performance** 7.1 ASD&CD H&S Committee Update With the help of Claire Dobson and Andy Verrecchia, we are aiming to effectively get the Acute Services H&S Committee up and running however, to date staff side representation remains outstanding. 7.2 HSCP H&S Assurance Group minute of 08.08.23 & update	

	Action - RL agreed to forward minute for circulation. RL added that there is a full Action Plan within the HSCP in terms of responsibilities around health and safety. Returns will be discussed at the next HSCP Health & Safety meeting in December 2023. In terms of training, RL advised that a Mandatory Training Dashboard is in place providing a monthly report to the HSCP SLT. She added that there is a trajectory to aim for 90% across all services by the end of the calendar year. NMcC was encouraged by the role specific health and safety responsibilities being actioned and added that it would be interesting for some of this information to be shared with the H&S Sub-Committee as things progress.	**RL**
8	**Any Other Business** 8.1 HSE Letter - Recommendation for managing Violence & Aggression & Musculoskeletal Disorders in the NHS In terms of the HSE letter of 28 March 2023 addressed to all NHS Trust and Board Chief Executives, we have not received a direct copy, however, BN **agreed** to draft some internal notes that respond to the points in the letter. Action - BN will draft notes for consideration. 8.2 NHS Fife Board Compliance around Entonox Levels (i) Assurance that NHS Fife is compliant with all aspects of Health and Safety Legislation around Entonox Levels: a) Undertake H&S inspections/COSHH risk assessments. b) Reduction of exposure (by engineering means and/or by provision of suitable personal protective equipment (PPE) as far as reasonably practicable. c) Provision of information, instruction, and training. d) Appropriate mitigation including elimination or substitution. (ii) Consider escalation to other forums out with Sub-Committee meetings? (iii) Formal response in support of the above to be sent to J Lambert, RCoM. PB advised that after meeting with pharmacy colleagues and key stakeholders and discussions held at the Clinical Governance Committee meeting on 8 September 2023, it was agreed that the best way forward in terms of identifying the risk	**BN**

and mitigation to individual members of staff would be to have a monitoring system in place with personal monitors for staff. This will identify whether people are being exposed to Entonox levels beyond the allowable levels.

PB added that he is aware of only two companies who supply Entonox personal monitors worldwide. Having spoken to one of the companies this morning and was assured by their positivity and being at the forefront in terms of technology. With this in mind, a mobile monitoring unit and a sample personal monitor is being organised for use in Fife.

NMcC advised that as a Board, a Policy is being developed around Entonox in terms of limiting use.

In terms of the environment, Entonox contains Nitrous Oxide which is a harmful gas and there has been an overall drive to reduce the levels of Nitrous Oxide in general.

8.3 Update following HIS Inspection Visit

NMcC provided an update on the recent HIS Inspection in terms of the issues that were raised regarding routine and reactive maintenance. He gave **assurance** to the Sub-Committee that the Estate Sector Manager for each site (Central Acute, Glenrothes & NE Fife and Dunfermline & W Fife) have identified and checked that the statutory compliance of the sites are fully up to date.

In terms of the planned upgrade to Ward 5, Phase 1, VHK the wards are now empty with ENT being temporarily moved to the Tower Block. Once complete, there is likely to be maintenance works carried out in Ward 6 and Ward 9 and this will take place throughout the remainder of the year.

8.4 Incident: Exposure to Asbestos

In view of the potential exposure to asbestos incident caused by an external contractor who drilled into a wall containing asbestos, NMcC gave **assurance** to the Sub-Committee that the Estates Department have set specific guidelines to ensure that safeguards are in place following the incident to avoid any reoccurrence.

8.5 Reinforced Autoclaved Aerated Concrete (RAAC)

NMcC provided an update to advise that a process for reviewing the Fife estate in terms of reinforced concrete has been agreed across NHS Scotland.

Every build within our estate was checked to determine the date in which blocks were built, particularly between 1950 and 1989

when we envisaged that this was the period with the most likelihood of a building containing RAAC.

Other aspects of our estate were checked including flat roofs and the pitch of roofs along with various other elements to determine whether the build should be checked in finer detail.

Of the thousands of blocks that were checked, we identified twenty-seven and passed these to Curry & Brown, Building Surveyors in their capacity as RAAC Survey Partner recently appointed by NHS Scotland Assure.

There are three elements to the survey process:

(i) RAAC Desktop Survey
Currie & Brown will initially conduct a desktop review which will involve speaking to and co-ordinating with Board contacts to obtain relevant existing building information, including but not limited to drawings, photographs, structural reports. The gathered information will be used to inform the Pilot and Discovery Surveys.

(ii) RAAC Pilot Survey
A pilot survey will be conducted to ensure the proposed methodology is tried and tested prior to the remainder of the properties being surveyed.

(iii) RAAC Discovery Survey
This is the physical surveys of the remainder of the properties which are assumed to contain RAAC. The report will detail associated risks, remedial actions, cost, and any routine monitoring suggestions for all RAAC planks identified with a Red or Amber RAG rating. This information will be in the form of a report for each Board.

NMcC added that, of the buildings surveyed to date, Discovery Surveys have identified that two of the buildings have no RAAC and one of the buildings has RAAC. For the time being, this has not been highlighted as a major concern, and it has been proposed that one part of the building is checked on a three-yearly basis and the remaining part of the building is checked on a yearly basis. Whilst the building was identified as containing RAAC, there is no evidence that this is failing.

The remaining 20+ reports should be received within the next 10 days.

To summarise, no evacuations or rendering buildings out of use has been identified, however, it is unclear as to what the government response will be moving forward.

	The Sub-Committee took **assurance** from the update and **noted** that an update will be given at the next H&S Sub-Committee when it meets on 8 December 2023.	**Andrea for the Agenda**
9	**Date & Time of Next Meeting** Friday 8 December 2023 at 12.30 pm on Teams	

INFECTION CONTROL COMMITTEE (Meeting on 9 August 2023)
No issues were raised for escalation to the Clinical Governance Committee.

Fife Health & Social Care Partnership | NHS Fife

Infection Prevention and Control Team

Infection Control Committee Minutes (unconfirmed)

09th August 2023 at 1400 via Teams

Item No	Subject
1	**Attendees** Janette Keenan, Director of Nursing (Chair) **JK** Julia Cook, Infection Control Manager **JC** Keith Morris, Infection Control Doctor and Microbiologist **KM** Lizzy Dunstan, Senior Infection Prevention & Control Nurse **ED** Suzanne Watson, Senior Infection Prevention & Control Nurse **SW** Mirka Barclay, Senior Infection Prevention & Control Nurse **MB** Paul Bishop, Head of Estates **PB** Midge Rotherham, Support Services Manager **MR** Fiona Bellamy, Senior Health Protection Nurse Specialist **FB** Jamie Gunn, Health Protection Nurse Specialist **JG** Claire Connor, Dental Practice Co-Ordinator **CC** Pauline Cummings, Risk Manager **PC** **Apologies** David Griffith, Neil McCormick , Norma Beveridge, Jim Rotheram, Aileen Lawrie, Pryia Venkatesh, Beverley Young
2	**Minute of Previous Meeting** Group approved previous minute as an accurate reflection.
3	**Action List** Action list shared and updated by members of the meeting.
4	**Standing Items**
4.1	**Risk Register** PC advised members of the meeting current 15 risks, one risk closed and another opened since last ICC. No high risk to report. Flexible hose risk has been closed. ICNET contract renewal added to risk register. Hand hygiene governance to be added as a risk. Discussion around QMH TH modular ceiling, PB to investigate. Off site area sterilisation unit, deep dive review is being presented to the next Clinical Governance Committee in September and Decontamination Group. The water safety deep dive review shall be presented after the decontamination deep dive.
4.2	**HAIRT Board Report** ED & JC presented the HAIRT report, which covers validated data for Quarter 1, and locally validated up to June 2023. **ECB:** Continues to be challenging, however reduction in cases reported. **CDI:** Increase in cases reported from January to end of June. **SAB:** Moderate risk of 9, challenges discussed (Dialysis and PWIDs). **SSI:** Programme still on hold and local teams are supported. **COVID 19:** Weekly ARHAI Scotland nosocomial report now ceased. Locally less outbreaks during this reporting period. **MRSA & CPE Screening:** April-June 2023 sitting at 98% compliance for MRSA and 100% CPE screening. **PWID** & **UCIG:** update **Hand Hygiene:** currently no robust digital systems for recording hand hygiene compliance, meetings held with eHealth with discussions of exploring a commercial audit package such as MEG. Action - further discussion with JK, JC and ADoN **Outbreaks:** Since last reporting period, 0 norovirus to report, 0 outbreaks of flu and 8 COVID-19

	ECB Annual Report - KM updated the committee on the 3 main contributing factors- urosepsis, CAUTIs and hepatobiliary. Hepatobiliary is diet related and possibly a public health issue. Catheters challenge is to reduce the number being used. The number of ECBs is reducing, particularly in the community (people with catheters are HCAI) could be related to prescribing: GP and pharmacies for UTIs, people receiving abx quickly and not developing bacteraemia.
4.3	**Care Home Update** SW updated on the IPC Care Home Team proactive programme with focus on the good engagement: monthly contact with all care homes and annual assurance walk rounds. Discussed the education report and training provided to care homes during 2022. The team are promoting the NES/SSSC app for Care Homes just launched July 2023. CAUTI work in care homes – SW presented at the last UCIG and now engaging with the bladder and bowel team. FB – raised the advanced notification from SG advising on upcoming changes to COVID-19 testing
4.4	**NHSS National Cleaning Services Specification** MR advised NHS Fife is above national average for cleaning scores and achieving green status. Discussed Quality Assurance audit methodology, in line with the Facilities Monitoring Tool, that a random sample of the rooms in an audit area are audited each month but over 12 months, every room on the Quality Assurance system will be audited. Following the HIS Inspection of MH services in February, in addition to the annual facilities services satisfaction survey a further questionnaire has been developed and is now in use, whereby during monthly Peer Audits, a patient or carer are asked to provide feedback on cleaning, environment and other facilities services. The NCSS report presented to ICC does capture a number of areas below 90%, MR assured that areas scoring below 90% are actioned and usually the score improves the next audit, if it still falls below 90% in second audit, this will be scrutinised to see what the issue is and what resources need to be considered to bring the area back to standard JK raised with committee members following recent HIS Inspection, concerns resulting from audits if not resolved at local level can be raised at ICC.
4.5	**Learning Summary** PC provided an overview of learning summary 44 – SAB associated with a midline; ward staff training on VADs and escalation identified as part of key learning. KM added as more midlines are being used, training is essential. PVCs insertion and maintenance is recorded electronically via Patientrack, however other VADs are not. No timeframe as yet to be added to Patientrack (other D&I programmes taking priority). JC added similar issue with significant time delay in development of eCatherter bundle, ED advised this has been raised at UCIG also.
4.6	**National Guidance** JC updated to recent changes to the NIPCM and the *Candida auris* briefing paper – further discussions with senior lab staff before recommendations can be implemented
4.7	**HEI Inspections Fife** JC shared feedback to the group, on the February MH HIS Inspection, monthly group chaired by HoN Tanya Lonergan. JK shared with the committee a high level update on the recent HIS Safe Delivery of Care Inspection, VHK 31st July – 2nd August, report expected in 10 weeks. A number of actions all ready implemented.
4.8	**Quality Improvement Programmes** **PWID** MB updated, the pathway is being finalised and almost ready to roll out, the clinical team have taken out requirement to swab suspected infected injection sites, JC has raised this as a concern with HoN Sally O`Brien. JK will discuss further with Lynn Barker. A treatment room for Addiction Services is being developed. **UCIG** ED advised the last meeting was held 23rd June, CCR for each CAUTI reviewed and lessons learned shared, continuing drive on education/training and QI. Following a pilot, changes to Patientrack electronic insertion and maintenance bundle update still awaited, unable to rollout further at this time.
4.9	**Education** ED advised IPC training programme continues. Supporting all NHS Fife HCWs and volunteers, teams sessions, face-to-face. IPC education programme up to March 2024, now bookable via TURAS Learn topics include:

	CDI, CPE and water safety. JC added NES have recently developed a new poster (shared with the WSG) and awaiting animation around best practice of sinks. MR to share link to animation.
4.10	**Infection Prevention & Control Audit Programme Update** ED advised audits have a dedicated IPC audit nurse and most inpatient and outpatient wards are largely up to date, with very little slippage for the 2 yearly rolling audit programme. HH compliance and technique is also incorporated within this. CC asked if audits were unannounced, advised typically yes. JC raised challenges with current IPC audit tool raised and IPCT exploring other options such as MEG to improve governance. The IPCT shall escalate concerns from audit programme to ICC
4.11	**HAI-SCRIBE** MB – updated the committee on current projects: project hydra, QMH TH reception treatment room, MH refurbishment **Levendale:** JC raised concerns with the environment in Levendale and the delay in patients transferring to Fife Council care.
	JK – had to leave the meeting, JC chaired the remainder of the ICC
4.12	**Capital Planning** JC advised the update from Ben Johnston- Health centres project currently on hold, Phase 1 VHK and Mental Health redesign at planning stage with MB to support from IPC.
4.13	**Infection Prevention and Control Annual Work Programme Update** For noting
5	**New Business**
5.1	**Incidents/Outbreaks/Triggers** **COVID-19 ASD** – reports noted **COVID 19 HCSP** – reports noted **CDI V22** An increase in CDI cases in V22 was identified, following ribotyping that showed no link to the 4 cases, the clinical team were thanked for their support during the review
5.2	**The HCAI Interim Strategy Development** JC provided a verbal report, the strategy launch on the 19th of June, Year 1 – deliverables for national level (SG, ARHAI and NES etc) Year 2 – focus on delivering locally at Board level Progress update to follow to the committee.
5.3	**The IPC Workforce Strategy 2022-24** JC advised an Oversight Board is being commissioned and paper (ToR and action plan) has been shared with the committee.
5.4	**ICNET AND LIMS** ED updated the group ICNET is an essential IPC electronic reporting system. A new Lab information management system (LIMS) is being rolled out nationally, to replace LabCentre, LIMS is required to be integrated with ICNet to ensure it is fully functional, as well as multiple other systems in Fife. Weekly LIMS meetings, chaired by NHS Fife Digital Services are held to provide a progress report of this integration and to discuss this challenging development, with a further extension required. JC advised members of the meeting that this ICNet risk is required to be added to the risk register.
5.5	**ICNET CONTRACT** JC advised members of the meeting the ICNET contract negotiations, it was raised previously Scottish Government was to develop a business case for an eSurveillance system for Scotland as a whole. The current national contract ends December 2023. ICMs have taken forward negotiations with national procurement. Currently cost pressures are indicating an increase of 34%. Next meeting planned 23rd August. There are number of risk associated which have been added to the risk register (risk 2532).
6	**Infection Control Committee's Sub Groups – Minutes/notes of meetings**
6.1	**Infection Prevention & Control Team** Members **noted** the notes of the meeting
6.2	**NHS Fife Decontamination Steering Group**

	Members **noted** the notes of the meeting
6.3	**NHS Fife Antimicrobial Management Team** Members **noted** the last meeting was held 2022
6.4	**NHS Fife Water Safety Management Group** Members **noted** the notes of the meeting
6.5	**NHS Fife Ventilation Group** Members **noted** the notes of the meeting
6.6	**NHS Fife HAI Scribe Planning Group** Members **noted** the notes of the meeting
6.7	**Quality Reports** Members **noted** the notes of the meeting
7	**Any Other Business**
	Hand Hygiene - This was discussed with members of the team earlier in the meeting and it was decided it will be added to the risk register and JK/JC to take forward discussions with ADoNs. **SSI Surveillance** – carried forward to next meeting as no ASD representation. **Renal Dialysis HBV UKHSA**- KM raised renal team have processes, clinical side would have to give assurance these are in place, SB noted a slight error in the document around requirement for renal staff vaccination and screening for HBV infectivity. JC& SB to raise with ARHAI Scotland. **PHS UCI Cycling World Championship** – no PH incidents reported. **IPC Framework 2023-25** – PC to provided JC a few minor suggested changes in an appendix, final paper to be brought back October ICC**.**
8	**Date of Next Meeting**
	ICC meeting schedule 2022-2023.

4th October 2023	1400-1600	Via Ms teams

Infection Control Committee

INFECTION CONTROL COMMITTEE (Meeting on 4 October 2023)
No issues were raised for escalation to the Clinical Governance Committee.

Fife Health & Social Care Partnership | NHS Fife

Infection Prevention and Control Team

Infection Control Committee Minutes (unconfirmed)

04th October 2023 at 1400 via Teams

Item No	Subject
1	**Attendees** Julia Cook, Infection Control Manager (Chair) **JC** Stephen Wilson, Consultant Microbiologist & Lead for Decontamination & Builds **SW** David Griffith, Consultant Microbiologist & Lead for Antimicrobials **DG** Elizabeth Dunstan, Senior Infection Prevention & Control Nurse **ED** Mirka Barclay, Senior Infection Prevention & Control Nurse **MB** Midge Rotherham, Support Services Manager **MR** Fiona Bellamy, Senior Health Protection Nurse Specialist **FB** Claire Connor, Dental Practice Co-Ordinator **CC** Yvonne Chapman (deputising for Pauline Cumming), Risk management **YC** Jim Rotherham (deputising for Paul Bishop), Facilities Manager **JR** Nykoma Hamilton, Infection Prevention and Control Nurse (notes of meeting) **NH** **Apologies** Janette Keenan, Keith Morris; Priya Venkatesh; Norma Beveridge; Pauline Cumming; Neil McCormack; Paul Bishop; Aileen Lawrie; Suzanne Watson
2	**Minute of Previous Meeting** Group approved previous minute as an accurate reflection.
3	**Action List** Action list shared and updated by members of the meeting.
4	**Standing Items**
4.1	**Risk Register** YC advised members of the meeting current 17 risks, 15 of these are moderate and previously reported and no changes to risk rating. Two further risks have been added since last ICC, one is a high level risk and another is low level. Both relate to Phase 1 of VHK. Timescales for review are being met. A few risks have actually reached target level. Risk scoping template presented by JC, 1st for awareness regarding IPC staffing. Starting from September for next 6 months in IPC specialist workforce due to vacancy and recruitment challenges with significant loss of experienced staff in a short space of time. All new IPCNs require support for job support, specialist study and development; in addition we have the challenges for winter that places pressure on system. IPC have a new Band 8A experienced Lead Nurse starting in November, new band 6 nurse starting in next 4-8 weeks and a further post out to advert. Hand Hygiene audit governance Scoping template. Until 2022, each ward or department who deliver patient care undertake hand hygiene opportunity audits of 20 a month. Decision made in October 2022 to cease the use of Lanqip as “not supported”, resulting in loss of a digital record of audits across NHS Fife, IPCT have met with Digital Information colleagues regarding this to explore options including external software.

	At next meeting new risk being added regarding ICNet and LIMS project and JC has had meetings regarding scoping template for this risk. Off site area sterilisation unit, deep dive review is being presented to the next Clinical Governance Committee and Decontamination Group. JR was asked to speak to this. NHS Tayside CSDU: weak SLA regarding decontamination, the building and plant is old with activity increased. NHS Fife has some resilience work to support. There are two plans for long and medium term and national group has been set for this. The water safety deep dive review shall be presented after the decontamination deep dive – meeting organised.
4.2	**HAIRT Board Report** ED & JC presented the HAIRT report, which covers validated data for Quarter 1, and locally validated up to August 2023. **SAB:** Below rate nationally for HCAI; Q2- NHS Fife below national rate for HCAI and above for CAI. VAD & PWIDs associated SABs remain a challenge **PWID**: ongoing improvement work supporting the Addictions team. Up to end of August 2023 there were 6 SABs associated with PWIDs. **SAB Dialysis Line:** all have been Datixed. **CDI:** for Q1 equal to HCAI national rate; Q2- above national for HCAI and below for CAI. HCAI CDI has increased and target extended to end of March 2024. CDI Risk is moderate and no new initiatives. **ECB:** Below the national rate for Q1 and Q2 in both HCAI and CAI. Biggest risk remains catheters, addressed by the NHS Fife Urinary Catheter Improvement Group. Q2 catheter related ECBs are 22% HCAI and 12.5% HAI. Marked improvement in those associated with trauma. ECB current risk is Moderate- 12 and aim is for risk level of 6. **SSI:** Programme still on hold and local teams are supported. **COVID 19:** Weekly ARHAI Scotland nosocomial report now ceased. Locally less outbreaks during this reporting period. **MRSA & CPE Screening:** Q2- 2023 sitting at 98% compliance for MRSA and 100% CPE screening. Well above national average **Outbreaks:** Since last reporting period, 0 norovirus to report, 0 outbreaks of flu and 10 COVID-19 (8 in HSCP and 2 VHK) **Hand Hygiene Audits**: no electronic capture of compliance **National Cleaning**: Q1 95.9% **Estates:** Q1 96.3% Hospital Inspection team: Mental health inspected earlier this year and monthly meetings continue. 18week report has just been submitted. In VHK unannounced inspection 31.07.23 and follow up on 14.08.23, factual accuracy report received.
4.3	**Care Home Update** Proactive work highlighted in report with positive interest in education. IPC Care Home team have been named NHS Fife Team of the Year!
4.4	**NHSS National Cleaning Services Specification** MR report circulated. Q1 NHS Fife above Scottish average compliance at 95.9%. April 2022 to March 2023 slightly above Scottish average with no areas of concern. Teams are busy with regular audits undertaken and some areas have two audits a month supported by Quality Assurance team. Mental Health audit- continuing to progress through actions from report. Should we display the domestic scores on SPSP area? CG raised the boards raised to discuss with Heads of Nursing for standardised approach.
4.5	**Learning Summary** YC updated the 1 learning summary - Review highlighted area for improvement, PVC checks undertaken.
4.6	**National Guidance** JC updated that the Scottish Government has paused most routine asymptomatic COVID testing, including NHS staff. Local guidance was shared for committee's awareness. NIPCM – the COVID-19 appendix has now been archived.
4.7	**HEI Inspections Fife** JC shared to the group the VHK 31st July to 2nd August. Factual accuracy report received yesterday. Issues raised regarding phase 1 environment: V5 planned refurbishment has been brought forward, leading to the

	ENT ward temporarily being moved to V10. HAI-SCRIBE meetings are now taking place weekly with Estates and IPC as well as Executive walk arounds recommenced.
4.8	**Quality Improvement Programmes** **PWID** IPC supporting the addictions team. There are plans for a treatment room in Cameron Hospital site for the service. Removed wound swabbing from the care plan and risk assessment completed. **UCIG** CG advised that the last meeting was September. Sally O'Brien is now taking the group further. Awaiting CAUTI bundle to be added to patientrak system.
4.9	**Education** ED advised IPC training programme continues. Supporting all NHS Fife HCWs and volunteers, teams sessions, face-to-face. IPC education programme up to March 2024, now bookable via TURAS Learn topics include: CDI, CPE and water safety. Winter education training programme to start soon for all staff online and in person. HCID training has been undertaken in V51 and A&E were also invited.
4.10	**Infection Prevention & Control Audit Programme Update** ED advised audits have a dedicated IPC audit nurse and most inpatient and outpatient wards are largely up to date, with very little slippage for the 2 yearly rolling audit programme. HH compliance and technique is also incorporated within this. Approximately a total of 62 undertaken since January and includes re-audits approx. 4 weeks later.
4.11	**HAI-SCRIBE** MB – updated the committee on current projects all listed in the report and the HAI-SCRIBE weekly meeting. One note of concerns is that there is not always full sector representation at these meetings. Preliminary meetings have begun for HAI-SCRIBE generic templates i.e sanitary ware/sinks Levendale: IPC had been highlighted issues, following notification in a further delay in the closure of this ward, lead to a walk around in August 2023, IPC only informed then about air sampling issues. Urgent PAGs held and patients now in Daleview/Fife Council
4.12	**Capital Planning** QMH theatre reception suite redevelopment- complete and open. Phase 1 Oversight Group VHK- V5 now into V10 and refurbishment ongoing. Stage 2 and Stage 3 HAI-SCRIBE completed but detailed plans for fixtures and fittings have not yet been shared with IPC or clinical teams. V6 had planned to have maintenance work commence in October with 9 week closure but due to bed pressures the work has been paused. Concerns raised by IPC about level of work required and missing components not accommodated for in scope of works. Mental health- rolling programme of the mental health wards in NHS Fife. Commencing in ward Q3 which is currently closed and several plans have been shared and discussed. Monthly project team meeting. Ben Johnston organised a 'Lessons Learned meeting' for NTC and details will be shared in due course.
4.13	**Infection Prevention and Control Annual Work Programme Update** For noting and updated for ICC
5	**New Business**
5.1	**Incidents/Outbreaks/Triggers** **COVID-19 ASD** – reports noted **COVID 19 HCSP** – reports noted **Lessons learned from COVID;** HSCP with unwell visitor in ward; testing changes caused some confusion. Patients had been incubating on admission to wards. Staff been working well with IPC but hindered by lack of isolation facilities in older estate in HSCP. Some bays have been closed and spread prevented. Acute: 2 bay closures, 1 linked to a relative. Clinical teams worked with IPC well. Newer facilities including side rooms and bay doors in phase 3 wards has facilitated avoiding whole ward closure. CDI Trigger in V22: Report confirmed that the cases were not linked through ribotyping.

	Endophthalmitis: surgical record noted that patient jumped in procedure and likely own flora caused infection.
5.2	**The HCAI Interim Strategy Development** JC provided a verbal report, the strategy launch on the 19th of June; Year 1 – deliverables for national level (SG, ARHAI and NES etc) Year 2 – focus on delivering locally at Board level
5.3	**The IPC Workforce Strategy 2022-24** JC advised an Oversight Board is being commissioned and paper (ToR and action plan) has been shared with the committee. Workforce collaboration event on 30th October and will update. Ongoing piece of work.
5.4	**ICNET AND LIMS** ED updated the group ICNET is an essential IPC electronic reporting system. A new Lab information management system (LIMS) is being rolled out nationally, to replace LabCentre, LIMS is required to be integrated with ICNet to ensure it is fully functional, as well as multiple other systems in Fife. Weekly LIMS meetings, chaired by NHS Fife Digital Services are held to provide a progress report of this integration and to discuss this challenging development, with a further extension required. Deadline now extended to end of December 2023. JC advised members of the meeting that this ICNet risk is required to be added to the risk register.
5.5	**ICNET CONTRACT** JC advised members of the meeting the ICNET contract negotiations, it was raised previously Scottish Government was to develop a business case for an eSurveillance system for Scotland as a whole. The current national contract ends December 2023. ICMs have taken forward negotiations with national procurement. Currently cost pressures are indicating an increase of 34%. Next meeting planned 23rd August. There are number of risk associated which have been added to the risk register (risk 2532).
6	**Infection Control Committee's Sub Groups – Minutes/notes of meetings**
6.1	**Infection Prevention & Control Team** Nil new to escalate. Dates are now out for the next year.
6.2	**NHS Fife Decontamination Steering Group** Nil to raise at ICC. Next meeting 10th November 2023.
6.3	**NHS Fife Antimicrobial Management Team** Members **noted** the last meeting was held 2022. NHS Fife has no Antimicrobial Pharmacist. Work undertaken moving guidance from one app to another after contract changes.
6.4	**NHS Fife Water Safety Management Group** Meets 9th October and water flushing will be raised.
6.5	**NHS Fife Ventilation Group** **Minutes to be circulated when received**
6.6	**NHS Fife HAI Scribe Planning Group** Now meets weekly and minuted meeting once a month
6.7	**Quality Reports** Members **noted** the notes of the meeting
7	**Any Other Business**
	SSI Surveillance For aware that audit support has been given to orthopaedic and maternity re SSI. Nationally SSI surveillance programme remains paused. ED raised that the IPCT have 1 part-time surveillance member of staff and limited capacity. JC working with HR for new job description and hope to advertise soon to provide resilience in the team and prepare for the possible recommencement of the SSI programme. IPC Framework 2023-2025. Feedback received from Pauline Cummings and with suggestions for terms of reference to sub groups, these shall be shared with the respective groups. In the interest of having an up-to-date IPC Framework the committee agreed the document to be a live document and the sub groups ToRs update accordingly when they are reviewed.

	ARHAI Annual Report for awareness of group.
8	**Date of Next Meeting**
	ICC meeting schedule 2022-2023.

6th December 2023	1400-1600	Via Ms teams

MEDICAL DEVICES GROUP

(Meeting on 13 September 2023)

No issues were raised for escalation to the Clinical Governance Committee.

Medical Devices Group

Minute Medical Device Group
Wednesday 13 September 2023 at 2 pm on Teams

Present

Neil McCormick, Director of Property & Asset Management (NMcC) (Deputy Chair)
Maxine Michie, Deputy Director of Finance (MM)
Iain Forrest, Medical Physics Manager (IF)
Julia Cook, Infection Control Manager (JC)
Robyn Gunn, Head of Laboratory Services (RG)
Alistair Graham, Associate Director of D&I (AG)
Richard Scharff, Radiology Clinical Activity Manager (RS)
Amanda Wong, Director of Allied Health Professionals (AW)
Kevin Booth, Head of Financial Services, Procurement (KB)
Shirley-Anne Savage, Director of Quality & Clinical Governance (S-AS)

In Attendance

Andrea Barker, Note Taker

The meeting was recorded on Teams
The order of the minute does not necessarily reflect that of the discussion

		Action
1	**WELCOME & APOLOGIES** Apologies were received from Iain MacLeod, Claire Steele, John Brown, Paul Smith, Murray Cross, Aylene Kelman, Elizabeth Muir and Satheesh Yalamarthi.	
2	**MINUTE OF LAST MEETING/MATTERS ARISING** The Minute of 14 June 2023 had the following text amendments and was updated accordingly: **Item 3.4** - GP/I4 Digital Solutions Procurement Policy - Work continues on the Digital Solutions Procurement Policy before it is submitted to the General Policies Group. **Item 4.1** - A discussion followed on eQuip database which is to be implemented as the new Medical Equipment Management System (MEMS) for NHS Fife which link to a centralized NHS Scotland system:	

	• Existing equipment asset and maintenance data will be transferred over from Micad to ~~Equip~~ eQuip. • Each piece of medical equipment will have a unique identifier prefix added for each NHS Board to avoid confusion with duplicate numbers in the central system. National Services Scotland (NSS) and other Scottish Government Agencies will have the ability to view data across all Boards. • Currently awaiting Digital & Information (D&I) to implement the local server then the system can be deployed. • All existing users will have the latest client software installed on computers and laptops. • The new client software will require user training to be carried out. • This will eventually link to the RFID system allowing us to share and track equipment (VHK only). <u>Scan for Safety</u> MEMS will be an integral part of an ongoing overarching national project "Scan for Safety" being implemented in the longer-term. <u>Post Meeting Note</u> Update (IF): Bullet point line 1 - Completed, but some catch up will be needed between cease of data input into MICAD and now. Also significant data tidying required. Bullet point line 3 - Successfully completed and server connection to two client PC/Laptops confirmed. Bullet point line 4 - Delayed due to staff shortage issue in D&I. Ongoing. Bullet point line 5 - Training done via TEAMS demonstrations for first key users. Recorded and available for cascade training.	
3	**<u>GOVERNANCE</u>** There were no governance matters to report.	
4	**<u>FOR DISCUSSION</u>** 4.1 <u>Suppliers Transmitting Data Policy</u> (deferred from the June meeting) AG advised that in relation to the IPO elements of the Policy, it has been picked up on how clear the data processing arrangements were in the contract documents. **<u>Action</u>** - AG to provide an update at the next meeting. 4.2 <u>Post Stroke Study - Modified Nasogastric Tube Device</u> (Frances Quirk)	**AG**

	The NHS Fife R&D Ref 23-023 Pharyngeal Electrical Stimulation for Acute Stroke Dysphagia Trial (PhEAST) SBAR and appendix papers were circulated and **noted** by the group. NMcC presented the Post Stroke Study - Modified Nasogastric Tube Device paper and asked if the group was comfortable to support the Study (NHS Fife R&D Ref 23-023 Pharyngeal Electrical Stimulation for Acute Stroke Dysphagia Trial (PhEAST) in NHS Fife prior to the paper going to the Clinical Governance Committee. The equipment is part of a trial and has not previously been used in Fife and will be supplied by the University of Nottingham. (a) It was noted that the device has a CE marking indicating that a product has been assessed by the manufacturer and deemed to meet EU safety, health and environmental protection requirements and that it had been used widely throughout the world. (b) AW noted that the paper contained several errors which she agreed to pick up directly with Frances Quirk. (c) In terms of the loan equipment, KB agreed to check with Paula Lee, Procurement to see if the Indemnity Form (covering equipment supplied by a manufacturer) has been received? **Action** - KB **agreed** to liaise with Paula Lee, Procurement to progress. (d) IF commented on the fact that the form may not cover a university as a supplier? **Action** - IF agreed to check this detail with Paula Lee, Procurement. The Medical Devices Group **agreed** that subject to the receipt of the relevant paperwork, it had no objections and was happy to **support** the Study if it is taken forward by the organisation. 4.3 Medical Devices & Equipment Internal Audit Report (B21/21) Key Performance Indicators (KPIs) for Medical Equipment within Annex 2 of CEL 35(2010) for consideration NMcC advised the group that there was an outstanding Internal Audit issue around Medical Device Key Performance Indicators (KPIs) in terms of which group they should sit. He added that the Capital Equipment Management Group (CEMG) had questioned whether they are the correct group for it to go to. Following discussions with the Internal Auditors, they believed that the Medical Devices Group was the right group for the KPIs to come to. The Medical Devices Group **agreed** to take on the role of receiving the KPI information.	**KB** **IF**

	NMcC suggested then that the SAFR return with Medical Devices KPIs report be circulated to the group for review to identify any potential gaps. He added that the SAFR return with Medical Devices KPIs contains an outdated set of indicators which have been around for many years and that once the equipment database is up and running effectively within NHS Fife, then this will provide a lot of this information going forward. As it stands, the SAFR Return with Medical Devices KPIs report is updated annually, however, it would be helpful to receive the information more regularly ie on a 6-monthly basis. NMcC advised that the requirement from the Scottish Government (SG) is around the usage of major equipment eg endoscopes and such like. He added that the SG are not asking about MRI Scanners or CT Scanners, however, this may be worth considering as a group. **Action** - Review of the SAFR return with Medical Devices KPIs report at the next Medical Devices meeting on 13 December 2023 in terms of the information we currently hold and what the gaps may be. 4.4 IRIC Safety Alert Process - Verbal Update (IF) The GP/E5 Policy for Processing Hazard & Safety Notices & Alerts was circulated and **noted** by the group. NMcC added that Safety Action Notices (SANs) are circulated through Datix the Safety Alert System and handed over to IF, as Incident Safety Alerts Officer for the organization, who gave a verbal update on the process to the group. One concern he had was the closing of the loop ie to identify if the correct actions had been undertaken or were valid. NMcC questioned whether an amendment should be made to the Policy to reflect this? IF advised that when the Policy was being discussed, an agreement could not be reached in terms of who would be responsible for carrying this out. To summarise, the group agreed to take forward for **assurance** to the wider organisation the question of is there something more we can do to ensure that SANs are being appropriately actioned? 4.5 MHRA National Patient Safety Alerts - Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from entrapment or falls The MHRA National Patient Safety Alert on Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices – risk of death from entrapment or falls was circulated and **noted** by the group. NMcC presented the National Patient Safety Alert to the group and advised that it was important to see that the items fall into the broad description of Medical Devices. He added that as much of the maintenance of beds and	**ALL**

	trolleys is carried out by the Estates Department. Therefore, he agreed to take forward the action. NMcC agreed to discuss the process around regular maintenance and checks of these pieces of equipment with Estates colleagues and Mike McAdams, Estates Compliance Manager. He added that these checks require to be carried out in conjunction with Clinical and Estates colleagues. **Action** - NMcC **agreed** to bring an update to the next Medical Devices Group when it meets on 13 December 2023.	**NMcC**
5	**FOR INFORMATION** There were no items to report.	
6	**MINUTES FOR NOTING** (a) CEMG Minute of 1 June 2023 The CEMG Minute of 1 June 2023 was distributed and **noted** by the group. (b) CEMG Minute of 6 July 2023 The CEMG Minute of 6 July 2023 was distributed and **noted** by the group.	
7	**ANY OTHER BUSINESS** 7.1 The Registration of the Laboratory Information Management System Software as a Medical Device RG raised the question of identifying the Laboratory Information Management System (LIMS) software as a medical device as there has been National discussions around whether the LIMS system requires to be registered as a Medical Device as there are certain aspects of what we do will require to be registered. NHS Fife will be the first Board to go live with LIMS who implement certain calculations and algorithms. Following a group discussion, AG and RG will discuss in finer detail out with the meeting. **Action** - RG and AG **agreed** to provide an update to the Medical Devices Group when it meets on 13 December 2023.	**RG & AG**

	NMcC added that this is an excellent example of a specific question that throws up a generic risk around how we deal with software as a medical device within the organization. The group **agreed** to add the item to our Risk Register as a generic risk. **Action** - NMcC to take forward. The group **agreed** for the item to be added to the next Medical Device Group Agenda for the meeting on 13 December 2023. **Action** - Andrea to add to the agenda. 7.2 NHS Fife Representation at Commodity Advisory Panel Meetings IF attended the Commodity Advisory Panel Meeting today which covered patient monitoring, anesthetic machines and ventilators and representation from NHS Fife was low. **Action** - KB **agreed** to gather details on the Commodity Advisory Panel meeting and feedback to the group at the next Medical Devices meeting on 13 December 2023. Equipment specifications are received by IF from the group and these are then passed over to the relevant Clinical Leads for review - details required on who they are? **Action** - Discuss at next Medical Devices Committee meeting on 13 December 2023 following feedback from KB.	**NMcC** **Andrea** **KB** **IF**
8	**DATE & TIME OF NEXT MEETING** Wednesday 13 December 2023 at 2 pm on Teams	

RESEARCH, INNOVATION & KNOWLEDGE GROUP

(Meeting on 3 October 2023)

No issues were raised for escalation to the Clinical Governance Committee.

NHS Fife

NHS Fife Research, Innovation and Knowledge

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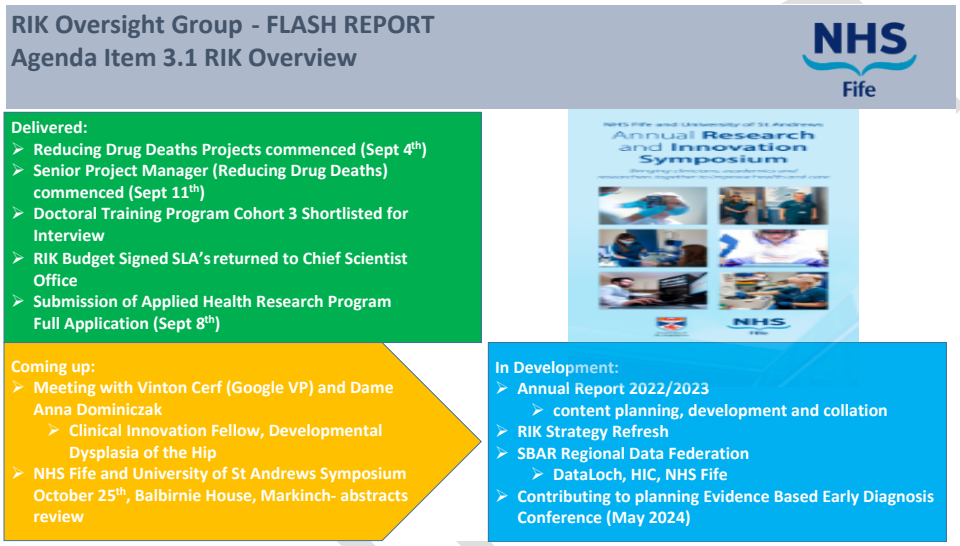
RESEARCH, INNOVATION & KNOWLEDGE OVERSIGHT GROUP MEETING
MINUTES
Microsoft TEAMS,

03 OCTOBER 2023 deferred from 19 SEPTEMBER (13.00 – 14.00)

		ACTION
	Present: Dr Chris McKenna, Medical Director, Executive Lead for Research, Innovation & Knowledge (CMcK) Prof. Frances Quirk, RIK Assistant Director (FQ) Neil Mitchell, Innovation Manager (NM) Anne Haddow, Lay Advisor (AH) Karen Gray, Lead Nurse (KG) Prof. Colin McCowan, Head of Population Health and Behavioural Science Division, University of St. Andrews (CMcC) Doreen Young, Head of Practice & Professional Development (DY) - representing Nicola Robertson Shirley-Anne Savage, Associate Director of Quality and Clinical Governance (S-AS) Ramsay Khadeir, Senior Project Manager, Reducing Drugs Death programme (RK) Sally Tyson, Head of Pharmacy, Development & Innovation (ST) - representing Ben Hannan In Attendance: Roy Halliday, R&D Support Officer – minutes (RH) Anna Borkowska, R&D Nursing Support Officer – observer (AB)	
1.0	**CHAIRPERSON'S WELCOME/APOLOGIES AND OPENING REMARKS** **Apologies;** Prof. Frank Sullivan, Director of Research, University of St. Andrews Dr Grant Syme, Physiotherapist Consultant Alistair Graham, Associate Director, Digital & Information	
2.0	**STANDING ITEMS**	
2.1	**OVERSIGHT OF R, I K OVERSIGHT GROUP MINUTE** CMcK welcomed all to the meeting. NM introduced Ramsay Khadeir, the new Senior Project Manager for the Reducing Drugs Death programme, all introduced themselves to Ramsay. The RIK Oversight Group Minutes were accepted with no amendments. **Actions:**	

	Action.5.2 Innovation Scout proposal – NM advised this is still ongoing but has been overtaken by the high workload with the Reducing Drugs Death Challenge with RK now in place, NM will be able to focus on this a bit more.	
2.2	**OVERSIGHT OF RIK OPERATIONAL GROUP MINUTE AND ACTION LIST** For noting - Nothing from this meeting required escalation.	
3.0	**STRATEGIC PRIORITIES/INITIATIVES**	
3.1	**RIK OVERVIEW**	



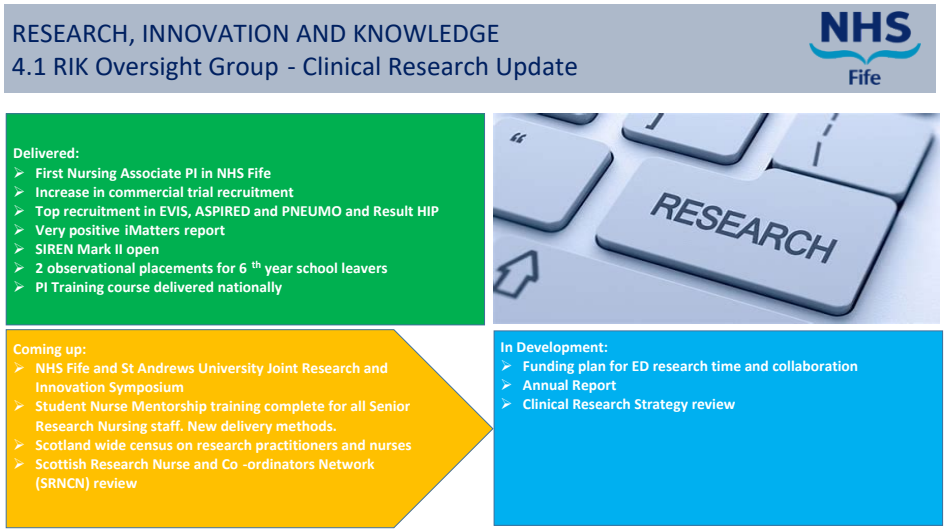
FQ advised that the Reducing Drugs Death programme commenced on 04th September, NM will give further information in his update.

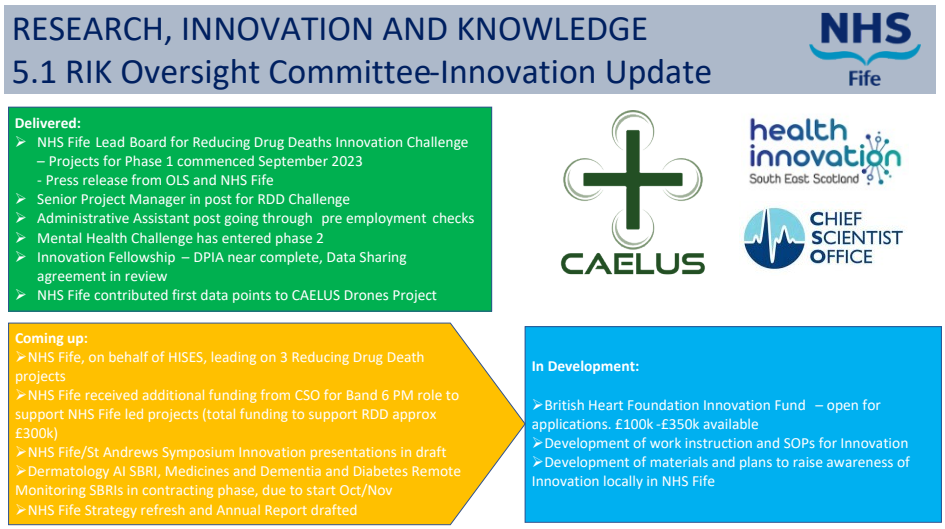
FQ also noted that interviews for the Doctoral Training Programme are taking place this week, four candidates have been shortlisted for interview for St Andrews projects.

FQ confirmed that the CSO budget for RIK has been agreed and was slightly higher than anticipated.

FQ has worked with St. Andrews colleagues to support submission of an Applied Health Research programme application to the CSO, this was submitted on 08th September.

FQ attended a meeting with Vinton Cerf, (Google Vice President, Chief Internet Evangelist) and Dame Anna Dominiczak from the Chief Scientist Office, discussing Clinical Innovation Fellow Joyce Henderson's Development of Displacement of the Hip (DDH) project looking at using the use of AI in the diagnostic assessment (DDH), this was a very productive discussion with recommendations from Vinton for connections

	to be made in his wider network. Discussion also took place with regard to supporting the wider innovation agenda in Scotland. The 2nd joint NHS Fife/University of St. Andrews Symposium will take place on 25th October, submitted abstracts are currently being reviewed, successful applicants will be notified on 6th October. FQ advised that the Leadership Team are currently finalising the 22/23 Annual Report and RIK Strategy, drafts will come to this meeting in December for approval. FQ added that a Development Session with the Clinical Governance Committee will be taking place on October 18th with a focus on the research and innovation partnership between NHS Fife and the University of St. Andrews.	
4.0	**RESEARCH AND DEVELOPMENT**	
4.1	**CLINICAL RESEARCH UPDATE**  KG advised that we now have the first Nursing Associate Principal Investigator's in NHS Fife, a Senior Nurse in the Emergency Department who will be supervised by a current PI. The department was the top recruiter in four UK studies for September. The team has also recently completed the placement of two sixth year school leavers intending to study medicine at university each spent a week in the department spending time with the clinical team. KG and members of the team will be delivering the first PI training sessions tomorrow.	

	KG advised that student mentorship training will be completed by all the Senior Research Nurse team within the next few weeks. As discussed in the last meeting KG advised that as part of her role within the Scottish Research Nurse Coordinating Network, the team are looking into performing a Scottish Research Nurse workforce census, this will be ongoing. KG advised that work is underway to introduce research studies with the Emergency Department and some of the staff recently visited the EMERGE study team in Edinburgh, KG is currently looking at funding plans with the Service Manager to free up time for the ED staff to undertake research, with the plan to look at some commercial trials which will generate income for the ED.	
5.0	**INNOVATION**	
5.1	**INNOVATION UPDATE**  NM advised that all eleven of the Reducing Drugs Death programme Phase 1 projects have now commenced, a press release has been issued by the Office of Life Science and CSO promoting this project. NHS Fife also issued a media release promoting NHS Fife's role supporting this national program NM noted that as well as the Senior Project Manager, Ramsay Khadeir (RK) a full-time administration assistant will be joining soon. The Metal Health Innovation challenge which is being led by NHS Lothian has now entered phase II, one of the two companies HISES has been working with has been successful for this, they will be looking at mental	

	health in school children and attempting to reduce the waiting time of CAMHS appointments. NHS Fife will be leading on three Reducing Drug Deaths projects and have received funding from the CSO to recruit a Band 6 Project Manager to support these projects. NM noted that innovation will have a major role at the joint symposium on 25th October and he is currently working on presentations. NM advised that the British Heart Foundation innovation fund is now open for applications with funding of between £100,000 to £350,000 being available. Development is ongoing for SOPs and WIs for Innovation along with the production of materials for raising awareness of innovation within NHS Fife.	
5.2	**REDUCING DRUG DEATHS CHALLENGE** Small Business Research Initiative (SBRI) funded by SHIP Scottish Health and Industry Partnership / Office for Life Sciences **5.2 ReducingDrug Deaths InnovationChallenge** ➢ 11 feasibility companies contracted for 01 September start date ➢3 companies working with HISES, focussing in NHS Fife initially ➢1 Demonstration company contract under review, due to commence 01 October ➢Senior Project Manager, Ramsay Khadeir, commenced in September with responsibility for the National Challenge ➢Administrative assistant role under pre-employment checks ➢1st milestone report due from companies and Challenge Steering group meeting in October ➢Webinar for all companies to present and meet being organised for October/November	

	Small Business Research Initiative (SBRI) funded by SHIP Scottish Health and Industry Partnership / Office for Life Sciences  NM advised that as previously noted, eleven companies have commenced the Phase 1 contracting stage and projects have begun. A webinar will be set up for all companies to present their products and will take place late October/early November. Three of these projects will be led by NHS Fife, NM will be working with Susanna Galea-Singer, Addictions Clinical Lead and Clinical Innovation Champion to connect with Clinicians to co-develop products with the companies involved. The three projects are: • AI overdose monitoring system to enable both self and responder digital alerts. To repurpose mental health screening and digital wearable technologies. • Rescue Patch - Transdermal controlled release combination patch naloxone and flumazenil • Handheld biosensor benzodiazepine detections and notification to user / responders	
6.0	**LIBRARY & KNOWLEDGE SERVICES**	
6.1	**LIBRARY STAFFING REVIEW** FQ advised that there had been some progress with the recruitment of a new Library & Knowledge Services Manager, A job description has been submitted and is being evaluated, the LK&S team had a visit last week from Catherine McLeod who is the new principal lead for knowledge management and discovery at NES, she has kindly offered to support our recruitment process and has volunteered to be on the interview panel.	
7.0	**PARTNERSHIP UPDATES**	
7.1	**DOCTORAL TRAINING PROGRAMME**	

	CMcC advised that the two students in cohort one have been in post for a year and are due their review soon. The two candidates for cohort two started in August and are settling in. Interviews for cohort three take place later this week with four candidates, with there being the option to appoint two. A meeting with other DTP Leads will take place in London in November.	
7.2	**JOINT RESEARCH OFFICE** CMcC noted that as mentioned earlier by FQ, an Applied Health Research programme application to the CSO was submitted in September, the topic is identifying people in the last year of life using Emergency Care services looking to create referral pathways to existing services that might better meet the patient's needs, interviews will be taking place during December, with outcome by the end of the year.	
7.3	**NHS FIFE & UNIVERSITY OF ST. ANDREWS PARTNERSHIP** CMcC advised that there is a new Professor of Infectious Diseases, Nick Feasey who will also be working as a Consultant at NHS Fife. CMcC discussed the SCREDS lectures being offered by NES, this is for doctors in training who have a PhD, they are allocated to a university one day per week, paid for by NES to allow them to develop a Clinical Academic career, an agreement with NES allows doctors who go through the DTP programme to become SCREDS lecturers for at least one year after they finish the programme, two NHS Fife appointments have been made lecturers, Dr Sinan Khadhouri and Mr Andrew Hall.	
7.4	**R&D/FIFE COMMUNITY ADVISORY GROUP**. AH updated from her report (attached to the Agenda) and wished to draw attention to the fact that members have been involved in planning meetings for the Inaugural Evidence Based Early Diagnosis (EBED) Conference to be held in St Andrews at the end of May 2024. The conference aims to help create an international community of practice and enquiry in the area of evidence based early diagnostics with the purpose of ensuring that individuals, societies, and health systems benefit from, rather than are harmed by the wave of new diagnostic options soon to commence in primary care and community settings. Evidence Based Early Diagnosis – Conference 2024 | Mackenzie Institute for Early Diagnosis (st-andrews.ac.uk)	
7.0	**AOCB** FQ reminded everyone of the need to register for the joint NHS Fife/University of St. Andrews Symposium if they were planning to attend. CMcK commended all on the great work that is taking place.	
8.0	**DATE AND TIME OF NEXT MEETING** Monday 11th December, 14.00 – 15.00	

AREA CLINICAL FORUM

(Meeting on 5 October 2023)

No issues were raised for escalation to the Clinical Governance Committee.

Fife NHS Board

Unconfirmed

MINUTES OF THE NHS FIFE AREA CLINICAL FORUM HELD ON THURSDAY 5 OCTOBER 2023 AT 2PM VIA MS TEAMS

Present:
Ailie Mackay, Speech and Language Therapy SLT Operational Lead (Vice Chair)
Robyn Gunn, Head of Laboratory Services
Chris McKenna, Medical Director
Susannah Mitchell, General Practitioner
Nicola Robertson, Associate Director of Nursing

In Attendance:
Sharon Crabb, Public Health Service Manager *(item 5.1 only)*
Fiona Forrest, Deputy Director of Pharmacy *(deputising for Ben Hannan)*
Lynne Johnston, Service Manager *(item 5.2 only)*
Hazel Thomson, Board Committee Support Officer (Minutes)

1. Apologies for Absence

The Chair welcomed everyone to the meeting.

Apologies were received from Aileen Lawrie (Chair), Jackie Fearn (Consultant Clinical Psychologist), Donna Galloway (Women Children & Clinical Services General Manager), Ben Hannan (Director of Pharmacy & Medicines), Emma O'Keefe (Consultant in Dental Public Health), Janette Keenan (Director of Nursing) and Amanda Wong (Director of Allied Health Professions).

2. Declarations of Members Interests

There were no declarations of interest from those present.

3. Minutes of the Previous Meeting held on 3 August 2023

The minutes of the previous meeting were **agreed** as an accurate record.

4. Matters Arising and Action List

The Forum **noted** the updates on the action list.

5. PRESENTATION

5.1 Anchor Institutions Strategy

S Crabb, Public Health Service Manager presented on the Anchor Institutions Strategy, and welcomed questions.

The Associate Director of Nursing updated the Forum on the work that is being undertaken in relation to increasing our nursing workforce. She also advised that we are in the early stages of looking at a magnet programme for Fife for nursing. In addition, the importance of infrastructure in terms of greenspace was highlighted. The Associate Director of Nursing agreed to arrange for a nursing representative to join the Anchor Institutions Group.

Action: Associate Director of Nursing

The Deputy Director of Pharmacy reported that there are pharmacy representatives who are exploring opportunities to utilise community pharmacies with a view of embedding them as Anchor Institutions within the community. It was also reported that a modern apprenticeship is being developed for medicines management support workers, and that more widely, work is being undertaken to raise the profile of pharmacy as a profession.

The Vice Chair provided an update on Allied Health Professionals (AHP), noting that they are looking at how they can deliver to the AHP public health framework. It was also advised that AHP foundation apprenticeships are being undertaken.

It was agreed that Forum members provide the presentation, and the questions within the presentation, at their subcommittees and/or groups, and feedback to the Public Health Service Manager who will include within the Anchor Institutions Strategy.

Action: Members

5.2 Scottish Government Women's Plan

L Johnston, Service Manager joined the meeting and presented on the Scottish Government Women's Plan.

The General Practitioner highlighted that the plan has resulted in a large increase of consultations within General Practice in relation to menopause, and that there has been limited support from secondary care. Discussion took place on the challenges in terms of capacity. The Service Manager agreed to feedback to the team, and the Deputy Director of Pharmacy agreed to link in with the Pharmacy team around the share care protocol.

Action: Service Manager/ Deputy Director of Pharmacy

Following a question from the Deputy Director of Pharmacy, the Service Manager advised that individual subgroups collate data in relation to outputs, activity & evaluations, and she agreed to provide this detail in the next update to the Forum.

Action: Service Manager

6. QUALITY / PERFORMANCE

6.1 Winter System Review Update

This item was deferred to the next meeting.

6.2 Escalations and Updates from Subgroups to the Area Clinical Forum

The Vice Chair opened up discussion around escalations and updates from subgroups to the Area Clinical Forum.

The Head of Laboratory Services highlighted the Audiology External Independent Review, and suggested inviting the Head of Audiology to present to the Forum. The Medical Director explained that the review is wider that audiology, and suggested bringing our response and action plan to the Forum, before it goes to the Clinical Governance Committee for assurance.

Action: Medical Director/Head of Laboratory Services

The Vice Chair advised that an ACF Development Session will take place in February 2024, with a focus on raising the profile of the ACF.

7. GOVERNANCE MATTERS

7.1 Rehabilitation Oversight Group Terms of Reference

This item was deferred to the next meeting.

7.2 Delivery of Annual Workplan 2023/24

The Forum **noted** the tracked workplan.

7.3 Proposed Meeting Dates 2024/25

The Forum **agreed** the proposed meeting dates for 2024/25.

8. UPDATE FROM EXTERNAL GROUPS

8.1 Area Clinical Forum Chairs Group for Scotland Update

This item was deferred to the next meeting.

9. LINKED MINUTES

9.1 Allied Health Professions Clinical Advisory Forum held on 2 August 2023 (unconfirmed)

9.2 GP Sub Committee held on 20 June 2023 (confirmed) & 15 August 2023 (confirmed)

9.3 Area Medical Committee held on 8 August 2023 (unconfirmed)

9.4 Area Pharmaceutical Committee held on 27 February 2023 (confirmed) & 24 April 2023 (unconfirmed)

The Forum **noted** the linked minutes.

10. ESCALATION OF ISSUES TO THE CLINICAL GOVERNANCE COMMITTEE

There were no matters to escalate to the Clinical Governance Committee.

11. ANY OTHER BUSINESS

11.1 Healthcare Science

It was agreed that the Head of Laboratory Services would present on Healthcare Science at a future meeting, to provide members with a deeper insight of that area.

Action: Head of Laboratory Services/ Board Committee Support Officer

12. DATE OF NEXT MEETING

The next meeting will take place on **Thursday 7 December 2023 from 2pm – 3.30pm** in the Boardroom, Staff Club, VHK.

AREA MEDICAL COMMITTEE

(Meeting on 8 August 2023)

No issues were raised for escalation to the Clinical Governance Committee.

Area Medical Committee

CONFIRMED NOTES OF THE AREA MEDICAL COMMITTEE (AMC) HELD ON TUESDAY 08 AUGUST 2023 VIA MS TEAMS

Present:

Chris McKenna (Chair)	Medical Director
Helen Hellewell	Deputy Medical Director, H&SCP
Fiona Henderson	Fife LMC Honorary Secretary
Iain MacLeod	Deputy Medical Director, ASD
Joy Tomlinson	Director of Public Health
Morwenna Wood	Associate Medical Director, Medical Education

In Attendance:

Catriona Dziech (Notes)	Executive Assistant to Medical Director

1 APOLOGIES FOR ABSENCE

Apologies were received from Ian Fairbairn, John Morrice, Satheesh Yalamarthi, Claire McIntosh, Glynn McCrickard

Calendar invite was declined by Phil Duthie, Robert Thompson, Sally McCormack, Susanna Galea-Singer

2 DECLARATIONS OF MEMBERS' INTERESTS

There were no declarations of interest.

3 MINUTES OF PREVIOUS MEETING HELD ON 27 JUNE 2023

The notes of the meeting held on 27 June 2023 were approved.

4 MATTERS ARISING

i) Update from Realistic Medicine (RM) Team

The Realistic Medicine Team will attend AMC on 12 December 2023 to provide an update.

Dr McKenna advised the RM Team are holding a Workshop on 20 September 2023 between 9.30am and 12.30pm in the Main Hall at Lynebank. Shirley-Anne Savage is currently working on the invitation list. Dr Hellewell agreed to seek wider representation from Primary Care.

Action: HH

5 STANDING ITEMS

i) Financial Position – Including *(IPQR)*

Dr McKenna advised the financial position remains unchanged. As reported at the previous meeting NHS Fife had been allocated more NRAC share. There will be discussion at EDG on 09 August 2023 about where

savings could be achieved. Maxine Michie would be invited to attend the next meeting on 10 October 2023 to give a fuller finance run down.

Action: CMcK

ii) Adverse Events Update – considered at the Clinical Governance Oversight Group

The notes of the Clinical Governance Oversight Group are included within these papers. There are no significant issues to highlight. Dr McKenna advised consideration is going to be given again to the sign off process for SAERs. A process had been put in place previously to clear backlog, but it was now a good time to move back to a more blended approach to sign off. It is hoped this discussion will take place before the end of the month.

Joy Tomlinson advised she has spoken with Nicola Robertson regarding the organisational learning group and how they might help with some of the cross-cutting themes that come through events. One theme being positive learning from communication issues when communication has been done well and making sure it is done well again in the future and where there has been challenges.

Joy Tomlinson said she had also shared with Nicola Robertson two public health related learning situations. Nicola Robertson has agreed to take both examples to the next meeting of the Group to consider how these organisational elements can be shared.

Dr McKenna highlighted the internal Auditors were clear there has been a lot of focus on the group to try to corral learning and then feed it back into the organisation for improvement.

Dr MacLeod said the group has struggled to find where it fits into the system, and it is trying to pick out relevant issues to move forward. There have been many meetings, without much progress but there is potential and willingness to share information. A trawl of SAER and LAER reports has been undertaken but no consistent themes were identified. Dr MacLeod will be meeting with Nicola Robertson to progress further and share learning points and find a forum to communicate.

Following discussion the Committee agreed at the end of every adverse event, it is key to have the opportunity to communicate and share learning across the organisation with all those involved.

As a way forward it may be helpful to reinstate EC4H courses for staff in Fife. Dr McKenna agreed to ask Kim Steele for an update as to whether we can deliver EC4H or if there were any barriers for delivering EC4H across the organisation.

Action: CMcK

Professor Wood said the other hope over the next few years would be to have simulation areas on three sites in Fife not just at QMH but also at Cameron and VHK to achieve learning. Professor Wood welcomed ideas from members.

Action: All

Dr McKenna suggested another way to communicate to the wider organisation would be through a Grand Round type event where feedback from SAERs could be discussed. Professor Wood suggested having a 10 / 15 minute slot for four similar themed SAERS focussing on learning. Dr McKenna agreed to discuss this with Martin Clark.

Action: CMcK

Dr MacLeod suggested another route would be one similar to the Medicines Management Team who issue a weekly email shot of "Lessons of the Week"

iii) Medical Staff Committee

Dr McKenna advised there is no update, and any suggestions welcome on how to move this forward.

It was noted there is a danger of medical staff using social media as a means of communicating with each other so there needs to be a functional Medical group, so things are not aired on social media. Although not the right format this could be via What's App Groups. Dr McKenna agreed to give this some further thought.

The Committee noted the function of the Medical Staff Committee is to provide professional medical oversight through to the Area Medical Committee.

Joy Tomlinson said there was a similar issue in Ayrshire in trying to get people enthused to attend meetings as there was no sense of the added value of the Committee. It was suggested if there was clear commission from the AMC for them to consider and raise specific issues this may encourage attendance.

It was suggested the main barriers to attendance could also be considered and thought given to holding the meeting in the evening at a set time each month. This may include a meeting attendance fee or time back arrangement as it is recognised that is not within daily limits of work. It should also be considered that the meeting could take place on Teams.

Dr McKenna agreed to considered using the Strategy as an opportunity to take the conversation back to the consultants and ask them to be part of how it progresses.

Action: CMcK

Dr McKenna also agreed to speak to Phil Walmsley about his role as Chair of the Medical Staffing Committee.

Action: CMcK

iv) Update from GP Sub Committee

Dr Henderson advised there was no update at this time.

v) Realistic Medicine

No update at this time.

vi) Medical Workforce

Dr McKenna advised he is holding a Senior Medical Leadership away afternoon on 26 September 2023 with one of the main topics being medical workforce strategies.

Dr McKenna advised there has been a good conversation with the Medical Director for NHS Professionals who run the Gateway programme about what they might be able to do for other groups of doctors, perhaps senior doctors, that we might be able to coach and teach and support to Caesar, to grow our own consultant workforce.

There are sixteen new doctors in our system who are hopefully settling into their job in Fife with local Teams supporting them to become integrated. This should mean we are not having to spend money on agency locums. It is hoped investment in these doctors result in them wanting to stay on in the region to the training programmes or indeed come back as GPs or consultants of the future.

Dr McKenna advised he is considering the feasibility of Fife becoming a pilot site for a training programme for Sports and Exercise Medicine. Hopefully this would come into effect from August 2024. There is a strong connection to Public Health and the ambitions set out in our Population Health and Wellbeing Strategy. NES are looking to Fife as a place where they can do business.

Professor Wood agreed to do a short 10-minute presentation on 26 September 2023 explaining Gateway doctors.

Action: MW

Professor Wood advised Gateway doctors are recruited through an organisation in England called NHS Professionals. They have various types of doctors, but the ones we have here now are Gateway Foundation doctors. Some of them want to be GPs so are being sent to the Community Hospital in their F2 year. It was agreed Professor Wood and Dr Hellewell would meet to consider identifying GP practices willing to take F2 doctors within their Practice.

Action: MW/HH

There are also the more senior refugee doctors. Currently the only ones in Fife are from Myanmar. NHS Fife had asked for physicians in the making because this is where there were gaps in money, but they would potentially be surgeons in the making. Professor Wood suggested it may be worth having a conversation about how we benefit more widely.

There is also work ongoing with the Royal College of Physicians where they are recruiting in India on an MTI basis but at a lower level, because previously they had been recruiting at a consultant or sub consultant level. A project is now underway looking at recruiting people who come for two years to pass their MRCP paces.

Professor Wood said there are other opportunities so it would be useful to discuss with the wider group at some point. Dr McKenna said the issues Professor Wood was raising fall into the strategic planning for the workforce currently and for the future. One of the outcomes of the Away Day on 26 September 2023 is to set out ideas on paper to produce a report.

Joy Tomlinson highlighted there is a UK wide workforce planning event taking place for Health Protection to which she has been invited to attend as chair of the Scottish Health Protection Network and to a meeting with the Four Nations on the 11 September 2023. Gaps have been identified, particularly in Health Protection Groups but there no increase in the number of trainees that are required. Donna is also leading a separate piece of work around the wider public health workforce working with Karen Wilson and Donna Milner from NES. This is at the stage of undertaking surveys and looking at our forwards national planning so that would be quite useful to link in with.

Joy Tomlinson agreed to attend the Away Day at Carnegie Library on 26 September 2023.

vii) Education & Training

Professor Wood advised the Scottish Government have agreed a new five year medical school at St Andrews University, where Fife will be the chief clinical partner. The first entry of students will be coming September 2023 and will undertake the traditional St Andrews BSc. This will be reconsidered to make it more fit for purpose and more curriculum aligned. The first cohort of students will come out to clinical practice in January 2026, which is the second-half of their third year.

SCOTCOM will have bases in Queen Margaret and Cameron Hospital and staff of all descriptions will need to be recruited. Professor Wood asked Members to contact her as early as possibly with any ideas. SCOTCOM should lead to significant expansion of facilities especially in relation to

having a SIM centre. It will not be the same as the QMH SIM centre but lower tech and more community focused and more utilised by Community Healthcare workers.

Work will also be undertaken to try and do more this year and subsequent years for postgraduate trainees in the way of simulation and getting more coordinated and organised for simulation.

Dr McKenna said this was massive development for NHS Fife. A Governance Structure is being agreed to oversee SCOTCOM in Board and in connection with St Andrews.

It was noted the full cohort is just under 200 per annum with the St Andrews intake being 55.

Professor Wood advised there are real opportunities to build medical education in the community through this course despite struggles with capacity to teach.

Professor Wood advised GCMs, GPs who teach SCOTGEM course, have been recruited. Eight candidates were interviewed and three have been recruited as permanent members of staff, all new to GP Practices in Fife.

Iain MacLeod advised he had received an enquiry from a Neurologist in Edinburgh who Fife would like to recruit who wishes to engage in some form of academia and sought advice from Professor Wood on how to start the process. Professor Wood advised this would need to be given some thought as there is a danger of upsetting existing activity. It was agreed this was not for discussion at AMC but could be discussed at a more informal group or Development Session with Dr MacLeod and Dr Hellewell on how Professor Wood could take this forward.

Action: MW, HH, IMcL

6 STRATEGIC ITEMS

i) GMS Implementation

Dr Henderson advised from a GP Sub perspective there was incredible frustration over the whole issue. There is nothing positive to say about the current situation in terms of where the staffing sits at, where the transitional agreement sits at and what the service provision looks like, and how practises are not benefitting from the contract.

Despite everybody's best efforts, it has not moved forward as it should, and general practice continues to get worse week on week with more talk of practices being handed back to the Board. This remains an on-going crisis.

Although not related to GMS Professor Wood said she thought politicians are really interested in medical workforce and concerned about lack of

applicants to medical schools and people dropping out throughout the training process. Directors of Medical Education across Scotland asked to meet with the civil servants to tell them what could be done to make it better. Having given a response there remains a mismatch between the problem and solution.

Professor Wood said thought needs to be given on how the get a medical staffing voice and how this can be replicated across Scotland, so politicians are forced to listen.

7 ITEMS FOR INFORMATION

i) Notes of the GP Sub Committee:
No notes for consideration.

ii) Notes of the Clinical Governance Oversight Group:
No notes for consideration.

iii) **Notes of NHS Fife Area Drugs & Therapeutics Committee: 26 April 2023**
Noted

8 AOCB

9 DATE OF NEXT MEETING
Tuesday 10 October 2023 at 2pm via MS Teams

AREA RADIATION PROTECTION COMMITTEE

(Meeting on 10 May 2023)

No issues were raised for escalation to the Clinical Governance Committee.

Area Radiation Protection Committee

RADIATION PROTECTON MEETING

Via Teams

Wednesday, 10th May 2023

9.30am – 10.17am

Present:

Dr Chris McKenna (Chair)
Nicola MacDonald, RPA, Head of Radiation Protection
Donna Galloway, General Manager
Gail Taylor, Superintendent Radiographer
Lesley Henderson, Superintendent Radiographer
Simon Willis, RPA, RWA
Claire Parry, Principal Physicist (RP)
Debbie Sliders, Public Dental Service
Laura Cluny, Principal Physicist (NM/RP)

Absent/Apologies:

Theatre staff
Jane Anderson, Radiology Services Manager

ACTION:

MRI Scanning / Pacemakers –
Compliance ongoing. Business case to be carried into the next financial year.

Radon Assessment for underground workers –
Laura Cluny hopes to have results by the next meeting.
Paul Bishop in Estates is leading on this.

Two sealed disks, sources for dose calibrator QC –
Laura Cluny advised the VHK had been done, but QMH was still outstanding.
Chris McKenna advised that if it's a funding issue with Planned Care, speak to Murray Cross.

Review of Supply of Dose Monitoring Badges -
Nicola MacDonald advised we are still trying to progress. Landauer lost a whole shipment of badges, which has never happened before. There are a number of other issues being investigated.

Lessons Learned -
Fife Orthopaedic Centre – Nicola MacDonald advised that nothing formerly had been written up but learning has been shared with colleagues across Scotland.
It was suggested to take this item off the Actions for this Committee.

MRI healthy volunteers
Protocols to be set up. Lesley Henderson advised some had been done for training purposes, including herself being a volunteer. Need to speak to Jane Anderson re this matter. Item to be taken off this Action Plan.

New Regulations, looking at AORD compliance –
Nicola MacDonald advised Medical Physics and Estates to be involved. A new member of staff had been appointed and had already commenced some investigations. This work will be on-going, any issues will come back to this committee.

AGENDA ITEMS:

HSC Consent Update
ECP Analysis –
Simon Willis advised the application fee would be between £1,000 and £5,000, not yet fixed. The application would be done electronically. No specific time, could be within the next 5 years.
We will have 3 months notice. It won't happen before October this year. Physicists will lead on this with support from Richard and Sally.

Classification of Nuclear Medicine Staff Update
Laura Cluny advised this is now underway, in line with expectation from HSE that virtually all staff working in Nuclear Medicine should be classified. Process already begun in Lothian, but need to have further discussion with Fife. A guidance document is nearly completed.

Breast Theatres at QMH – do not need to be classified.
Gail Taylor advised there are less than a dozen staff members working in Nuclear Medicine.

Annual Compliance Reports
Gail Taylor read out a report for Radiology. Key notes are:

- All VHK Radiation Protection Supervisors had been reviewed.
- Two RPS had attended training at the Western General Hospital.
- Radiology Referrals have escalated.
- Radiology Risk Assessments updated.
- Pregnant staff – this needs to be updated.
- The Team had been praised for the level of investigation.
- Local rules will take place 2022/2023

Debbie Sliders advised that another RPS had been trained for PDS. There had been 2 radiation incidents, which had been student errors. 2 OPGs need to be replaced as were causing too many incidents. Otherwise all is going well. A new Clinical Director had been appointed, unsure if had yet take up the post.

Jodie McGoldrick, Nurse in Charge of Theatres: No issues, other than there was more medical staff issues rather than nursing issues. Need to train some more RPS and set up IR(ME)R training. Nicola MacDonald to meet with Clinical Director.

Staff Dose Report:
Clare Parry advised this was very well controlled in NHS Fife and gave some figures.
Will move to quarterly badge monitoring, but not for Nuclear Medicine or Interventional staff.
This will be from July.

Radiation Incident Report
Nicola MacDonald advised there had been 150 incidents in 2022, only 6 involved staff, and 5 of the patient incidents were externally notifiable. A member of staff had been in the CT room when the scan had started.

Staff should be encouraged to DATIX.
Local rules need to be clear for Theatre staff.
Overall the numbers are very low.

Environmental Dose Monitoring
Simon Willis advised this is carried out every 3 years.
There is a Report in the Teams folder for reference.
6 surveys have been carried out at QMH and 2 at VHK
Shielding checks had been done across 10 rooms, no issues found.
C-arm doses, all positive.
Public Dental Service is done monthly. All going well.
Nicola MacDonald advised dental badges to be done quarterly.

Any Escalations:
Nicola MacDonald advised that both her and Clare Parry had reviewed the RP Policy on 9th May 2023. Laser and MR to be taken out. There will be 3 stand alone Policies, these will be progressed once the NHSL ones have been ratified.

Any Other Business
None

Next Meeting
Dr Chris McKenna advised the next meeting will take place on Tuesday, 14th November 2023.

CANCER GOVERNANCE & STRATEGY GROUP

(Meeting on 17 August 2023)

Report on the National Cancer Strategy Alignment to go the Clinical Governance Committee to provide assurance.

Cancer Framework Annual Delivery Plan Year 2 to go to the Clinical Governance Committee.

Cancer Governance & Strategy Group

NHS FIFE CANCER GOVERNANCE & STRATEGY GROUP (CGSG)

Unconfirmed Note of the Meeting Held at 09:30 on Thursday 17th August 2023 via Microsoft Teams

Present:	**Designation:**
Nick Haldane (NH)	Lead Cancer GP
Murdina MacDonald (MM)	Lead Cancer Nurse
Rishma Maini (RM)	Consultant - Public Health
Linda McGourty (LMcG)	GP
Chris McKenna (CM) Chair	Medical Director
Kathy Nicoll (KN)	Cancer Transformation Manager
Frances Quirk (FQ)	Assistant Director Research, Development & Innovation
Nicola Robertson (NR)	Director of Nursing, Coroporate
Shirley-Anne Savage (SAS)	Associate Director of Quality and Clinical Governance
Sarah Scobie (SS)	Consultant – Clinical Oncologist
Fiona Towns (FT)	Patient Representative
Amanda Wong (AW)	Associate Director of Allied Health Professions
Apologies:	**Designation:**
Paul Bishop (PB)	Head of Estates
Nicky Connor (NC)	Director Health and Social Care
Izzy Corbain (IC)	Patient Representative
Claire Dobson (CD)	Director of Acute Services
Fiona Forrest (FF)	Deputy Director of Pharmacy
Susan Fraser (SF)	Associate Director of Planning & Performance
Alistair Graham (AG)	Associate Director Digital and Information
Ben Hannan (BH)	Director of Pharmacy & Medicines
Janette Keenan (JK)	Director of Nursing
Neil McCormick (NM)	Director of Property and Asset Management
Margo McGurk (MMcG)	Director of Finance and Strategy
Emma O'Keefe (EO'K)	Consultant – Dental Public Health
John Robertson (JR)	Lead Cancer Clinician - Surgery
In Attendance:	**Designation**
Kerri Davidson (KD)	Consultant - Haematology
Stephanie Guillaumier (SG)	Consultant – Urology Planned Care
Rebecca Hands (RH)	Clinical Governance Administrator (minute taker)
Ian Mitchell (IM)	Consultant – Urology Planned Care

		Action
	Welcome	
	CM welcomed everyone to the meeting. CM welcomed Fiona Towns to the meeting as the new patient rep.	
1.	**Apologies for absence**	
	Apologies for absence were **noted** from the above named members.	

		Action
2.	**Unconfirmed Note of the previous NHS Fife Cancer Governance & Strategy Group Meeting of 31 May 2023 via Microsoft Teams**	
	The Unconfirmed Note of 31 May 2023 was **accepted** as an accurate record.	
3.	**Action Log**	
	041122#6 – Meeting to be rescheduled. 300323#2 – To be carried forward to the next meeting. 310523#1 – SAS, KN and Mims attend this group. This action can be closed. 310523#2 – To be carried forward to the next meeting. 310523#3 – KN provided a paper on this and it has been shared with the group. This action can be closed.	
4.	**GOVERNANCE**	
4.1	**Acute Cancer Services Delivery Group Update**	
	This will be carried forward to the next meeting.	
4.2	**Cancer Risks**	
	This will be carried forward to the next meeting.	
4.3	**Cancer Framework Risks**	
	SAS advised that herself and KN have met on a few occasions to discuss these. They have also met with the risk team to get some guidance on how to present those risks. There is currently risks under the headings of: • Cancer Workforce • Financial Delivery • Digital and Information • Edinburgh Cancer Centre (ECC) • Property and Estate They are currently querying a couple of them which was around Digital and Information, and ECC; however, the lead cancer team thought that they were relevant risks. SAS advised they are almost at the stage of sharing and for comments. KN advised these risks will go to the Cancer Leadership Team then will come to this group.	
5.	**STRATEGY/PLANNING**	
5.1	**National Cancer Strategy Alignment**	

		Action
	KN advised the group the 10 year cancer strategy has been published along with a 3 year action plan. The strategy has been reviewed alongside our Cancer Framework to ensure alignment and to identify any gaps. 11 ambitions have been identified in the strategy which aligns well with the commitments in the Cancer Framework. KN shared a table with the group which shows our commitments. The aim of the 3 year action plan is to recover and stabilise systems. In relation to the action plan, KN is currently going through the actions to see if there is anything we have not yet considered. On first look we seem to be doing what we need to do. The only action we had not included was around genomics. A lot of the actions are not at Board level. KN has had a discussion with Nicola McCloskey-Sellar and she advised that they were looking at the actions from a regional perspective. The Scottish government are in the process of developing a monitoring and evaluation framework to cover the duration of the strategy CM asked the group if this should go to the Clinical Governance Committee. KN advised she keeps this up-to-date so is able to provide a report to any group. CM advised a report will be taken to the Clinical Governance Committee.	**KN**
5.2	**Cancer Framework Annual Delivery Plan Year 2 Update**	
	SAS advised the Year 2 Cancer Framework has been drafted using actions and objectives outlined in the NHS Fife Annual Delivery Plan and the NHS Fife Medium Term plan, and has been carried forward from the Year 1 Cancer Framework action plan. SAS asked the group to review their area and update or add any objectives as required which are expected to be completed by March 2024. Other next steps taken will be to begin engagement with teams through the Cancer Leadership Team and through MS Forms to ensure we reach as many people as possible. CM advised this paper should also go to the Clinical Governance Committee.	**KN**
5.3	**Framework for Effective Cancer Management**	
	KN advised the next Framework for Effective Cancer Management update for the Scottish Government is due in September. The update goes through the Acute Cancer Services Delivery Group and the Cancer Leadership Team and is signed off by both CM and CD. To date we have completed 65% of the actions (34). There are 15 in	

		Action
	progress and 2 not started, these are referral audits. We received a paper recently called Revive your Cancer Performance Management: lessons learned from engagement with NHS Lothian. A SBAR was written by KN to assure focus on the framework for effective cancer management and that they had considered the recommendations in this paper. This was also tabled at the Acute Cancer Services Delivery Group and the Cancer Leadership Team. Actions have been identified for 2023-24 which are documented within our Annual Delivery Plan and Medium Term Plan. There were some things mentioned in the paper which are not identified as actions for us but may wish to consider: • Share articles of interest in local newsletters/briefings • Share any comments, quotes, from senior managers, CE and Executive Teams • Continue to raise awareness of cancer through monthly newsletter • Awareness of cancer audit team members and roles with a specific focus on cancer audit team – help other staff understand how things work at a local level • Review and assess the need for additional updates/education - NHS Lothian carried out a series of workshops with trackers and other staff • Sharing relevant information and information • What does our weekly timetable of events look like • Where to reports go KN asked if these should be considered at this group or at the Acute Cancer Services Delivery Group. MM advised it is for this group to consider and there is something that should be done about promoting the wider work. MM noted it may be worthwhile considering doing quarterly bite size messages. MM also noted it will be worthwhile to promote through StaffLink and to present at the Grand Round twice a year. KN advised they will take this through the Cancer Leadership Team to discuss how this will be done.	
5.4	**Projects Update**	
	Community Pharmacy This will be carried forward to the next meeting. *RCDS Expansion* MM advised CM that they are hoping to send over a paper on this shortly. MM noted that they are now expanding to colorectal and they have had 59 referrals through the service. There are a few teething problems,	

		Action
	however, it is going well. The RCDS is sustaining activity and diverts 1200 referrals per annum from general surgery. The first 6 months of expansion into the GI cancers has resulted in diverting approximately 400 patients. It is anticipated we will divert 800 referrals from the colorectal service the first six months of operation. Evidence from RCDS care opinion indicates higher levels of patient satisfaction. Service delivery outcome findings are that patients were impressed with the speed of investigations, results and tailored communication approach, with staff taking the time to assess and understand their individual health and social background in depth. *Single Point of Contact Update* KN advised the group that recently quite a lot of work has happened to improve the Single Point of Contact Hub (SPOCH). • Optimal Lung Cancer Pathway Integration – SPOCH will support radiology to ensure reduce waits to CT by: o Arranging U&E if not done/up to date o Contacting the patient to advise of CT date, specific instructions and what to expect o To facilitate vetting post CT one day reporting by updating TRAK advising when CT report available o Advise patient of 1st OPA and what to expect – The aim of this is to reduce waits to 1st OPA by way of a rapid access CT with one day turnaround and expedited 1st OPA • RCDS – Colorectal – We have now gone live with the RCDS Colorectal pathway – SPOCH will be responsible for management of the negative qFIT pathway and follow up, which will ultimately include arranging PIR and ACRT as appropriate – SPOCH will make the first outpatient appointment and introduce the service where the patient is for a consultant review – Letters done for colorectal qFIT which will be put in TRAK • Other improvements – We are looking at 'closing the loop' for 'good news' results for both lung and colorectal – We will also aim to implement the Regrading Framework as part of the vetting process – Queuebuster will be implemented, with an expected go live in September – As part of the lung cancer expansion we will be looking at the	

		Action
	SPOCH team taking updates on patient symptoms and performance status prior to 1st OPA to aid planning *Pathways Review* • Prostate Improvement Pathway – The nurse-led pathway for patients referred with a PSA <10 went live to date. There is close collaboration with the consultants to ensure robust vetting is taking place – It is expected that patients will receive their 1st OPA within a week (current wait is 2 weeks) – This pathway will integrate with SPOCH and any information has been tailored to suit the appointment type allocated at vetting – We are also exploring how the tracker can provide early support to further reduce waits in the pathway – Aim to significantly reduce the waits in the pathway from referral to MDT – The updated protocol for GPs for optimum prostate referral is now available in SCI gateway – We continue to work with the prostate team to improve the post MDT part of the pathway, however, capacity constraints will continue to make this challenging. Meantime we will aim to ensure any processes post MDT are as slick as possible to minimise any wasted days • Optimal Lung Cancer Pathway – Part of the optimal lung cancer pathway work has focussed on expanding into SPOCH to improve initiation of the pathway – When the group was set up baseline measures were done, measuring waits between steps in the pathway and CWT performance – Once pathway improvements are embedded we will review the baseline measures and performance to evaluate improvement, this should be around December time. – As well as the integration into SPOCH some other improvement have been made: o GP can request a same/next day CXR for patients with suspected lung cancer o Bronchoscopy and Outpatient clinics have changed days which has reduced the wait to MDT (average of 11 days and is now average 6.5 days) o All patients are referred to Maggies for Universal Prehabilitation as part of the lung pathway – MM is doing some work in collaboration with Edinburgh who introduced this a while ago and have had some very positive outcomes. o A bundle checklist has been agreed for surgical patients which have been posted around the clinics. – There are issues within the pathway which are outside our	

		Action
	control which impact on the pathway such as waits to PET and molecular testing. There is mention of enhancing diagnostics (including PET) and more complex molecular testing features in the national strategy; however, there is nothing specific identified in the action plan.	
6.	**FUNDING**	
6.1	**Funding Update**	
	KN advised of the following funding: • Cancer Waiting Times - £685,234 + £91,000 - Funding has now been released. Non recurring until March 2024. Thereafter, it is expected that funding will be released on a recurring basis from April 2024. • AO/SACT - £103,000 recurring. Nicola McCloskey-Sellar is chasing Scottish Government for the expected £3m recurring of which we should expect our NRAC share for 2023-24 in addition to this. • RCDS/RCDS Expansion - £339,581 - This has been released and is non recurring until March 2024. • SPOCH - £107,354 - This has been released. This should be recurring funding; however, it is allocated on an annual basis. • DCE Community Pharmacy - A project proposal was put forward but more detail is required. No further update received. • DCE Optimal lung cancer pathway - £171,353 - This has been released and is non recurring until March 2024. • CRUK Prostate - £213,000 - This has been confirmed and released. The funding is for 2 years from June 2023. • Macmillan posts - Project Manager is in post – awaiting update on allocation. Patient experience person is expected to be in post in September. CM advised a lot of the CWT money was put towards projects in urology as it was seen to be one of our most challenging areas. CM asked how are we holding ourselves to account for the use of the money. CM asked how are we assessing the outcomes of patients and value for money for the investment we are getting. KN advised there was a considerable amount of money put towards urology from the CWT specific funding about extra waiting lists for surgery for the end of the pathway for robotic prostatectomy. KN advised we have £1.9m worth of bids coming in this year. KN advised what she is aiming to do this year is to go to the Patientrack meetings to try and ascertain how that money is being spent on a more regular basis. KN advised she always keeps a regular update on that it is being spent and if there is any slippage but not necessarily effectiveness. KN agreed with CM that they do need to do this more robustly. CM advised this is a discussion for out with the meeting.	

		Action
6.2	**RCDS Plan Beyond 2024**	
	MM advised the paper that is being prepared will include this. Work is ongoing to demonstrate cost savings as total service model needs to be taken into account. They need to undertake costing exercises taking cognisance of the onward referral and the request for repeat CT scan on radiologist recommendation. Work is still required to confirm the economic evaluation and costing to sustain current activity. Although RCDS is a cost effective model it can be very difficult to show cost saving as other work moves into the vacated space.	
6.3	**Patient Involvement**	
	MM advised NHS Fife was appointed fixed term funding from Macmillan Cancer Support for the appointment of a Macmillan Project Patient Involvement Coordinator to fund the establishment of a Macmillan Oncology Improvement Project. This grant is for a fixed period of 24 months. The funding for this post was secured at the end of the 2021 alongside the funding for the Project Manager post. They initially appointed into the Project Manager pathway in the spring 2022, however, they had some human resources challenges; therefore they put a pause on the recruitment of the patient involvement post. The Project Manager post was re-advertised early 2023 and they recruited into the post 4 months ago. They are now looking to recruit the band 5 Patient Involvement post to support the cancer nursing specialists' services to embed the care experience improvement model into practice. Macmillan cancer support Awarded £165,998 for both posts. CM will go through the paper and will discuss with MM offline.	
7.	**QUALITY/PERFORMANCE**	
7.1	**Cancer Waiting Times Q1 2023**	
	KN advised the Q1 2023 publication was published in June 2023. Performance deteriorated for the 62 day standard. 62 day - 69.4% (a decrease from 72.6% last quarter). There was a total 76 breaches with 54 (71%) of them being in urology. We did not meet the 31 day standard again achieving 92.7%. There were 28 breaches. 85% of the breaches were in urology (24 breaches) The tolerance of breaches is 13 for 62 day and 19 for 31 day. Adjusted waits are now published. These are not related to the 62 or 31 day	

		Action
	standard and can be accessed via the Public Health Scotland website. Q2 submission is due and draft figures show: • 62 day - 78.4% (52 breaches, 31 of which urology) • 31 day - 96.6% (12 breaches, all urology)	
7.2	**Effective Breach Analysis SOP**	
	KN advised the group the Effective Breach Analysis SOP was published earlier in the year. As a recap, the aim of this is to ensure effective escalation to avoid breach and ensure effective breach analysis and action where breaches occur. Through the Acute Cancer Services Delivery Group an action plan has been agreed with almost half of the actions having already been completed. There are still some actions which we need to work through namely: • Agree how the template to support breach analysis should be rolled out to ensure actions are put in place where themes emerge. • Update MDTs proformas to include any upstaging of cancer where there has been a delay. • Agree a programme of attendance of services at the Acute Cancer Service Delivery Group to update on performance, challenges and actions to improve. A meeting has been arranged with CD, BH and Sally McCormack to review outstanding actions.	
7.3	**Regrading Guidance**	
	KN advised the group they will be aware that the regrading guidance was published in May 2023. In Fife approximately 16% of referrals are downgraded or sent back to the referrer from an urgent suspected cancer referral and almost 8% are upgraded. This practice varies across specialties. There is variation in practice around informing the GP. Some services such as dermatology and breast have a robust process to advise the GP of a downgrade or advise it is being rejected and why. The aim of this guidance is to ensure consistency across all specialties. An action plan has been drafted and presented to the Acute Cancer Services group and the Cancer Leadership Team. The next steps are to widely circulate the recommendations. It has been agreed that regrading will be implemented as part of the improvement work in lung, colorectal and as part of the prostate nurse led pathway.	
7.4	**Quality Performance Indicators**	

		Action
7.4.1	**Testicular 2021-22**	
	SG went through the papers that were shared with the group. Case ascertainment for NHS Fife is 100% In NHS Fife 13 patients (11 previous cohort) were diagnosed with Testicular Cancer NHS Fife met 8 of the 10 QPIs (including sub-QPIs) for Testicular cancer. QPIs not met: • **QPI 3 - Patients with testicular cancer should have primary orchidectomy within 3 weeks of ultrasonographic diagnosis (USS).** The QPI target was not met showing a shortfall of 18.1% (3 cases) 1 had sperm banking in Tayside. 2 had pathway delays due to service pressure and capacity • **QPI 6-: Patients with stage I seminoma receiving adjuvant single dose Carboplatin should receive within 8 weeks of orchidectomy** The QPI target was not met showing a shortfall of 28.3% (1 case) delayed due to patient holidays, in turn delaying chemotherapy. There were no actions identified for NHS Fife.	
7.4.2	**Bladder 2021-22**	
	IM went through the papers that were shared with the group. Case ascertainment for NHS Fife was 226%. NHS Fife met 8 of the 15 (including sub QPIs) QPIs reported for this cohort of bladder cancer patients. QPIs not met: • **QPI 2: Quality of TURBT at initial resection** – detailed description with tumour location size, number and appearance (6 cases); where the resection is documented as complete or not (4 cases); where detrusor muscle is sampled within the specimen (7 cases). • **QPI 4: Early TURBT** – all T1 or high grade Ta* (*where multifocal or >3cm) NMIBC to have re-resection within 42 days from TURBT1 (25 cases); high grade NMIBC with no detrusor muscle at TURBT1 to have re-resection in 42 days (9 cases); NMIBC where resection was incomplete at TURBT1 to have re-resection in 42 days (3 cases). • **QPI 6: Lymph Node Yield** – pelvic lymph node dissection (>10 nodes) to at least level 2 undertaken at radical	

		Action
	cystectomy (6 cases). There were 3 actions identified for NHS Fife as follows: • **QPI 2(iii) [SCAN wide action]** Clinically deemed high grade or high risk procedures should be booked in for dedicated Bladder cancer surgeons only to perform. • **QPIs 4(i)-(iii) [SCAN wide action]** Identify where main delays are for re-resections to bring repeat procedures in line with the six week QPI target. • **QPI 6 [Fife specific action]** Fife service to document the level of lymph node dissection clearly in the operation notes.	
7.4.3	**Lymphoma 2019-20 & 2020-21**	
	KD went through the papers that were shared with the group. *2019-20* Case ascertainment for NHS Fife is 99.7% NHS Fife met 3 of the 9 (including sub-QPIs) QPIs for Lymphoma. QPIs not met: • **QPI 2 Treatment Response:** The target was not met with a shortfall of 1.1% (2 cases). Both cases exceeded the 91 day target, one by 2 days and the other by 21 days (this was a clinical need as patient too unwell to attend CT). • **QPI 4 Cytogenetic Testing:** The target was not met showing a shortfall of 13.8% (5 cases). 3 did not have MYC test requested because the patients were unfit for chemotherapy. 1 had tissue sent to lab for processing but results were not reported and 1 had insufficient tissue for MYC test to be performed. • **QPI 5 MDT Discussion:** The target was not met showing a shortfall of 5% (9 cases). All were initially diagnosed by other specialities before referral to Haematology. • **QPI 12 Treatment Response in Hodgkin Lymphoma:** Part 1 - The target was not met with a shortfall of 30% (1 case). A CTCAP was performed after 2 cycles instead of a PET CT. The scan was discussed at the regional MDM to inform further management. Part 2 - The target was not met with a shortfall of 80% (1 case) where the report was available 6 days after the PETCT was performed. • **QPI 14 Clinical Trials:** Fife – 0% recruitment.	

		Action
	There were no actions identified for NHS Fife. *2020-21* NHS Fife met 5 of the 9 (including sub-QPIs) QPIs for Lymphoma. QPIs not met: • **QPI 2 Treatment Response:** The target with a shortfall of 27.5% (9 patients). The post imaging date was changed at patient request for 1 patient. 4 patients were treated with adjuvant radiotherapy and had post treatment CT of chest abdomen and pelvis (CTCAP) at 94 days to 98 days after completing radiotherapy. 1 patient had atypical disease location and had MRI as end of treatment imaging. 3 patients had completed their treatment at time of submission but have not yet completed the time period required to get their post treatment imaging. • **QPI 4 Cytogenetic Testing (within 3 weeks of treatment):** The target with a shortfall of 40% (1 case), where the MYC test result was delayed. This did not alter management and the patient received appropriate treatment. • **QPI 12 Treatment Response in Hodgkin Lymphoma:** Part 1 - All 4 patients had interim PET 2 scans. 1 patient did not attend PET appointment and would have met QPI if had attended on original date. 2 patients had early PET prior to day 9, cycle 3 chemotherapy not delayed. 1 patient had PET at correct time but cycle 3 then subsequently delayed for alternative clinical reason. Part 2 - There were no eligible patients in Fife. • **QPI 14 Clinical Trials:** Fife – 0% recruitment**.**	
7.4.4	**Acute Leukaemia 2020-21 & 2021-22**	
	KD went through the papers that were shared with the group. *2020-2021* Case ascertainment for NHS Fife is 110%. NHS Fife met 3 of the 6 (including sub QPIs) QPIs for Acute Leukaemia. QPIs Not Met: • **QPI 3 Proportion of Patients Discussed at MDT**: Fife did not meet the target with a shortfall of 26.8% (7 cases). 5 patients with AML were considered too frail to undergo bone marrow sampling and the result would not have changed supportive care management. 1 patient was discussed in detail informally with consultant in another board and was managed appropriately. 1 patient had bone marrow sampled	

		Action
	but inclusion for discussion at the Haematology MDM was overlooked, however on review, the patient was managed appropriately with best supportive care. • **QPI 8 Clinical Trials with Curative Intent:** Fife did not meet the target. (0/3 patients eligible). 2 patients were eligible for AML 19 but received DA + GO as per working group guidance. 1 patient was not eligible for the trial although they met inclusion criteria for this QPI. • **QPI 14 Clinical Trials QPI:** Fife – 0%: Trial activity was halted during Covid-19 pandemic There was one action identified for NHS Fife: • All patients should be registered at MDM, including where management would not change. *2021-22* Case ascertainment for NHS Fife is 95% In NHS Fife 19 (22 previous cohort) were diagnosed with Acute Leukaemia. NHS Fife met 7 of the 13 (including sub-QPIs) QPIs for Acute Leukaemia. 3 of the QPIs were not assessed as no patients met the criteria. QPIs Not Met: - • **QPI 3 Proportion of Patients Discussed at MDT**: Fife did not meet the target with a shortfall of 0.3% (1 case) who was being treated for MDS which then transformed to AML. This QPI was an action point in 2020-21 and now shows a 26.5% increase in attainment. • **QPI 10(ii) Intensive Chemotherapy in Older Adults:** Fife did not make the target with a shortfall of 12.5% (4 cases). 3 patients did not have trial status recorded locally. • **QPI 12 Palliative Treatment**: Fife did not make the target with a shortfall of 40% (3 cases). They were not considered clinically well enough to receive palliative SACT and were treated appropriately with best supportive care. **There was one action identified for NHS Fife:** • Ensure that trial status is recorded at MDM.	
8.	**CANCER RESEARCH**	
8.1	**Cancer Research Update**	
	FQ advised that they currently have 27 studies in the cancer portfolio.	

		Action
	Since the last meeting they have had 11 new patients recruited across 3 studies; 2 colorectal cancer and 1 breast cancer. The studies in set up are 2 breast cancer studies and a lung cancer study.	
9.	**REALISTIC MEDICINE**	
9.1	**Realistic Medicine Update**	
	LMcG advised that there is a desire to use the principals of realistic medicine to ensure that they are delivering value based care. CM advised the group there is a realistic medicine workshop that is being held on the 20th of September at Lynebank.	
10.	**LINKED COMMITTEE MINUTES**	
10.1	**Cancer Managers' Forum (28/04/2023)**	
	This was noted by the group.	
10.2	**Acute Cancer Services Delivery Group (03/05/2023)**	
	This was noted by the group.	
10.3	**Cancer Leadership Team (23/05/2023)**	
	This was noted by the group.	
10.4	**Rapid Cancer Diagnostic Service Oversight Group (31/03/2023 & 27/06/2023)**	
	This was noted by the group.	
10.5	**SCAN Regional Cancer Strategy Group (09/03/2023)**	
	This was noted by the group.	
10.6	**South East Region Cancer Innovation Programme Governance Group (04/05/2023)**	
	This was noted by the group.	
10.7	**Cancer Performance and Delivery Board (11/05/2023 & 08/06/2023)**	
	This was noted by the group.	
10.8	**Cancer Waiting Times Data and Definitions Group (21/04/2023)**	
	This was noted by the group.	
10.9	**Earlier Cancer Diagnosis Programme Board (31/05/2023)**	
	This was noted by the group.	
10.10	**SCAN Regional Cancer Planning Group (12/05/2023)**	
	This was noted by the group.	
11.	**Items to Note**	
	No items to note	

		Action
12.	**ISSUES TO BE ESCALATED TO EDG/CLINICAL GOVERNANCE COMMITTEE**	
	Report on the National Cancer Strategy Alignment to go the Clinical Governance Committee to provide assurance. Cancer Framework Annual Delivery Plan Year 2 to go to the Clinical Governance Committee. CM advised an update on RCDS may need to go to the Clinical Governance Committee before it comes to this group due to meeting dates.	**KN** **KN**
13.	**ANY OTHER BUSINESS**	
	No any other business.	
14.	**Date of Next Meeting**	
	The next meeting will be on Thursday 02 November 2023, 14:00-16:00 via MS Teams	

CLINICAL GOVERNANCE OVERSIGHT GROUP (Meeting on 22 August 2023)
No issues were raised for escalation to the Clinical Governance Committee.

Clinical Governance Oversight Group

Date: 24/08/2023
Enquiries to: April Robertson
Telephone Ext: Microsoft Teams

CONFIRMED MEETING NOTE OF THE NHS FIFE CLINICAL GOVERNANCE OVERSIGHT GROUP HELD ON TUESDAY 22 AUGUST 2023 via MICROSOFT TEAMS

Attendees

Norma Beveridge (NB)	Director of Nursing, Acute Services Division
Pauline Cumming (PC)	Risk Manager
Fiona Forrest (FF)	Deputy Director of Pharmacy & Medicines
Claire Fulton (CF)	Lead for Adverse Events
Catherine Gilvear (CG)	Fife HSCP Quality, Clinical Care & Governance Lead
Benjamin Hannan	Executive Director of Pharmacy and Medicines
Janette Keenan (JK) (Co-chair)	Executive Director of Nursing
Aileen Lawrie (AL)	Director of Midwifery
Dr Iain MacLeod (IM)	Deputy Medical Director
Siobhan Mcilroy (SM)	Head of Patient Experience
Dr Chris McKenna (CMcK) (Chair)	Medical Director
Dr John Morrice (JM)	Associate Medical Director of Woman & Children
Elizabeth Muir (EM)	Clinical Effectiveness Manager
Nicola Robertson (NR)	Director of Nursing, Corporate
Shirley-Anne Savage (SAS)	Associate Director of Quality & Clinical Governance
Amanda Wong (AW)	Director of Allied Health Professions
Prof Morwenna Wood (MW)	Consultant Nephrologist – Renal Medicine

In attendance

Lee Cowie (LC)	Clinical Services Manager, Child/Adolescent Mental Health, HSCP
Dr Susanna Galea-Singer (SG-S)	Clinical Lead, Addiction Services, HSCP
Tanya Lonergan (TL)	Head of Nursing, HSCP
Tom McCarthy (TM)	Portfolio Manager
April Robertson (AR)	Clinical Governance Administrator (Minute Taker)
Dr Gavin Simpson (Dr Simpson)	Consultant, Anaesthetics

Apologies

Lynn Barker (LB)	Director of Nursing, HSCP
Dr Sue Blair (SB)	Consultant in Occupational Medicine
Dr Helen Hellewell (HH)	Associate Medical Director, HSCP
Dr Sally McCormack (SMcC)	Associate Medical Director for Emergency & Planned Care
Geraldine Smith (GS)	Lead Pharmacist, Medicines Governance

	Items	Action
1	**Apologies for Absence**	
	Apologies for absence were noted from the above members.	
2	**Minutes of the last meeting held on 20th June 2023**	
	The Group confirmed that the note from the meeting held on the 20th of June 2023, was a true reflection of what was discussed.	
3	**Matters Arising/Action List**	

3.1	Deteriorating Patients **(CMcK/NB)**	
	NB informed the group that there was now approval for the Welsh Allyn equipment test phase through Capital Equipment prioritisation. A short-life working group is being put together to help decide how best to operationalise this 6 month phase. The equipment has arrived and was waiting for Digital & Information (D&I) to work on the interfacing. NB will give an update at the next meeting.	**NB**
3.2	NEWS2 **(Dr Simpson)**	
	Dr Simpson informed the group that NHS Fife was fully committed to NEWS2, which they had previously paused in 2019 due to it being a more sensitive scoring system. Digital & Information (D&I) will be leading the roll out of the project which should be implemented within the next 12 months. The nursing input to this project will be supported by our Deteriorating Patient / Resuscitation Lead, Kate Gaunt who has just recently taken up post.	
4	**GOVERNANCE**	
4.1	Q1 Deteriorating Patient Report April - June 2023 **(Dr Simpson)**	
	Dr Simpson shared the Q1 Deteriorating Patient Report with the group, giving some background on how good management of our 'Deteriorating Patient' is the safety net for NHS Fife. He thanked EM, Cheryl Waters and their team for all their great work in putting together this report which was the amalgamation of 3 reports over 8 years, the design of this report was the "envy of other boards". The detail is extremely useful and powerful as it gives focus on where our limited resources should be concentrated in order to make improvements which is what will be happening over the next 12 months. The first deteriorating patient workshop will be held tomorrow 23rd August 2023	
4.2	NHS Fife Deteriorating Patient Project Brief **(TM)**	
	TM shared the project brief with the group explaining; At a previous meeting of the CGOG it was agreed to progress improvement work for the care and management of deteriorating patients as a priority. This paper provides and updates on the work to date and includes a draft project brief which outlines the proposed approach to this improvement work. The group discussed the project brief and approved the proposed approach. The deteriorating patient project seeks to re-launch 'Know the Score' This project is intended to improve the quality and safety of patient care by Ensuring that systems and processes that underpin Know the Score are in place for clinical staff so that they are aware when a patient is deteriorating and can provide the appropriate level of care. This includes Increasing our timely recording of Patient Vital Observations using Patientrack e-observations and using an Early Warning Score (EWS) such as Fife Early Warning Score (FEWS) or the NHS Scotland National Early Warning Score (NEWS2)	

	Embedding a structured response (SR) for patients identified with high Early Warning Scores. Ensuring all appropriate patients have a completed DNA-CPR form. Ensuring every patient with a DNA-CPR will have a HACP (Hospital Anticipatory Care Plan) Continuing a comprehensive review and audit of every cardiac arrest to provide contemporary learning and adaptive improvement. Working with the principles of Realistic Medicine, supporting staff to provide patient centred care helping patients and their families to make decisions about the care they receive. Aligning with recommendations of national guidelines and approaches including SIGN 167 (Care of Deteriorating Patients) and the Scottish Patient Safety Programme. It is believed that collectively these actions will result in a reduction in the number of avoidable cardiac arrests across NHS Fife. As part of the scoping work, the Deteriorating Patient Group is engaging with a wide range of stakeholders. An engagement workshop is planned for Wednesday 23rd August. This engagement will be used to inform the approach to supporting improvement. The aim is that by September 2024 we will improve the management of deteriorating patients across all inpatient settings in NHS Fife. The Clinical Governance Oversight Group supported the continuation of this project based on the enclosed project brief and notes that further updates, including a more detailed project plan, will be brought to December meeting. CMcK added that the amplification of deteriorating patient work is of key importance. He also noted that Admissions Unit 1 (AU1) sees so much volume, complexity and acuity of patients passing through that hopefully this report would get into this detail, so that areas could be identified where recommendations be made or perhaps, identify an issue requiring another piece of work. GS agreed, quoting that AU1 has the highest percentage (30%) of all the acuity in NHS Fife and 10% of cardiac arrests. Providing any standardised, “easy to roll out” systems would improve the safety net in AU1 or indeed in other areas, i.e. Ward 43. CMcK concluded that the group could take assurance from the excellent work from everyone involved in pulling the reports together.	**TM**

4.3	SBAR Alcohol & Drug Death Reviews - Addiction Services, August 2023 **(SG-S)**	
	SG-S gave an insightful synopsis on report; The high prevalence of drug and alcohol deaths continues to be a challenge across Scotland. Although the prevalence of alcohol and drug deaths in Fife is below the national average, the demand for alcohol and drug death reviews by Addiction Services continues to be high. This, compounded with resource challenges and Covid restrictions, resulted in a situation where timeliness of reviews and 'closing the loop' process became a concern. For Fife, epidemiological data highlights that for drug deaths: • Males account for the majority of deaths; • Most drug deaths occur in the 35-44 age group; • Majority of death occur in areas of high deprivation; • Heroin/opioids (97%), benzodiazepines (78%) and gabapentinoids present in toxicology reports; • 68% not in treatment at time of death. A similar picture for alcohol deaths where Fife falls below the national average - at 18.7 per 100,000 heads of population compared to 20.8 per 100,000. Since the previous report in November 2022, there has been a lot of work completed in reviewing alcohol and drug related deaths. At the time of writing this update, Addiction Services now have **1 outstanding (out of the previous 74) cluster reviews.** The review could not be completed - awaiting additional information prior to completion. Addiction Services also have **19 outstanding reviews that had previously only been reviewed through the Multi-Disciplinary Drug Death Review Group** (**MDDRG) process**. <u>LAERS:</u> At the time of writing this report; Addiction Services have 12 outstanding LAERS to complete, with 7 of these having been completed by Addiction services and awaiting final approval and sign off, these are all pre April 2022. The other 5 LAERs overdue are nearing completion by the Service. Addiction Services have not met the target of reviewing all outstanding deaths by March 2023 – but have made considerable progress towards the target. Monthly cluster and LAER meetings will ensure that outstanding cluster reviews and LAERS will be completed by October 2023. The cluster reviews standard operating procedure has been revised, the new version seeks to: • address rate-limiting steps to the timeliness of reviews – e.g. delayed post-mortem reports; • merge review processes for drug-related deaths and alcohol-specific deaths; change the name 'cluster reviews' to 'deaths in service' review	

	All learning's from deaths reviewed through cluster reviews, LAERS, and MDDRG reviews have been inputted into the Datix reporting platform against each incident web identifier. In conclusion SG-S asks that; • The group acknowledge the work which has progressed thus far – particularly the significant progress in addressing the backlog (up to April 2022) of cluster reviews and LAERs and in the inputting of all learning's into the Datix reporting platform against each incident web identifier. • The group acknowledge the positive integrated joint work that is underway between Fife Addictions Services, Public Health and Alcohol and Drug Partnership. • For assurance, we would like to recommend that the work continues to progress with a further paper to be presented to the CGOG and (Quality Matters assurance Group) QMAG in December 2023 to report on progress. CMcK thanked SG-S for her comprehensive report. AL highlighted that if there were any women who had been pregnant within the 12 months preceding her death, could her team (Maternity Services) be made aware. These deaths are reported to (Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries) MBRRACE, and they could be part of the cluster review. BH informed the group that on behalf of the Alcohol & Drug Partnership (ADP), he chaired the Alcohol Specific Death group for Fife. The current remit of that group is to take 2 pieces of research and put recommendations back to the ADP for commissioning around alcohol specific deaths. One of these pieces of work is a public health led review of alcohol deaths in Fife; this would be completed by December. NR shared that there is a reinvigoration of the Organisational Learning Group (OLG) and they would be reaching out to see if there were any learning's which could be shared with the wider organisation.	**SGS**
4.3.1	Alcohol & Drug Death Cluster Review in Service Standard Operating Procedure **(SG-S)**	
	This was noted by the group.	
4.3.2	SBAR Alcohol & Drug Death Reviews - March 2022 **(SG-S)**	
	This was noted by the group.	
4.3.3	Alcohol & Drug Death reviews - Addiction Services - Quality Matters Assurance Group (QMAG) November 2022 **(SG-S)**	
	This was noted by the group.	
4.3.4	HSCP Cluster Review Sign Off & Clinical Care Governance Team (CCGT) Sign Off **(SG-S)**	
	This was noted by the group.	
4.3.5	Deaths in Service Themed Action Plan **(SG-S)**	

	This was noted by the group.	
4.4	NHS Fife Health & Social Care Partnership Clinical Governance Assurance Update **(CG)**	
	CG informed the group that the Quality Assurance Report (Clinical) is a standing agenda item and presented for assurance; data across each of the portfolios provides oversight across thirteen key quality indicators; the Executive Summary highlights areas of improvement and deterioration; Items to highlight from that report are: The group discussed the adverse event position, noting a deteriorating position for overdue incidents in the holding area and those awaiting review; with an improvement (upward shift) in the number of incidents being approved. This will be reviewed in the portfolio QMAG and monitored via the Quality Matters Assurance in Healthcare (QMASH), however there was a consensus to support review and improvement. A deteriorating upward shift in the number of falls (extending to 7 data points) was reported within Complex and Critical Care however falls with harm was noted to be sitting with three data points below the median. With regard to pressure ulcers (PU), there were no statistically relevant emerging themes or trends noted across partnership inpatient wards; however a consecutive increase in hospital acquired pressures ulcers occurred between February 2023 and April 2023, alongside a continuing increase of PU incidents in the community. A continued increase in medication incidents within partnership inpatient wards was noted; ongoing work and interventions with the multi disciplinary teams remains ongoing and is being led by the Deputy Director of Pharmacy. An SBAR was presented for reassurance at the meeting on 26th June on all work underway. Within Mental Health inpatient wards an upward trend was noted for all incidents from December 2022 to April 2023. A sustained improvement occurred for incidents involving a ligature from July 2022 to March 2023. The rate of restraint within mental health inpatient wards also demonstrated a rise in incidents being reported in April 2023. The rate of physical violence also demonstrated a rise in April 23; of the physical violence incidents reported, 42% involved the use of restraint. A sustained improvement occurred in the rate of self-harm incidents from June 2023 to February 2023 reducing the median from 3.40 to 1.85. The Mental Health Quality Improvement (MHQI) team are supporting a range of quality improvement activities across HSCP mental health inpatient wards, including Simple Pleasures; PRN Reports; Older Adult Community Mental Health Team Quality Standards; Scottish Patient Safety Collaborative.	
4.5	NHS Fife Health & Social Care Partnership Clinical Governance Inspection Update SBAR **(LC)**	
	Lee presented his report to the group; The Mental Welfare Commission (MWC) has continued their programme of inspection visits across mental health and learning disability services. This report	

provides an update regarding the visits to a number of inpatient areas and identifies recurring themes over the last 12 months.

This report is presented for information and assurance regarding work in progress to improve service delivery and patient experience.

The ward areas visited since the last update are:

- Mayfield, Lynebank Hospital, Dunfermline (20/04/23)
- Daleview, Lynebank Hospital, Dunfermline (25/05/23)
- Muirview, Stratheden Hospital, Cupar (20/07/23)
- Elmview, Stratheden Hospital, Cupar (20/07/23)
- Hollyview, Stratheden Hospital, Cupar (27/07/23)

Final reports have been received from MWC for Mayfield and Daleview.

Informal feedback has been provided by MWC for Muirview, Elmview and Hollyview.

LC focused on the recommendations from the reports for brevity which were;

Mayfield, Lynebank Hospital, Dunfermline. Visit date 20/04/23

1. Managers should consider identifying a system that captures daily contact between staff and patients in their electronic care record.
2. Managers should ensure that a system is in place to ensure consistent completion of s47 paperwork and accompanying treatment plans where required.
3. Managers should improve the privacy for patients in the garden area; this should be considered as essential to promote safety, privacy and dignity for all patients and staff.

The recommendations from 1. & 2. Actions are complete and 3. The work has been approved and a start date is awaited.

Daleview, Lynebank Hospital, Dunfermline. Visit Date 25/05/23.

1. Managers should consider the addition of an activity coordinator to the ward-based team, to support patients and develop a consistent programme of recreational and therapeutic activities.

A recommendation for this action has been picked up across the whole service:

An SBAR completed for submission to Senior Leadership Team (SLT) which proposes the reconfiguration of Band 3 Health Care Support Work into Activity Coordinator roles. This is a recurring theme across all of Mental Health and Learning Disability services and proposal would be to implement service wide.

Muirview & Elmview, Stratheden Hospital, Cupar. Combined visit on 20/07/23

Informal feedback:

- Generally positive feedback, special mention to SCN in Muirview making a palpable difference to the ward since the MWC visit last year.
- Records of care and Care plans were of mixed standard.
- Exemplar care plans were identified in both Elmview and Muirview and suggested that these be used to showcase to the teams.

- Patients complained of being bored and stressed by other patient's distress with no planned activity to distract them.

- No issues identified for T2 and T3 records of authority to provide treatment. Highlighted as being 'much improved' from previous visit.

- Issue identified Sec 47b certificates and covert medication pathways not always being reviewed 3 monthly.

Recommendations will include

1. Lack of Staffing resource impacting on delivery of Person Centred care
2. Requirement for dedicated activity coordinators in each ward.

Overall this feedback was generally positive, they said that the lack of staff was affecting person centred care and again mentioning the need for dedicated activity co-ordinators. This was not necessarily that the staffing was low but there was a recognition that the use of bank and agency staff was having an effect on person centred care

Hollyview, Stratheden Hospital, Cupar. Visited on 27/07/23.

Informal feedback:

- MWC commented on Hollyview's culture of care, standards of practice and innovations such as QR codes for information on MHA and medicines.

- MWC review team heard very positive feedback from patients about their experiences at Hollyview

- The review team identified Hollyview as a very good ward environment, very well maintained with a good outdoor space for patients

- Health records for patients were found to be excellent and consistently person-centred.

- Mental Health Act documentation was reported to be excellent and it was recognised that NHS Fife have demonstrated significant improvement especially in regard to Part 16 MHA.

- Highlighted the need for an Activities Coordinator in order to provide meaningful activity to patient group.

Recommendations will include:

1. Requirement for dedicated activity coordinators.

Recurring Themes:

There was an acknowledgement that reduced staffing numbers and use of bank staff impacted on consistent person centred care.

CMcK thank LC for his report which he felt very reassured by adding that the staff should fell really proud of their work. Once all the work around these inspections is complete this will be escalated to Clinical Governance Committee.

4.5.1	NHS Fife Health & Social Care Partnership, Mental Welfare Commission action plan across services **(LC)**	
	The action plan was noted by the group.	
4.5.2	Mental Welfare Commission for Scotland, announced visit and action plan, Mayfield Ward, Lynebank Hospital Visit 20 April 2023 **(LC)**	
	The action plan was noted by the group.	
4.5.3	Mental Welfare Commission for Scotland, announced visit to Elmview Ward, Stratheden, 19 July 2022 **(LC)**	
	This was noted by the group.	
4.5.4	Mental Welfare Commission for Scotland, announced visit to Hollyview Ward, IPCU, Stratheden, 25 August 2022 **(LC)**	
	This was noted by the group.	
4.5.5	Mental Welfare Commission for Scotland, announced visit to Muirview Ward, Springfield, 28 June 2022 **(LC)**	
	This was noted by the group.	
4.5.6	Mental Welfare Commission for Scotland, announced visit to Radernie, Low Secure Unit, Stratheden, 22 August 2022 **(LC)**	
	This was noted by the group.	
4.5.7	Mental Welfare Commission for Scotland, draft report, announced visit to Daleview Ward, Lynebank, 25 May 2023 **(LC)**	
	The draft report was noted by the group.	
4.5.8	Mental Welfare Commission for Scotland, unannounced visit to Ravenscraig Ward, Whyteman's Brae Hospital, Kirkcaldy, 9 January 2023 **(LC)**	
	This was noted by the group.	
4.5.9	Mental Welfare Commission for Scotland, announced visit to Cairnie House, Stratheden Hospital, Springfield, 3 October 2022 **(LC)**	
	This was noted by the group.	
4.6	NHS Fife Health & Social Care Partnership Missing Persons Update **(TL)**	
	TL presented the paper in order to give assurance of the work that is being undertaken by the short-life working group on missing persons within the Health & Social Care Partnership (HSCP) and specifically around mental health services. The data highlights that between July and November 2022 there was an upward trend in missing person incidents which then decreased between December and February 2023. This then rose sharply between February and March 2023. Between March and May 2023 there has been 50 incidents reported under criteria of missing patients; 6 patients have accounted for 26 of these incidents. The reasons for the increase are unclear, and may relate to variations in reporting practices and assessment of risk. There are also a high number of incidents occurring in one particular ward,	

	Ravenscraig as evidenced below over a 12 week period. For context the function of Ravenscraig is comparable to Lomond and Ward 2 (General Adult Psychiatry), Ravenscraig currently have 27 beds, Lomond and Ward 2 have 30 beds each. It has also been noted that there may be issues with the swipe access; right next to the door there is a green button to allow you to exit. Some work is being undertaken with estates for this button to be moved further up the ward to allow time for staff to notice those who shouldn't leave the ward. TL informed the group that she chaired the short-life working group and so far they have had 2 meetings, where Police Scotland is involved. There is also a table-top exercise with Police Scotland planned for 31 August 2023, including key representatives within HSCP, health social work and social care looking at the learning from their incidents and how they can work in collaboration with the police. • There is a plan to work alongside the Datix team once it is decided what further fields / interrogation of the system, is required they would like to see. Work also has to be undertaken with training staff to ensure all required fields (whilst not mandatory) are being completed. • Learning from adverse events – previously completed LAERs/SAERs for missing persons are to be identified and the recommendations from these reviews are to be collated to identify any relevant themes and target areas for improvements. • The Fife HSCP Clinical Risk Assessment and Management Procedure has recently been updated and is being promoted throughout the Mental Health and Learning Disability Service. Effective use of this risk assessment will also aid in accurate assessment of risk level for missing persons. • There is inconsistency in grading of risk level which appears to be out with normal variation of individual patient risk i.e. upon review of specific incidents, the risk grading appears not to be consistent with the Missing Persons Policy. This may be a further training issue, however it was also agreed that the wording of the relevant appendix of the policy would be reviewed by a sub-group to consider if there could be improvements in this to better guide clinicians in their assessment of risk. • Other training opportunities - an anti-absconding package which was successfully implemented in London has been identified and shared with the group for further consideration at the next meeting. There may be measures/training from this package which could be implemented in the service. The group is scheduled to meet on 3 more occasions by the end of 2023 and a flash report will be provided through the QMAG structures updating on progress and completed actions from the group. CMcK thanked Tanya for her presentation which gave the group assurance.	
4.7	NHS Fife Clinical Effectiveness Register **(EM)**	
	EM advised this paper shows the last 6 months of projects registered of which there are 46, 38 are from the Acute Services Division and 8 are from HSCP. The spreadsheet included details the projects registered.	

	Top 5 reasons for projects; • 32 - Direct impact on patients • 19 - Service evaluation • 18 - Evidence based guidelines • 12 - Potential for change • 11 - Reducing harm **Approval status & Assistance;** • 57% of projects have been approved by line managers • 41% of staff requested assistance & of these 47% were offered support • CMcK asked how these projects linked back to the Organisation Learning Group, the OLG should be identifying themes and areas to which these projects should be working. EM explained that the majority of these projects are either approved by line managers, heads of nursing or clinical directors because they are relevant to improvement within their directorate. For the Acute Services Division they are captured within the directorate reports which feed back in outcomes and learning.	
4.8	NHS Fife Clinical Policy & Procedure Update **(EM)**	
	EM advised at their June meeting, the NHS Fife Clinical Policy & Procedure Co-ordination & Authorisation Group that there was one new procedure approved. • NHS Fife Wide Procedure Trial without Catheter There are **five** Fife wide procedures and **one** acute services division procedures past their review date. The group were given assurance that they have a 94% compliance rate for all clinical policies and procedures for NHS Fife. CMcK acknowledged the huge amount of work which went into keeping all of our clinical policies and procedures for Fife current.	
4.9	NHS Fife Activity Tracker **(EM)**	
	EM shared the following with the group; One new Consultation; • Health and care (Staffing) (Scotland) Act 2019 statutory guidance consultation issued 22 June 2023 One new Publication; • Healthcare Staffing Programme (HSP) Two new standards were issued; • Congenital heart disease CHD standards published 24 July 2023	

	• Standards for cataract surgery published 26 July 2023	
4.10	NHS Fife Corporate Risk Register **(PC)**	
	PC presented a summary of the corporate risks which align to the Clinical Governance Committee and their status. She pointed out that there has been a reduction in the rating of Corporate Risk 3 - Covid-19 Pandemic. Consideration will be given to the potential for this risk to be closed as a corporate risk due to the continued effectiveness of vaccination and the reduced impact of illness in the population. The final decision will be taken through EDG and the appropriate governance routes to retain or close as a corporate risk. PC also brought to the attention of the group, the Deep Dive review into Corporate Risk 16 - Offsite Area Sterilisation and Disinfection Unit Service, which will be presented to the Clinical Governance Committee on 8 September 2023.	
5	**ADVERSE EVENTS & DUTY OF CANDOUR STATUS UPDATE**	
5.1	NHS Fife Adverse Events KPI's **(CF)**	
	CF pointed out from the report; As part of continuing to improve processes we have been working with the CPR SBAR Review Team to streamline the completion and review process of Cardiac Arrest SBARs. From 1st September the process will move to fully electronic, with the SBAR completion and review taking place within the related Datix record. 15 minute Bite-size training sessions were taking place twice per day, every day, w/b 21/08 and 28/08 on TEAMS and the uptake from staff so far had been good. CF commented that there was nothing significant to note from the KPI report which was within the papers for all to read.	
5.2	NHS Fife Adverse Events Themes & Trends Report **(CF)**	
	CF shared with the group that the number of reported major and extreme events has decreased from a monthly average of 40 per month in the last 12 months, to 37 per month over the last few months. There were no themes of major / extreme events identified from the themes analysis, so the opportunity was taken to focus further on the 589 open actions (443 of which are overdue for completion within the timeframe) and the top action types which are; • Training & Education • Documentation • Care & Treatment • Communication & Feedback • Policies & Procedures	

	Improvement work has commenced with the first stage of raising awareness of actions and offering support from the Adverse Event and Risk Management Team through a sharing of information on Staff Link. Information was shared in May 2023. This resulted in an observed increase in the number of actions closed with 91 action closed in May and 111 in June. This is an increase from on average 50 actions closed per month in the preceding 12 months and is reflected in an improvement in the KPI target currently set at 50% of actions closed within timeframe. Looking further at some of the barriers there might be to closing these actions on time; • 50 of the overdue actions are assigned to staff that no longer have an active Datix account • Predominantly across the organisation actions can only be viewed by the person that assigned or is responsible for the action • 203 of the 443 overdue actions are assigned within an organisational structure that no longer exists in particular the restructure of the Health & Social Care Partnership CMcK suggested a "deep cleanse" so these actions can be looked at and a decision can be made to see if these actions are still current. A meeting will be arranged involving CMcK, CF, SAS, NB, IM, LB, NR, CG and BH for this "housekeeping" exercise. NR highlighted that as well as overdue actions we also have a significant number of overdue Datix incidents that were no or minor outcome in terms of harm that are sitting in the holding area. CMcK suggested these could be looked at, at the same time as the open action cleanse. CF concluded that as well as having this "deep cleanse" they need to ensure that they address the current barriers so that the same problems don't re-occur in another 3 years.	**AR**
6	**PATIENT EXPERIENCE**	
6.1	Patient Experience Flashcard **(JK/SM)**	
	SM shared with the group that she had been looking at the yearly report for complaints, concerns and enquiries; there has been an increase throughout of 12.42%, with a large increase in concerns & enquiries of 51%. This shows that there is a lot of work happening within the Patient Experience department. The overall themes haven't changed over the last year; • disagreement with treatment • co-ordination and clinical treatment • staff attitude • unacceptable waiting times for appointments and admissions. At the end of July 80% of live complaints were still awaiting statements or approvals showing there is a lot of work to be done within the services. The complaints currently being received are generally more complex, often multi-directorate, making the process very difficult and the complexity scoring higher.	

	There was currently as workforce planning tool running to calculate what staffing is required for the high volume of complaints /communications officers were dealing with. SM informed the group that collating information for "care opinion" was going very well. One of their officers was going out to the wards to collect these "stories" from patients who did not have internet access and otherwise these would not be heard. This has resulted in over 100 stories being collected from May - August which is fantastic. It is important that they are able to capture the learning from these complaints. They are looking to link the complaints through Datix to the SAERs and LAERs and do a scoping exercise to find out how all the services are recording their learning and this can be shared with the wider organisation. JK concluded that a meeting was planned with Susan Fraser, Associate Director of Planning & Performance and Bryan Archibald, Planning & Performance Manager, to look at a target operating model with regard to the backlog / handling of complaints.	
7	**STRATEGY & PLANNING**	
8	**QUALITY/PERFORMANCE**	
8.1	NHS Fife Integrated Performance & Quality Report July 2023 **(CMcK)**	
	The report was noted by the Group.	
9	**LINKED COMMITTEE MINUTES**	
9.1	NHS Fife Clinical Policy & Procedure Co-ordination & Authorisation Group 19th June 2023 **(EM)**	
	The minutes of the meeting were noted by the group and no escalation is needed.	
9.2	NHS Fife Point of Care Testing Committee - 7 June 2023 **(EM)**	
	The minutes of the meeting were noted by the group and no escalation is needed.	
9.3	NHS Fife Organ Donation and Tissue Committee - 29th June 2023 **(NR)**	
	The meeting minute was carried forward to October meeting.	
9.4	NHS Fife Health & Social Care Partnership Quality Matters Assurance Group - 16th June 2023 **(LB)**	
	The minutes of the meeting were noted by the group and no escalation is needed.	
9.5	NHS Fife In Patient Falls Steering Group - 9th August 2023 **(NB)** - carried forward to October meeting	
	The meeting minute was carried forward to October meeting.	
9.6	NHS Fife Tissue Viability Working Group - 6th July 2023 **(LB)**	
	This meeting was cancelled next meeting 17th August 2023 carried forward to October meeting.	

9.7	NHS Fife Resuscitation Committee - 24th May 2023 **(JK)**	
	The minutes of the meeting were noted by the group and no escalation is needed.	
9.8	NHS Fife Organisational Learning Group - 18th August 2023	
	The meeting minute was carried forward to October meeting.	
9.9	NHS Fife Acute Services Division Clinical Governance Committee - 19th July 2023 **(IM)**	
	The meeting minute was carried forward to October meeting.	
9.10	NHS Fife Deteriorating Patient Group **(IM)** - 4th July 2023	
	The meeting minute was carried forward to October meeting.	
9.11	NHS Fife Health & Social Care Partnership Falls Oversight Group - 17th April 2023 **(LB)**	
	The minutes of the meeting were noted by the group and no escalation is needed.	
10	**ITEMS TO NOTE**	
10.1	NHS Fife Clinical Governance Oversight Group Workplan 2023 - 2024 **(EM)**	
	There was nothing to highlight from the Workplan.	
11	**ISSUES TO BE ESCALTED**	
	No issues for escalation.	
12	**ANY OTHER BUSINESS**	
	No Other Competent Business.	
	Date of Next Meeting 24th October 2023 09:30 via Microsoft Teams	

AREA DRUG & THERAPEUTICS COMMITTEE

(Meeting on 16 August 2023)

No issues were raised for escalation to the Clinical Governance Committee.

Area Drug & Therapeutics Committee

UNCONFIRMED

MINUTES OF THE MEETING OF THE FIFE DRUGS AND THERAPEUTICS COMMITTEE HELD ON WEDNESDAY 16 AUGUST 2023 AT 2.00PM VIA MICROSOFT TEAMS

Present: Mr Ben Hannan (Chair)
Ms Claire Fernie
Dr Iain Gourley
Dr Claudia Grimmer
Dr Helen Hellewell
Dr Sally McCormack
Mr Fraser Notman
Ms Olivia Robertson
Ms Andrea Smith
Ms Amanda Wong
Ms Doreen Young

In attendance: Ms Geraldine Smith (items 6.3, 7.1, 7.4, 7.5)
Ryan Headspeath (item 7.6)
Mr Duncan Wilson (item 11)
Ms Sandra MacDonald, Administration Officer (minutes)

ACTION

1 WELCOME AND APOLOGIES FOR ABSENCE

Mr Hannan welcomed everyone to the August meeting of the ADTC.

Apologies for absence were noted for Claire Dobson, Dr David Griffith, Maxine Michie, Dr John Morris, Nicola Robertson (Doreen Young representing), Rose Robertson, Satheesh Yalamarthi.

2 MINUTES OF PREVIOUS MEETING ON 21 JUNE 2023

The minutes of the meeting held on 21 June 2023 were accepted as a true record.

3 ACTION POINT LOG

The action list was discussed and actions updated/completed as agreed.

Communications Process for Guidance approved through the MSDTC

Mr Notman provided an update on discussions between Pharmacy and the Communications team. The plan going forward is to centralise all medicines guidance documents into one location on Stafflink and reduce the number of people who have administrative access to upload guidance documents. Work to identify guidance documents currently available on Stafflink or held by individual Specialties/departments is progressing. A project plan to be brought to the next ADTC meeting. **FN/AM**

Collaboration Between the Antimicrobial Stewardship Teams
Action completed.

Pharmacy First Approved List
Mr Notman provided feedback from the consensus meeting to discuss suggestions for amendments to the Pharmacy First approved list. The final list will be approved in the coming months. Action closed.

4 ANY OTHER MATTERS ARISING FROM THE MINUTES

There were no other matters arising from the minutes.

5 DECLARATION OF INTERESTS

There were no declarations of interests.

6 ADTC SUB-GROUP UPDATE REPORTS

6.1 East Region Formulary Committee

Mr Notman introduced the update report from the East Region Formulary (ERF) Committee and highlighted key points.

All adult chapters of the ERF have been reviewed and approved. Review of the paediatric chapters is progressing. The Cardiovascular, Gastrointestinal and Respiratory paediatric chapters have been approved by the ERFC and will be added to the ERF website. The next paediatric chapter scheduled for review is the Central Nervous System.

The successes of the ERFC were noted, including the transition to the full adult regional formulary and cross-region collaboration promoted by the work carried out on the ERF. Challenges were highlighted around communicating the application process to ensure consistency of approach. The application process is being reviewed and an easy to read flow-chart developed.

The ADTC noted the update from the ERF Committee and the good progress made.

6.2 MSDTC

Dr McCormack introduced the update report on behalf of the MSDTC and highlighted key points.

Business as usual is continuing and the group is functioning well. Submissions continue to be received in the appropriate format. A change in professional secretary was noted (now Alice Mathew, Senior Pharmacist Senior Pharmacist Medicines Utilisation and Therapeutics). Membership has also been reviewed to ensure wider clinical perspective and four new members have joined the committee (Interim head of Nursing Emergency Care, Head

of Nursing Planned Care, Nurse Consultant, Consultant in Addictions Psychiatry).

The ADTC noted the update on behalf of the MSDTC and the workplan for the next 6 months.

6.3 Medical Gas Committee

Ms G Smith introduced the update report on behalf of the Medical Gas Committee and highlighted key points.

The ADTC noted the work undertaken by a multidisciplinary team including Estates, Medical and Pharmacy representatives to remove the nitrous oxide manifolds at Queen Margaret Hospital and Phase 1 and 2 at the Victoria Hospital. Plans are in place for the Victoria Hospital Phase 3 nitrous oxide manifold to be decommissioned by the end of October 23.

It was noted that all actions in response to the National Patient Safety Alert on the use of oxygen where patients do not have access to medical gas pipeline systems have been completed.

An issue relating to insufficient trainers to deliver training to Porter Staff on medical gas handling and storage was highlighted. It was noted that a train the trainer session has been organised for September 2023.

The ADTC noted that Ms Smith was stepping down as Chair of the Medical Gas Committee and Claire Steele, Head of Pharmacy - Medicines Supply and Quality will take over as Chair from 1 September 2023. The ADTC thanked Ms Smith for her work on behalf of the Medical Gas Committee.

The ADTC noted the update report on behalf of the Medical Gas Committee.

7 SBARs/Updates

7.1 Annual Medicines Safety Report

Ms G Smith introduced the Medicines Safety in NHS Fife: Review and Improvement report and briefed the ADTC on the background to this.

The purpose of the report is to provide assurance on the current position with regard to medicines safety in Fife and detail the programme of work to be undertaken over the coming year.

The report outlines the overarching focus on medicines safety and links with the Board's work on High-Risk Pain Medicines as well as other key clinical areas identified for targeted improvement: anticoagulants, insulin, lithium and sodium valproate. The report details recommendations around identified themes and trends, programmes of work already taken forward including implementation of the weekly Medication Safety Minute and provides a summary of the actions to be taken forward within the next 12 months.

The ADTC welcomed the report and was supportive of the level of detail and format. The ADTC proposed further refinement around the classification of missing medication and details of communication methods (in addition to BLINK) for cascading information. Ms Smith and Mr Hannan to consider circulation to other appropriate groups prior to Clinical Governance Committee in November. **GS/BH**

7.2 Valproate Audit and Improvement Plan

Mr Notman introduced the report - Valproate - Medicines Safety Programme. The report provides an update on the current position and actions taken since the previous report presented to the ADTC in June 2023.

The ADTC noted the progress made, including a reduction in the number of women and girls of childbearing potential prescribed Valproate medicines in Fife and an improvement in the numbers of patients meeting all four audit standards of the Valproate Pregnancy Prevention Programme.

A discussion followed around patients who are not willing to accept highly effective contraception and the importance of a robust communication/ documentation process for discussions between the specialist and the patient.

The ADTC was supportive of establishment of a multidisciplinary group to oversee implementation of the Valproate Pregnancy Prevention Programme. The multidisciplinary group should also consider what assurance would look like beyond the audit data and be reactive to any future national guidance.

The ADTC thanked all those involved in the work around the valproate audit and improvement plan and noted assurance by the progress made and the plan for moving forward. To be brought back to the ADTC in 6 months. Any issues to be escalated at an earlier stage. **FN**

7.3 Prescribing in Renal Impairment (DOACS)

Mr Notman introduced the SBAR - DOACS - Medicines Safety Programme and briefed the ADTC on the background to this.

The paper provides an update on progress to date with undertaking reviews of dosing of Direct Oral Anticoagulants (DOACS) in patients with renal impairment.

Due to the large number of patients prescribed a DOAC in Primary Care, it was decided that the first cohort of patients to be reviewed would be those patients prescribed a DOAC with a coding for chronic kidney disease. The paper outlines the progress made to date and the proposals for actions going forward to review the remaining patients with CKD currently prescribed a DOAC in primary care to ensure that they are prescribed the correct dosage in relation to their renal function; review processes for initiation and monitoring of DOACs within acute and community hospitals; engage with GP Cluster Quality Leads to develop safe systems of prescribing and monitoring of DOACs on an ongoing basis; and engage with the Vascular MCN to review

current NHS Fife DOAC guidance. The proposed timeline for completion of actions is March 2024.

The ADTC was supportive of the proposed actions for going forward. A detailed plan to be brought back to the next meeting. **FN**

7.4 Provision of Medicines on Discharge

Ms G Smith introduced the Provision of Medicines on Discharge Audit report and briefed the ADTC on the background to this.

An audit on the provision of medicines on discharge in NHS Fife was undertaken in November/December 2022 as part of the Safe and Secure Use of Medicines Policy and Procedure (SSUMPP) Audit and Assurance Programme. The purpose of this audit was to seek assurance that the correct processes are followed when medicines are required to be provided to patients to facilitate their discharge from hospital.

It was noted that during the audit period over 95 discharges were observed and 88.5% were compliant with the correct discharge process. Any non-compliance observed was addressed at the time.

The ADTC noted the good compliance with the discharge process and the recommendations for communication of the audit results/raising awareness of the correct process to follow when patients are provided medicines on discharge. Action plans and recommendations to be monitored through the Safe and Secure Use of Medicines Group and escalated to the ADTC in the event of any concerns. **GS**

7.5 Medical Gas Stores and Ward Audit

Ms G Smith introduced the Medical Gases Stores and Ward Audit reports and briefed the ADTC on the background to the audit.

The audit is undertaken on an annual basis across stores, wards and all departments holding medical gases to assess compliance with legal and best practice requirements. All outstanding actions from Pharmacy have been completed and an action plan developed in order to support staff in areas where any non-compliance has been identified. The Medical Gas Committee has reviewed the report in detail and will monitor action plans to ensure that all outstanding actions are completed. The detail of the audit report will also be shared with the Heads of Nursing.

The ADTC noted the Medical Gases Stores and Ward Audit reports for awareness and assurance with regard to the management of medical gas cylinders and pipeline equipment within NHS Fife. An update from the Medical Gas Committee to be provided to the ADTC in 6 months' time.

7.6 Shared Care Agreements

7.6.1 Apomorphine

Mr Headspeath introduced the revised Shared Care Agreement for Apomorphine and highlighted key changes.

The ADTC noted the key changes including updating of contact points. A potential issue with capacity of the sharps bins was highlighted. A statement has been added to the Shared Care Agreement to request that General Practices prescribe 1L sharps bins for needle and line disposal to facilitate supply by Community Pharmacy.

It was also noted that the Shared Care Agreement includes a link to the NHS Fife Policy and Procedures for the Shared Care of Medicines. It was agreed that pending approval of the revised Policy the previous version should be referenced.

The ADTC approved the proposed revisions to the Shared Care Agreement for Apomorphine. To be taken to the LMC for consideration.

7.6.2 Darbepoetin Alfa (Aranesp®)

Mr Headspeath introduced the revised Shared Care Agreement for Darbepoetin Alfa and highlighted key updates to the formatting and contact points.

There was a discussion around potential additional monitoring requirements in Primary Care. It was noted that monitoring would be undertaken in Primary Care once the patient is stable. Specialists would be contacted for advice in the event of an issue. It was noted that implications for additional blood pressure monitoring would be minimal as this could be undertaken at routine blood test appointments. Dr Hellewell to feed blood pressure monitoring requirements into ongoing discussions around the local enhanced service. **HH**

The ADTC approved the proposed revisions to the Shared Care Agreement for Darbepoetin Alfa. To be taken to the LMC for consideration.

8 Risks Due for Review in Datix

Mr Notman took the ADTC through the risks scheduled for review. It was noted that the template has been updated to include initial, current, likelihood, probability and target RAG status.

Risk 1347 – Shared Care Protocols
The ADTC was content with the detail of risk 1347. Refinements to the risk to capture assurance around the actions taken to minimise the probability of the first two points in the risk description were agreed; the overall risk for shared care to remain. It was proposed that a new risk should be written. **FN**

9 ADTC-COLLABORATIVE/SCOTTISH GOVERNMENT COMMUNICATION

9.1 ADTCC July Newsletter

The ADTC noted the ADTCC July Newsletter.

10 EFFECTIVE PRESCRIBING

10.1 Pharmacy First Approved List

Discussed under item 3 Action Point Log.

10.2 NCMAG Quarterly Update

The ADTC noted the NCMAG quarterly update.

10.3 NCMAG 109 - Pemetrexed plus cisplatin

The ADTC noted the NCMAG 109 Pemetrexed plus cisplatin Advice Document.

10.4 NCMAG 110 - Abiraterone

The ADTC noted the NCMAG 110 Abiraterone Acetate Advice Document.

10.5 Early Access to Medicine Scheme

- **Dostarlimab**

The ADTC noted the Early Access to Medicine Scheme Operational Guidance for Dostarlimab for use in first-line treatment of primary advanced or recurrent endometrial cancer.

- **Glofitamab**

The ADTC noted the Early Access to Medicine Scheme Operational Guidance for Glofitamab for the treatment of adult patients with relapsed or refractory diffuse large B-cell lymphoma (DLBCL), after two or more lines of systemic therapy.

11 HEPMA Update

Mr Wilson provided a verbal update on the current contractual position and progress with electronic prescribing and the implementation of HEPMA.

The forthcoming expiry of the contract with Microguide was also noted. Work to move to the Scottish Antimicrobial Companion App is progressing.

12 PACS/SMC Non Submissions

12.1 Latest Submissions

The table detailing the latest PACS2/SMC non submissions was noted.

13 POINTS FOR RAISING AT CLINICAL GOVERNANCE COMMITTEE

There were no items identified as requiring escalation at this stage to the Clinical Governance Committee. The Annual Medicines Safety Report to be submitted to the Clinical Governance Committee after refinement.

14 ANY OTHER COMPETENT BUSINESS

There was no other business.

Other Information

a **Minutes of Diabetes MCN Prescribing Group 30 May 2023**. For information.

b **Minutes of Heart Disease MCN Prescribing Sub-Group -** next meeting 24 August 2023.

c **Minutes of Respiratory MCN Prescribing Sub-Group 14 June 2023**. For information.

d **Date of Next Meeting**
The next meeting is to be held on **Wednesday 25 October 2023 at 2.00pm via MS Teams**. Papers for next meeting/apologies for absence to be submitted by 11 October.

IJB QUALITY & COMMUNITIES COMMITTEE

(Meeting on 30 June 2023)

No issues were raised for escalation to the Clinical Governance Committee.

IJB Quality & Communities Committee

Fife Health & Social Care Partnership

Supporting the people of Fife together

CONFIRMED MINUTE OF THE QUALITY & COMMUNITIES COMMITTEE
FRIDAY 30 JUNE 2023, 1000hrs - MS TEAMS

Present:	Sinead Braiden, NHS Board Member (Chair) (SB) Councillor Rosemary Liewald Councillor Lynn Mowatt Ian Dall, Service User Rep, Chair of the PEN (ID) Morna Fleming, Carer's Representative (MF) Kenny Murphy, Third Sector Representative (KM) Paul Dundas, Independent Sector Lead (PD)
Attending:	Dr Helen Hellewell, Deputy Medical Director (HH) Nicky Connor, Director of Health & Social Care (NC) Lynn Barker, Director of Nursing (LB) Lynne Garvey, Head of Community Care Services (LG) Lisa Cooper, Head of Primary Care and Preventative Care Services (LC) Rona Laskowski, Head of Complex and Critical Care Services (RL) Jennifer Rezendes, Principal Social Work Officer (JR) Simon Fevre, Staff Side Representative (SF) Scott McCallum, Service Manager, Corporate Parenting (SMcC) Alan Adamson, Service Manager, Quality Assurance (AA) Avril Sweeney, Manager, Risk Compliance (AS) Heather Bett, Senior Manager, Children Services, Sexual Health & BBV and Rheumatology (HB) Lesley Gauld, Team Manager, Strategic Planning (LGal) Ruth Bennett, Health Promotion Manager (RB) Tracy Harley, Service Manager Participation and Engagement (TH)
In Attendance:	Jennifer Cushnie, PA to Deputy Medical Director (Minutes)
Apologies for Absence:	Councillor Sam Steele Councillor Margaret Kennedy Cllr Graeme Downie Alistair Grant Dr Chris McKenna, Medical Director Ben Hannan, Director of Pharmacy and Medicines Roy Lawrence, Principal Lead for Organisational Development & Culture Christine Moir, Head of Education and Children's Services (Children and Families/CJSW and CSWO) Catherine Gilvear, Quality Clinical & Care Governance Lead (CG)

No	Item	Action
1	**CHAIRPERSON'S WELCOME AND OPENING REMARKS** The Chair welcomed everyone to the HSCP Quality & Communities Committee. SB extended her sincere thanks to all HSCP staff who continue to work above and beyond in what continues to be an extremely challenging working environment.	
2	**DECLARATION OF MEMBERS' INTEREST** No declarations of interest were received.	
3	**APOLOGIES FOR ABSENCE** Apologies were noted as above.	
4	**MINUTES OF PREVIOUS MEETINGS HELD ON 16 MAY 2023** The previous minutes from the Q&CC meeting on 16 May 2023 were reviewed and no alternations or corrections were requested. The minutes were taken as an accurate record of the meeting.	
5	**ACTION LOG**	
6	**GOVERNANCE**	
	6.1 Lived Experience – Methilhaven Care Village The slideshow of photographs showing the Methilhaven Care Village as it evolved was presented by Nicky Connor. NC, who has spent time at the Village, the first of its' kind in Scotland, described the excellent facilities comprising a care home, sheltered housing, supported living and a nursery, all on one site. NC spoke very highly of the staff working within the facility with forward thinking and enthusiastic attitude. All IJB Members will be invited to the formal opening taking place in September. The presentation was brought to Committee for **Information.** SB thanked NC for the presentations and hoped the news of the ground-breaking project would be shared widely. Cllr Liewald seconded SB's comments.	
	6.2 Quality Matters Assurance LB introduced the Quality Matters Assurance Paper, brought to Committee for Assurance.	

	LB advised QMAG meets minimally six times per year and is clinical and professionally led by herself with support from the Deputy Medical Director and Chief Social Work Officer. The purpose of the group is to seek assurance from each portfolio that clinical and care governance is discharged effectively within the Partnership, whilst meeting the statutory duty for the quality of care. LB stated, the matters discussed at Fife HSCP QMAG on 21st April are summarised and these items were brought to the Group for learning, advice, assurance, review of risks and escalation. KM queried where legal responsibility lies. NC confirmed responsibility sits with the Chief Executives of FC and NHS Fife re statutory duties they hold for the quality of services delivered. She stated, the IJB is required to have a level of oversight and advised, by November 2023, a Clinical & Care Governance Framework with strengthened performance reporting will be in place. Currently, an overview of the work taking place is being brought, to show how the work connects with both Partners and how it supports responsibilities held by the IJB. KM would like the documentation to be made available to give confidence progression is being made as should be. LC felt confident HH, LB and JR will take this on board and will achieve the correct balance through the Framework.	
	6.3 External Inspection Report - deferred	
	6.4 Adult and Child Protection IJB Risk 10 Assurance JR introduced the report which is seeking assurance around the NHS overarching governance for Adult Support and Protection. She advised, the content of the paper gives an in- depth detail of the governance and JR talked through the various tiers and the branches coming from each. The report has come through QMAG and is brought to Q&CC for assurance. SB ask if Committee can take assurance a multi-agency response is being used. JR advised the report gives assurance there are systems in place to enable this. ASPC improvement plan and ASPC conveners report which comes to IJB annually giving assurance, however, did not have specific date. The Committee confirmed they were assured the correct governance structures are in place for Adult and Child Protection.	
	6.5 Home First Strategy	

	LG brought the Home First Strategy for discussion and decision to progress to IJB. LB outlined the route the Strategy has taken thus far, and where it will progress to following Q&CC. LB advised the Strategy outlines the strategic direction for the Home First model and sets out the transformational initiatives which are relevant to the three elements of the strategy. These are prevention and early intervention, person centred at the heart of all care decisions, and a whole systems approach. She spoke of feedback around early intervention and prevention featured at the start of the Strategy and changes were made. LB highlighted the main aims of the Strategy, including the vision of enable everyone in Fife being able to live longer healthier lives at home or in a homely setting. The sub-groups which enable the programme were outlined. Cllr Liewald was very supportive of the Strategy and reported very good feedback she has received. MF felt the Strategy is well-written and had various questions which she will email separately to LB. She did wish to raise the subject of Carers in this context, as they may be willing to take on more responsibility than is necessarily good for them. She spoke of IT, FC and NHS systems speaking to one another, as this is not easy currently. LB welcomed all comments and advised there has been a huge amount of consultation which has included Carers, has not been drawn through into SBAR, she will ensure this is corrected. ID felt the Strategy begins well, however, too much emphasis is placed on preventing hospital admission and releasing from hospital quickly, he felt more balance is required. ID referred to the diagram on eligibility criteria and asked at what stage intervention is made. He also queried KPIs, reference to Mental Health and the Risk Register. It was agreed, LG will pick up these points directly with ID offline as it was felt he may not have the most recent version of the Strategy. KM was happy to see the Strategy has a good level of detail. He also queried the KPIs. LG explained how the KPIs are calculated and the relevance of noting, future reports which come back will be performance related. LG will pick up out with the meeting. PD thanked LG for the Strategy which he is fully supportive of and felt to be comprehensive with considerable detail. He raised the subject of Care@Home staff currently being unable to administer medications at level 3. He felt to meet the early intervention/ prevention aim, this is imperative. He spoke of a special interest group looking at this and felt it should be included on the Risk	**LG**

	Register. He would welcome off-line conversation. LG was in agreement. SB asked if the Home First Strategy was specifically for Older People. LG advised the majority will be over 65yo, although does include all adults - does not include children and/or young people. Where mental health fits in and decision making around release from hospital was discussed. ID raised concerns around lack of evidence re early intervention. LG assured steps have been taken since previous feedback from ID. She advised interface care, supporting people within the community, will be more strongly detailed within the report.	**LG**
	6.6 Care Inspection, Care at Home Fife LG advised, the report comes to Committee for Noting. She stated the Care at Home Service has been inspected and the report highlights the rates awarded, the recommendations and the action plan to meet the recommendations. She advised, the Care at Home Service was previously inspected in Jan 2020, when all 3 parts were graded with 4's. She was delighted to say, despite the Pandemic having a significant impact, particularly within Workforce, a grade of 4 has been maintained. LG personally met with the Inspectors and she was told Fife is one of the few Care at Home Services which has received grades of 4. Lots of different actions were recommended and an action plan has been agreed. PD thanked LG for the report and spoke of the difficult period which had been experienced throughout the Pandemic, and with a high turnover of staff and felt it was an encouraging report to read.	
	6.7 Carer's Strategy 2023-2026 NC presented the report for consideration and support to progress to IJB. She advised the Strategy looks at HSCP's responsibilities to the Carer's Scotland Act and requirement to publish a local carer's strategy at least every 3 years. Extensive engagement and consultation has taken place at the end of 2022/early 2023. NC detailed the various means of engaging with Carers and Carers organisations. A Strategic needs assessment underpins the Strategy and NC gave detail. Progress investments made were outlined along with forward planning for the next two years were explained. NC advised the Strategy is aligned to both National and Local Strategies and spoke of workforce development and spoke of recognising the critical importance of supporting carers. She highlighted the main points from the SBAR and advised the Strategy has been endorsed by the Joint Carer's Strategy Group. NC welcomed any comments, particularly from MF. MF advised she has points she will discuss off-line. She wanted to say, reaching out to unpaid carers was important work, carer's	**MF/FMcK**

	strategy funding has gone into additional social workers posts, adult carer support plans and young people statements wants to see a measurable outcome. NC will feed back to FMcK and ensure all points are taken forward. SB queried some of the figures, stated as doubling but no further detail. NC will feedback. ID felt communication is the key to identifying more carers and should be given high priority. Cllr Liewald was happy to see the very good work with The Wells reported with drop-ins increasing. She suggested The Wells could offer a good opportunity for conversations to take place helping to identify carers. There was discussion around advertising of the support available. TH spoke of the work the PA Team are doing around chemists, GP surgeries and on the street.	**NC** **NC**
	6.8 Fife Primary Care Strategy LC introduced the Primary Care Strategy, which was commissioned jointly by the Director of HSCP and NHS Fife Medical Director focussing on medium to long term plans to support high quality accessible care to the population of Fife for PC Services. This is one of the 9 key enabling strategies, underpinning the Partnerships Strategic Plan to support the vision for people of Fife to live independent healthier lives. LC gave an overview of the Services provided and outlined the main themes within the Strategy. The five priorities and principles within the Strategy were described. LC spoke of the significant participation and engagement work carried out to shape the Strategy ensuring the focus is on what matters to the population of Fife. The governance structure in place will give oversight, once there is a move to implementation, and formal reporting will come forward to give assurance of the Implementation Plan and Delivery Plan achieving the ambition of the Strategy. MF felt the document was very readable and queried the reason for Dental Service child registrations dropping, also Community Pharmacy, she believed some big chains are blocking new Community Pharmacies being opened and queried the reason. LC welcomed feedback advised the meeting a Summary version of the Report is to be released for easier reading. She is aware of child registration reduction and gave assurance work will be targetted looking at this. Re-established the oral health improvement programmes, one of which is the Childsmile programme, ensuring an early intervention approach. LC spoke of the complexities of Pharmacy registration which is directed through National legislation structures. Currently Fife are	

		on a journey working around these. She advise a Pharmacy Application Committee convened within Fife to manage Pharmacy applications There was discussion around the legislation relating to Community Dentistry and Pharmacy. In particular, ID felt legislation to be flawed. NC advised of work being carried out through LC's Team in partnership with NHS Fife, looking at internal processes around PPC. Internal improvements identified which can be made, engaged with Ben Hannan and Alistair Grant. NC gave assurance being looked at despite challenges around legislation. LC agreed, Dentistry access is very challenging and stated her Team are looking at novel and new approaches to support and improve work with independent contractors and Dentists. KM felt the participation and engagement results showed poor engagement from people of Fife. He suggested new methods of engagement should be considered, encouraging greater involvement. He commented he felt the Strategy, in places, appeared to cross over to operational plans for implementation. NC wished to clarify the method of participation and engagement which included a higher number of individuals and explained the background. She spoke of the 9 underpinning Strategies of the Partnership's Strategic Plan and work which will take place to ensure these are connecting as intended with an annual delivery plan which connects the key priorities, informing performance reporting each year. SB thanked everyone for their comments. She acknowledged concerns around Dentistry and Pharmacy. Information regarding public engagement work should be corrected to reflect the true engagement which took place. SB advised the committee were content to progress the Primary Care Strategy to the IJB.	**LC**
	6.9	**Child Protection Annual Report 2022/2023** HB introduced the report which she advised, ties in with the presentation given by JR around IJB Risk 10. The report covers the period 2022/23 and gives assurance appropriate child protection arrangements are in place. HB described the teams and the work being undertaken. She stated the report gives assurance the children of Fife are protected from harm and any concerns relating to their welfare are identified and addressed in a timely manner. The key drivers, leadership, accountability and governance arrangements and	

	processes were outlined. Also, activities taking place throughout 2022/23, including successes and challenges. HB spoke of progressing into 2023/24 and the work planned, she mentioned the Child Protection Guidance published in 2021, which is to be implement by April 2024. She outlined the work carried out by the small team across a range of areas and the development, education and training within the team. She advised the Team are looking to expand to include a Learning & Development Officer and a Clinical Effectiveness Co-ordinator from beginning of August. HB outlined the role of the new team members. Cllr Liewald thanked HB for a detailed report and welcomed the Team expanding and felt there is now a much-improved service available. SB agreed with Cllr Liewald's statement.	
	6.10 Participation & Engagement Strategy / Updated Planning with People Guidance 2023 TH introduced the report on behalf of Fiona McKay for assurance. The P&E Strategy, which is based on the Scottish Government Planning with People Guidance 2021, was endorsed by the IJB at the end of 2021. This Guidance was since reviewed to support a Human Rights based approach and to align with the care improvements and recommendations of the Independent Review of Adult Social Care. The P&E Strategy is brought back to Committee to give assurance it continues to be in alignment with the Planning with People Guidance. TH advised work is ongoing and the Strategy is live. She spoke of the Carers Forum which is currently being built upon. KM was supportive of the Strategy, although felt there was a lot of demand placed on the Team and asked how to proactively engage more people and gave examples of poor engagement. This question was discussed at some length. Virtual engagement and face-face within the Community is taking place and stated the goal of the Strategy is to engage more members of the population. Fully compliant with the Health Improvement Scotland Quality Framework, expected to develop and grow. ID stated himself and MF have been fully involved, with some way to go. He felt additional funding would be beneficial. Cllr Liewald encouraged the P&E Team to utilise Councillors to promote P&E work where appropriate.	
	6.11 Corporate Parenting Board – 6 Month Update SMcC introduced the report on behalf of C Moir. The 6 Month Update was brought to Committee for assurance. He advised the	

	Board meets quarterly and is attended by a wide range of Senior Officers across the Partnership. SMcC outlined the remit of the Board which is to improve outcomes and life chances for children and young people with Care Experience. Four priority areas which have been further developed during the previous 6 months, include 'Belonging to Fife' which SMcC explained, improving school attendance, supporting and improving young people's mental health and developing lived experience groups. SMcC gave details relating to the work. Cllr Liewald spoke highly of the work taking place. ID reiterated Cllr Liewald's comments and spoke of a positive experience story and thanked SMcC for the work he and the Team are carrying out.	
	6.12 Annual Performance Report 2022-2023 AA presented the report on behalf of Fiona McKay, brought for consideration and recommendation for progression to IJB. AA highlighted the main points from the report. He advised further detail will come to the Strategic Planning Group in July and will then be progressed to IJB. AA stated, the Annual Report must be published by the end of July and to ensure the report goes through the Committee process on a timely basis to seek approval, indicators have not been provided. He advised, indicators will be provided by 4th July and will be included when the report goes to the IJB. MF thanked AA for the report which she felt was very readable. She asked if abbreviations could be more clearly explained.	**AA**
	6.13 Quality & Communities Strategic Risk Register AS presented the Strategic Risk Register on behalf of Audrey Valente for awareness and discussion. The Register sets out the IJB Strategic Risks which may pose a threat to the Partnership in achieving its objectives in relation to quality & care governance and quality of care. AS advised, the Register was last presented to Committee in November 2022 and is scheduled to come to Committee on a 6-monthly basis. AS advised the Risks continue to be managed by the Risk owners and were last reviewed in May '23. The Risks are presented in order of residual risk score, this takes into account the current level of management actions and internal control in place. AS highlighted the risks which have a high residual risk score and advised there are a number of risks at an operational level which are monitored at the QMAG meeting and managed by Service Managers. If a risk raises concern, it will be escalated to SLT and to a strategic level if necessary. She spoke of work ongoing	

	developing a deep dive review process for Strategic Risks, piloted by Finance, Performance & Scrutiny and agreed at Audit & Assurance Committee. These deep dive review reports will be brought back to Q&CC going forward. The Committee were assured quality & communities risks are being managed.	**AS**
	6.14 Risk Appetite Statement AS again brought the report for discussion and recommendation to the IJB. She advised this follows on from a lot of work which took place Dec '22 and at the IJB Development Sessions in Feb '23. The report has been previously recommended to IJB at Audit & Assurance in July '23 and will go to Finance, Performance & Scrutiny w/c 03.07. AS gave an overview of the report and explained the risk process, including how tolerance levels are applied. It is the intention to apply the risk appetite to all IJB Strategic Risks and to use it when considering risks related to decisions being taken by the IJB around Strategy, development, budget, etc. Cllr Liewald commented the Development Session was very enlightening and gave good understanding of the process. The Committee were content to approve the Risk Appetite Statement to progress to IJB.	
	6.12 Health Promotion Service Annual Report 2022/23 LC welcomed Ruth Bennett to present the report to Committee. RB introduced the report which had been requested by the PHWBC for information. RB outlined the main topics of the report which included the role of the Service, key National and Local strategic drivers, commitment to early intervention and prevention with a focus on up-stream determinants of health and the report sets out the range of the work undertaken and the Services provided with examples to illustrate how the Health Promotion Service works to achieve this. The report also provides examples to illustrate the response made to recover and remobilisation from the Pandemic. Examples showing how the team have contributed to working across H&SC portfolio and gave examples of these. And also contributed to HSCP & NHS Fife commitment to anchor institutions, giving examples. MF felt specific reference to carers is missing, particularly in relation to recovery from the Pandemic where carers took on extra responsibility as people did not want others coming into their homes and this has not changed due to various reasons. MF would like to see in the Equality & Diversity para 335 some specific mention of carers and the effects on them during and post Pandemic. RB thanked MF for her comments.	

	Cllr Liewald thanked LC and RB for the report and stated she was particularly pleased with Food for Fife Strategy, there is also a community growing project with community orchards being developed where members of the community grow their own. In the Cowdenbeath area, this is expanding with plots of land being identified for use. She asked if this work can be included within the report. Many benefits, including mental health. RB will ensure comments are fed back. LC welcomed the feedback and she referred to MF's comments around carers. LC wanted to give assurance, as the Service moves forward, in the development of the prevention and early intervention strategy, carers and what matters to carers, will be threaded through the Strategy.	
7.0	**EXECUTIVE LEAD REPORTS & MINUTES FROM LINKED COMMITTEES**	
	7.1 Quality Matters Assurance Group Confirmed Minute from 21.04.23 **No comments.**	
	7.2 Strategic Planning Group Unconfirmed Minute from 17.05.23 **No comments.**	
	7.3 Clinical Governance Oversight Group Confirmed Minute from 18.04.23 **No comments.**	
	7.4 Equality & Human Rights Strategy Group No new minute available.	
	7.5 Fife Drugs and Therapeutics Committee Confirmed Minute from 26.04.23 **No comments.**	
8.0	**ITEMS FOR NOTING** **No comments.**	
9.0	**ITEMS FOR ESCALATION** Methilhaven Care Village.	
10.0	**AOCB** No further business raised.	
11.0	**DATE OF NEXT MEETING** Thursday 07 September 2023 – 1400-1700hrs	

QUALITY & COMMUNITIES COMMITTEE

(Meeting on 7 September 2023)

No issues were raised for escalation to the Clinical Governance Committee.

IJB Quality & Communities Committee

Fife Health & Social Care Partnership

Supporting the people of Fife together

UNCONFIRMED MINUTE OF THE QUALITY & COMMUNITIES COMMITTEE THURSDAY 07 SEPTEMBER 2023, 1000hrs - MS TEAMS

Present:	Sinead Braiden, NHS Board Member (Chair) (SB) Councillor Rosemary Liewald Councillor Lynn Mowatt Councillor Sam Steele Ian Dall, Service User Rep, Chair of the PEN (ID) Morna Fleming, Carer's Representative (MF) Colin Grieve, Non-Executive Board Member (CG) Kenny Murphy, Third Sector Representative (KM)
Attending:	Dr Helen Hellewell, Deputy Medical Director (HH) Nicky Connor, Director of Health & Social Care (NC) Amanda Wong, Director of Allied Health Professionals (AW) Lynn Barker, Director of Nursing (LB) Catherine Gilvear, Quality Clinical & Care Governance Lead (CG) Lynne Garvey, Head of Community Care Services (LG) Lisa Cooper, Head of Primary Care and Preventative Care Services (LC) Rona Laskowski, Head of Complex and Critical Care Services (RL) Jennifer Rezendes, Principal Social Work Officer (JR) Simon Fevre, Staff Side Representative (SF) Avril Sweeney, Manager, Risk Compliance (AS) Leesa Radcliffe, Clinical Services Manager (LR)
In Attendance:	Jennifer Cushnie, PA to Deputy Medical Director (Minutes)
Apologies for Absence:	Councillor Margaret Kennedy Cllr Graeme Downie Ben Hannan, Director of Pharmacy and Medicines Roy Lawrence, Principal Lead for Organisational Development & Culture Christine Moir, Head of Education and Children's Services (Children and Families/CJSW and CSWO) Paul Dundas, Independent Sector Lead (PD)

No	Item	Action
1	**CHAIRPERSON'S WELCOME AND OPENING REMARKS** The Chair welcomed everyone to the HSCP Quality & Communities Committee. SB extended a warm welcome to new Member, Colin Grieve, Non-Executive NHS Board Member. SB thanked HSCP staff	

	who continue to work above and beyond in what continues to be an extremely challenging working environment.	
2	**ACTIVE OR EMERGING ISSUES**	
	Helen Hellewell advised 'Active and Emerging Issues' has been newly introduced to the Committee's Agenda. This items will be verbal and will bring forward any relevant issues which are important for the Committee to know, for which there has not been time to prepare Papers. HH wanted to make the Committee aware of the re-phasing of the Covid 19 and Flu Vaccination Programme. She explained this is due to the new strain of Covid 19 and the Government has instructed all Boards to protect those most vulnerable, in the first instance. This involves bringing forward vaccinations for Care Home residents, those over 75 and those with weak immune systems. Care Home delivery has been brought forward to 18 September and over 75 yo's / weak immune systems to the beginning of October. HH spoke of extensive, on-going comms which are being actioned. She explained a slight hold up with the self-booking on-line system, which will continue to be monitored. A paper will be brought to a future meeting for further assurance. No questions were raised.	**H Hellewell**
3	**DECLARATION OF MEMBERS' INTEREST** No declarations of interest were received.	
4	**APOLOGIES FOR ABSENCE** Apologies were noted as above.	
5	**MINUTES OF PREVIOUS MEETINGS HELD ON 30 JUNE 2023** The previous minutes from the Q&CC meeting on 30 June 2023 were reviewed and no alterations or corrections were requested. The minutes were taken as an accurate record of the meeting.	
6	**ACTION LOG**	
	The Action Log from the meeting held on **30 June 2023** was approved as accurate and updates noted.	
7	**GOVERNANCE**	
7.1	**Quality Matters Assurance** The report was brought for assurance by HH on behalf of Lynn Barker. HH gave an overview of the current clinical and care governance arrangements, systems and processes which are in place across the Partnership and outlined the matters discussed at Fife HSCP QMAG. HH advised, increased emphasis will be placed on social work and social care aspects at future meetings and a draft of the Clinical & Care Governance Framework will be brought to the next Q&CC meeting. HH added, the QMAG meetings currently fall out of sync with the Q&CC meetings, however, in the new year, these shall be aligned to bring more recent reports. Questions were invited.	**L Barker / H Hellewell**

	MF queried mental health incidents and asked for an explanation for the upward trend of occurrences. HH told of continuous monitoring which takes place and explained the complexities of the trends. CG advised, additional information is collected and is looked at in different ways, ensuring all necessary mitigations are in place and deeper dives carried out where appropriate. Cllr Liewald thanked HH for the paper and queried the statement "we now have monthly unit manager quality assurance meetings for HSCP care homes, chaired by the Care Home Manager and Care Home Lead Nurse". NC advised this refers to the National Direction to have a care home assurance group in place, which includes all the care homes in Fife, not only managed care homes. LG gave further detail around these meetings.	
7.2	**Community OT Service Waiting Times** LG introduced the report which was brought to Committee for discussion and to emphasise the increased demand in the service and where resource is to be focused. LG introduced Leesa Radcliffe, Clinical Services Manager who was available to answer any questions at the end of the presentation. LG described the ongoing work within the COT service and outlined mitigations in place and how waiting times are managed. The Committee were asked to consider proposals to make further changes to the way the COT Service operates with LG giving detail. She finished by stating it was acknowledged the waiting times are sub-optimal and recognised the impact this is having on service users. The paper was brought to committee to ask for recognition the Service does regard the waiting times as unacceptable and are working to ensure these are reduced. KM felt there was insufficient trend data to show the scale of the challenge. He acknowledged there was a lot in the report which was good common sense, however, would welcome a later paper to give assurance around quality of care. He also queried some of the waiting time data relating to those 'at greater risk' and 'moderate risk'. LG advised the trend data was omitted by herself, she will circulate. She explained some figures include people awaiting housing. LR advised, on occasion, major adaptions are required to be made by housing services. Whilst the person is awaiting the work's completion, the individual remains on the waiting list, thus increasing waiting times. MF asked what support is given for people in urgent need of assistance, should targets be missed? LG stated, all 'critical' needs will be met, those deemed 'moderate' will be regularly monitored and other supports put in place, ie Third Sector Organisations, District Nurses and other Partners and Services ensuring the individual is safe. MF queried the length of time until the Carer's Strategy Funded OT post is filled. LR advised, the post is actively being recruited to currently.	

	SF felt it would be useful to see which other Services need to be involved, ie Housing. He also queried why there was no mention of increasing staffing, the complexities of which were discussed and raised in the recent staff questionnaire. LG advised lack of funding was the main reason and spoke of the imminent development session which will be looking at addressing some of the problems which came through the questionnaire. The re-hab model in the community is hoping to reach out to many more people, currently being addressed, although not directly by employing Community OT Council staff. ID was not supportive of the paper and felt it did not give assurance. He told of people who have not contacted the service, as they felt there was no help there, instead bought their own equipment/home improvements. He felt the situation is going to become worse and queried why implications for Fife Council/NHS had been marked 'not applicable'. He advised urgent attention is required. LG felt radical steps are being taken and are outlined in the report. She suggested PMO support may be helpful to rapidly improve the situation with a plan. She advised Fife are one of three Partnerships in Scotland who are assessing and considering 'moderate risk and below'. She felt the Service is very committed to progress improvement. She will take ID's suggestion to put a rapid PMO approach into further improvements. Cllr Liewald had concerns around what HSCP trying to do and the connection with other services. She felt once assessment is carried out, services are not connecting, there are time delays and suitability of equipment is a concern, she felt this should be investigated. It may be a restructuring is required and Cllr Liewald voiced her serious concerns. LG noted the concerns and stated, for the moderate cohort, the service is now working with The Wells, which may release capacity to address 'most urgent'. LR spoke of meetings and engagement with Housing, Contractors and Community Occupational Therapy. Cllr Mowatt gave a positive lived experience story, indicating the system is working in some cases. SB asked if a PMO approach can be taken and NC agreed, there will be a meeting with the Team. She thanked LG and LR who reflected openness and transparency and welcomed frank feedback. Further consideration will be given and an update will come back to Committee.	**N Connor, L Garvey, L Radcliffe**
7.3	**Deep Dive Review for IJB Risk 26 Primary Care Services** LC brought the report for Discussion and Assurance. She introduced Avril Sweeney who was present to assist with questions. LC stated, the Deep Dive Review for the Primary Care Services is number 26 on the IJB Risk Register and seeks to demonstrate how the risk is being managed and sets out relevant assurances.	

	LC explained the Appendices of the report. Appendix 1 details the work which has taken place to truly understand the Risk and Appendix 2 outlines the questions which support the process, giving focus as the Deep Dive is taken. She drew attention to the description of the risk and the external and internal factors which impact the risk level. She also outlined the SMART controls in place with timescales and details of mitigating actions. By implementation of the Primary Care Strategy, it is hoped the risk factor will in time move from 16 to 8. LC spoke of the level of assurance which is felt to be 'reasonable' around the mitigating actions and control measures in place. She drew attention to external factors which are expected to evolve and change whilst moving to implementation of the Strategy. Questions were invited. There was considerable discussion around the Risk, concerns included funding and staffing. LC fully acknowledged the concerns, however, through innovative thinking, upskilling of the present workforce, along with the local ambition to deliver the PC Strategy and Workforce Strategy, she felt change is already happening. KM was keen to see evidence. NC thanked KM for his comments and explained the reason and process for a deeper dive, which will come through the Audit & Assurance Committee. She stated feedback will go back and she invited KM to email Avril Sweeney with any suggestions of how this balance can be reached, stressing feedback is welcomed and continuous improvement is aimed for. Cllr Liewald felt comms to general public making it clear exactly the services which are provided is vital. LC agreed with Cllr Liewald's comments and advised correct comms is one of the key elements of the Strategy, as well as National comms. NC asked for feedback – she queried if the concept of bringing a deeper dive of any risks which sit with Q&CC was a helpful exercise, SB stated it was very helpful.	
7.4	**MWC Overview** This report is deferred to 02 November meeting.	
7.5	**Mental Health Estates Initial Agreement** This report is deferred to 02 November meeting.	
8	**LIVED EXPERIENCE – will come forward to 02 November 2023 meeting.**	

9	**STRATEGIC PLANNING & DELIVERY**	
9.1	**IJB/HSCP Resilience Assurance Annual Report** This report was brought to Committee by LG for Assurance and Discussion. LG stated, the Civil Contingencies Act was amended in March 2021 to include the IJB as Category 1 Responders under the Act. LG gave an outline of the Assurance Framework and the work which has taken place. She stated the framework provides assurance the Partnership effectively prepares for, responds to and recovers from, civil emergencies which impact on Fife's Communities and the delivery of Health and Social Care Services. LG expanded on several points from the report. Feedback was welcomed. NC thanked LG, AS and all of the team who have worked to enable the creation of the framework which recognises and values the responsibilities held by NHS, FC and also the IJB. She spoke of the massive piece of work which has taken place to reach this stage. KM felt the Framework to be comprehensive and spoke of the importance of protecting the most vulnerable of Fife residents. He questioned the cyber resilience of the IT Systems within NHS Fife and FC and asked if it is a priority to protect data and systems which enable services within communities to continue, should there be an attack. LG advised she had attended a presentation on this topic. AS explained, cyber-attacks are a high risk which are actively monitored for and spoke of preventative systems which are in place. She advised, there is a priority list of systems to be protected, of which health and social care are high. Care at Home being particularly vulnerable with a technology team to establish workarounds, should an attack occur. Cllr Liewald spoke of an incident which occurred in her Ward in 2020 where many homes were flooded. She felt if HSCP had been part of the First Response team, they would have been able to help a great deal more than what was done at the time. Therefore, she was very supportive and welcomed the Resilience Framework. MF questioned the recording of incidents and when FC and NHS Fife will be using the same IT systems. NC completely agreed and advocates for joined up IT systems at a national level, filtering down. She will continue to champion for shared IT systems. CG commended the very detailed report. Embedding this into the organisation will be the next stage to implement and ensure everyone understand it. Cllr Steele was particularly pleased to see the incident debrief and lessons learned which can often be missed. LG agreed this was an important part of the report.	

9.2	**Winter Planning 2023/2024 (incorporating Winter Reflections 2022/23)** This report is brought to Committee by LG for Discussion and Assurance. She advised, the report gives an update on actions agreed last winter and describes work being undertaken to prepare for winter 2023/24. LG highlighted pressures, which have not subsided since 2020. As far back as data shows, 2022/23 having been the most pressurised winter to date. Demand for services was significant and she commended the teams on continuing to flex and be agile to meet demands. LG explained the new actions which have been introduced to help meet demand, including Predicted Day of Discharge and Front Door Teams. Performance data was outlined and graphs explained, with Fife seeing an all-time high in weekly discharge figures. Comparisons with national averages was given. LG stated, Scottish Government have developed ten recovery drivers which have been incorporated into Fife's Annual Deliver Plan for 2023/24, two of which are covered in the report – more care to be delivered in the community and improved access to urgent and unscheduled care. LG described the additional actions being taken in preparing for winter 2023/24, including reducing admissions due to long term conditions and telecare service redesign for social care. LG spoke of quality of care being at the forefront of all decisions made, working with planned day of discharge which is done with the patient, carer/family, 'what matters to you' is the fundamental question asked at the patients' admission. Funding and workforce were also outlined. MF commented she was pleased to see learning from recent years. She asked LG if she was confident care packages will be available on the planned date of discharge, LG explained, weekly meetings are held reviewing every patient in hospital with a delay code, to ensure care packages are in place. Needs are usually met, with only ~ 5 or under, where care packages cannot be arranged for various reasons. ID queried if there remains a problem in NEF to secure care packages and care home placements. LG advised, there is a good improvement in care packages and care homes. SB was impressed with the work which has been taking place and congratulated everyone involved. She would be interested to know more about the assessment and rehab centre model, which will be brought to Committee by Lisa Cooper at a future meeting. NC suggested team members from the Community Care Services be invited to the next IJB Development Session to discuss some of the innovative models which are being taken forward.	**V Salmond**
10	**LEGISLATIVE REQUIREMENTS & ANNUAL REPORTS**	
10.1	**Duty of Candour 2021/22 FC and NHS** The reports were introduced to Committee by AS, for FC and HH for NHS. They were brought for Assurance. As part of the Duty of	

	Candour provision in the Health (Scotland) Act 2016, details of when and how duty of candour has been applied are recorded. HH advised the reports demonstrate obligations are being fulfilled with the Partners correctly through their system. Annually, the Health Board publishes a Duty of Candour report. HH explained Incidents are identified through the Adverse Event Process where there is a need to be transparent with a patient and their carer/ family if care has not gone so well. HH highlighted the various themes which come through the reports, mainly falling into 3 themes – tissue viability, theatre & surgery incidents and then a smaller number of smaller incidents. All learning from Duty of Candour reports is shared with services. Patients and carers/family receiving an apology in a timely manner is improving and will continue to be worked on. AS advised of a similar situation for FC, for SW and SC services of which HSCP is a part, also including children's services, housing services, criminal justice services also. The report highlighted a number of instances where Duty of Candour has been identified and the learning obtained from it. No questions were asked.	
10.2	**Fife Alcohol and Drug Partnership Annual Report 2022-23** SB advised the report has been to IJB and is brought to Q&CC for completeness. FMcK introduced Lynda Reid-Fowler, Policy Co-ordinator, Fife Alcohol & Drug Partnership to help answer any questions. FMcK advised the report comes in two parts, firstly the Annual Report 2022/23 and secondly the Government Return, for across the whole of Scotland - a Return which HSCP are required to complete. FMcK told of work the Partnership have been involved with for the MAT Standards (medication assisted treatment) introduced by SG in 2021. She advised, within the MAT Standards, there are many requirements which must be met and told of a recent event at Rothes Halls around designing the Strategy for 2023-26. The event was well attended with lived experience service-users who have come through the programme. Feedback received indicated it had been both emotional and uplifting. FMcK was heartened to hear funding being invested is making a real difference. The number of deaths through alcohol has dropped, although is still high throughout Scotland. She stated the focus will increase on alcohol, alongside drug issues, throughout 23-26. FMcK spoke of rapid re-housing projects which are currently awaiting funding. The ADP Strategy will come through committees once complete. Questions were invited. Cllr Liewald commented she was heartened by the work taking place across the alcohol and drug partnership. She felt, the programmes have given her a great deal of insight into the excellent work which is taking place. She acknowledged much needed work relating to alcohol abuse, is taking place. She mentioned Art Therapy and a connection with DAPL.	

	ID was encouraged to see the success of peer support and peer programmes and was fully supportive of greater emphasis being placed on alcohol abuse. Legislation around alcohol pricing and its complexities were discussed.	
10.3	**Security Data Breach Incident** This report is brought to Committee for assurance by HH on behalf of Lynn Barker. HH conveyed thanks to the Chair for accepting a late paper. HH gave a summary of a data breach incident at a Community Hospital recently, whereby a member of the public impersonated a member of Bank Staff. Before being discovered, the individual had received a sheet which detailed patients on the ward. HH outlined the steps taken to investigate and to ensure there will be no re-occurrence, including significant policies put into place. The incident was reported to the Information Commissioner and it is likely a reprimand will be issued to NHS Fife, which will be published on the ICO website. NHS Fife will be required to evidence steps taken to ensure there is no re-occurrence of the breach. ID queried the CCTV being switched off. NC advised, this was human error and there has been a review across the organisation to ensure there is learning from the incident.	
11	**LOCALITIES**	
12	**OTHER**	
13	**EXECUTIVE LEAD REPORTS & MINUTES FROM LINKED COMMITTEES**	
	13.1 Quality Matters Assurance Group Confirmed Minute from 16.06.23 **13.2 Strategic Planning Group** Unconfirmed Minute from 11.07.23 **13.3 Clinical Governance Oversight Group** Unconfirmed Minute from 20.06.23 **13.4 Equality & Human Rights Strategy Group** No minute available. **13.5 Fife Drugs and Therapeutics Committee** Unconfirmed Minute from 21.06.23	
14	**ITEMS FOR NOTING**	
15	**ITEMS FOR ESCALATION** Community OT Service Waiting Times - SB asked if a PMO approach can be taken and NC will have a meeting with the Team. An update will come back to Committee.	

16	**AOCB**	
17	**DATE OF NEXT MEETING**	
	Thursday 02 November 2023 – 1400-1700hrs **(Please note change of start time from 1000hrs)**	

HEALTH & SAFETY SUBCOMMITTEE

(Meeting on 8 September 2023)

No issues were raised for escalation to the Clinical Governance Committee.

Health & Safety Subcommittee

Minute of the H&S Sub-Committee Meeting
Friday 8 September 2023 at 12.30 pm on Teams

Present
Neil McCormick (Chair), Director of Property & Asset Management (NMcC)
Rona Laskowski, Head of Complex Critical Care Services, Fife HSCP (RL)
Janette Keenan, Director of Nursing (JK)
David Miller, Director of Workforce (DM)

In Attendance
Billy Nixon, H&S Manager (BN)
Anne-Marie Marshall, Manual Handling Team Lead (A-MM)
Paul Bishop, Head of Estates (PB)
Ian Campbell, Interim Head of Spiritual Care (IC)

The order of the minute may not reflect that of the discussion
The meeting was recorded on Teams for transcribing after the meeting

No.		Action
1	**Welcome & Apologies** NMcC welcomed the group to the meeting. Apologies were received from Chris McKenna and Conn Gillespie. Action - NMcC and DM **agreed** to meet with Staff Side in terms of increasing attendance and resilience within health and safety representation at the Health & Safety (H&S) Sub-Committee and also at HSCP H&S meetings.	**NMcC/DM**
2	**Minute/Matters Arising**: The Minute of 9 June 2023 was approved as an accurate record. Matters Arising Matters Arising from the previous minute were included in the Agenda and discussed at today's meeting.	
3	**Governance Arrangements**: There were no Governance Arrangements to report.	

4	**Operational Updates** 4.1(a) H&S Incident Report (Jun-Aug 2023) The H&S Incident Report for the period June to August 2023 was distributed and **noted** by the Sub-Committee. Incidents Summary: Musculoskeletal (staff): 5 reported incidents in the quarter 15 incidents in the period April to August 2023 Riddor (all) 7 reported incidents in the quarter 17 incidents in the period April to August 2023 Self-Harm (patients) 63 reported incidents in the quarter 162 incidents in the period April to August 2023 Sharps (staff): 35 incidents reported in the quarter 57 incidents in the period April to August 2023 Slips, Trips & Falls (staff) 12 incidents reported in the quarter 21 incidents in the period April to August 2023 Violence & Aggression (staff) 334 incidents reported in the quarter 850 incidents in the period April to August 2023 NMcC added that often regular violence and aggression racially and sexually motivated incidents occur on more than one occasion with certain individuals, a subject that has been raised at recent Staff Governance meetings. He advised that our Violence & Aggression Advisor has been actively approaching individuals to offer support. IC advised that the Spiritual Care Team has been involved with the A&E Team in relation to violence and aggression incidents. He enquired as to whether there was a particular hotspot within Acute. NMcC **proposed** that IC be introduced to Bill Coyne, V&A Advisor. IC **agreed** to contact BN to arrange to meet Bill Coyne. 4.1(b) Consideration for Violence & Aggression Training be Mandatory across Fife	

	In terms of the high number of violence and aggression incidents being recorded, BN advised the Sub-Committee that he is collaborating with his team to consider that Violence and Aggression training be made mandatory across Fife. BN will prepare an SBAR for discussion at EDG. The Sub-Committee **agreed** to this way forward. NMcC **agreed** to take the report forward to EDG for approval. 4.1(c) Incidents Dashboard - Month-on-month Trends DM **supported** the content of the Incident Report and suggested that it would be interesting to see in the Incident Dashboard how incidents from the previous quarter compare in terms of trends. The Sub-Committee **agreed** that BN take forward trend analysis details on future Incident Dashboards Action - BN **agreed** to include this information on the next Incident Report (Sept to Dec 2023). 4.1(d) Escalation of the Quarterly H&S Incident Report NMcC proposed that it would be useful to have the quarterly Incident Report added as an item for noting at either Staff Governance Committee or the Area Partnership forum to widen health and safety activity reporting across Fife. The Sub-Committee **agreed** to the proposal. Action - DM will take forward the proposal and provide an **update** on progress at the next meeting. 4.1(e) Fire Extinguishers in Mental Health Settings A discussion took place around the access to and safety surrounding fire extinguishers in mental health settings. This followed a report of a fire extinguisher being used as a weapon towards staff, which raised the one question of whether we can prevent or reduce similar incidents happening in the future. The Sub-Committee **supported** A-MM progressing with this with a view to advising the H&S Sub-Committee of any updates. 4.2 Moving & Handling Report (June 2019 - June 2023) BN advised the Sub-Committee that the Manual Handling Training uptake is at 80% which is a good result. The Manual Handling Analysis Report was distributed and **noted** by the Sub-Committee.	**BN** **DM**

	A-MM gave a detailed discussion and comparison on manual handling course delivery and attendance figures for the period June 2019 to June 2023. Thanks were extended by the Sub-Committee to the Moving & Handling Team for the great work they are carrying out. NMcC added that following the Covid-19 Pandemic and the difficulties faced during this time, NMcC commended the Health & Safety team overall for their commitment and hard work in achieving the great results we see today. 4.3 Sharps Review Update Sharps incidents were discussed at item 4.1. The Sharps Review Update will remain a standard agenda item on the H&S Sub-Committee agenda. 4.4 Face Fit Testing Update BN advised that the requirement for Face Fit Testing has reduced following the Covid-19 Pandemic, however the scheduled machine test continues on a monthly basis for those who fail the local test. Action - BN and JK **agreed** to liaise regarding the co-ordination of Face Fit Testing in terms of a possible Central Database and **agreed** to provide an update at the next H&S Sub-Committee meeting on 8 December 2023. 4.5 Learning & Development - all H&S /Manual Handling Training Packages Update A-MM **advised** that scheduled courses continue to be well attended. There have been several over subscriptions, however, these continue to be monitored and extra training sessions are provided to encompass them. 4.6 Anti-Ligature Discussion RL advised the group that there is a schedule of refurbishment being developed which involved the HSCP Clinical team and the NHS Fife Estates team. At present, the teams are preparing for the decant of patients and staff from Ward 3, QMH in preparation for the schedule of works to begin as soon as possible and from there, the teams will continue to work through the refurbishment. Investment funding will be provided over the next 3 years from both the HSCP and NHS Fife. She added that the works have also been supported by the Fife Health Charity which is a welcome addition.	**Andrea for the Agenda** **BN/JK**

	On a softer side, investment has been made in a café at Stratheden and bids are being received for improvements to outdoor space which will complement the statutory works. A Short Life Working Group is in the process of being set up and is being co-ordinated by the Business Manager of the HSCP. Work continues with the proposed development of a Ligature Policy and literature has been gathered from Boards across the country will be considered when compiling a local policy. This will apply not only to the HSCP but Board wide including community hospitals and several of our Acute hospital wards. Representation is therefore sought from these areas to join and be part of the Short Life Working Group. The Sub-Committee **agreed** that the upgrade works are welcomed which will create a better overall environment for our mental health patients, staff, and visitors. JN advised that positive valuable feedback was received following a visit from the Mental Welfare Commission on 7 September 2023 including improved changes to the nursing team and the environment. RL extended thanks on behalf of the Sub-Committee to the staff team and everyone else who helped achieved the positive result.	
5	**NHS Fife Enforcement Activity** BN **advised** that there was no enforcement activity to report within NHS Fife or any other Boards at this time.	
6	**Policies & Procedures** There were no Policies and Procedures updates to report.	
7	**Performance** 7.1 ASD&CD H&S Committee Update With the help of Claire Dobson and Andy Verrecchia, we are aiming to effectively get the Acute Services H&S Committee up and running however, to date staff side representation remains outstanding. 7.2 HSCP H&S Assurance Group minute of 08.08.23 & update	

	Action - RL agreed to forward minute for circulation. RL added that there is a full Action Plan within the HSCP in terms of responsibilities around health and safety. Returns will be discussed at the next HSCP Health & Safety meeting in December 2023. In terms of training, RL advised that a Mandatory Training Dashboard is in place providing a monthly report to the HSCP SLT. She added that there is a trajectory to aim for 90% across all services by the end of the calendar year. NMcC was encouraged by the role specific health and safety responsibilities being actioned and added that it would be interesting for some of this information to be shared with the H&S Sub-Committee as things progress.	**RL**
8	**Any Other Business** 8.1 HSE Letter - Recommendation for managing Violence & Aggression & Musculoskeletal Disorders in the NHS In terms of the HSE letter of 28 March 2023 addressed to all NHS Trust and Board Chief Executives, we have not received a direct copy, however, BN **agreed** to draft some internal notes that respond to the points in the letter. Action - BN will draft notes for consideration. 8.2 NHS Fife Board Compliance around Entonox Levels (i) Assurance that NHS Fife is compliant with all aspects of Health and Safety Legislation around Entonox Levels: a) Undertake H&S inspections/COSHH risk assessments. b) Reduction of exposure (by engineering means and/or by provision of suitable personal protective equipment (PPE) as far as reasonably practicable. c) Provision of information, instruction, and training. d) Appropriate mitigation including elimination or substitution. (ii) Consider escalation to other forums out with Sub-Committee meetings? (iii) Formal response in support of the above to be sent to J Lambert, RCoM. PB advised that after meeting with pharmacy colleagues and key stakeholders and discussions held at the Clinical Governance Committee meeting on 8 September 2023, it was agreed that the best way forward in terms of identifying the risk	**BN**

and mitigation to individual members of staff would be to have a monitoring system in place with personal monitors for staff. This will identify whether people are being exposed to Entonox levels beyond the allowable levels.

PB added that he is aware of only two companies who supply Entonox personal monitors worldwide. Having spoken to one of the companies this morning and was assured by their positivity and being at the forefront in terms of technology. With this in mind, a mobile monitoring unit and a sample personal monitor is being organised for use in Fife.

NMcC advised that as a Board, a Policy is being developed around Entonox in terms of limiting use.

In terms of the environment, Entonox contains Nitrous Oxide which is a harmful gas and there has been an overall drive to reduce the levels of Nitrous Oxide in general.

8.3 Update following HIS Inspection Visit

NMcC provided an update on the recent HIS Inspection in terms of the issues that were raised regarding routine and reactive maintenance. He gave **assurance** to the Sub-Committee that the Estate Sector Manager for each site (Central Acute, Glenrothes & NE Fife and Dunfermline & W Fife) have identified and checked that the statutory compliance of the sites are fully up to date.

In terms of the planned upgrade to Ward 5, Phase 1, VHK the wards are now empty with ENT being temporarily moved to the Tower Block. Once complete, there is likely to be maintenance works carried out in Ward 6 and Ward 9 and this will take place throughout the remainder of the year.

8.4 Incident: Exposure to Asbestos

In view of the potential exposure to asbestos incident caused by an external contractor who drilled into a wall containing asbestos, NMcC gave **assurance** to the Sub-Committee that the Estates Department have set specific guidelines to ensure that safeguards are in place following the incident to avoid any reoccurrence.

8.5 Reinforced Autoclaved Aerated Concrete (RAAC)

NMcC provided an update to advise that a process for reviewing the Fife estate in terms of reinforced concrete has been agreed across NHS Scotland.

Every build within our estate was checked to determine the date in which blocks were built, particularly between 1950 and 1989

when we envisaged that this was the period with the most likelihood of a building containing RAAC.

Other aspects of our estate were checked including flat roofs and the pitch of roofs along with various other elements to determine whether the build should be checked in finer detail.

Of the thousands of blocks that were checked, we identified twenty-seven and passed these to Curry & Brown, Building Surveyors in their capacity as RAAC Survey Partner recently appointed by NHS Scotland Assure.

There are three elements to the survey process:

(i) RAAC Desktop Survey
Currie & Brown will initially conduct a desktop review which will involve speaking to and co-ordinating with Board contacts to obtain relevant existing building information, including but not limited to drawings, photographs, structural reports. The gathered information will be used to inform the Pilot and Discovery Surveys.

(ii) RAAC Pilot Survey
A pilot survey will be conducted to ensure the proposed methodology is tried and tested prior to the remainder of the properties being surveyed.

(iii) RAAC Discovery Survey
This is the physical surveys of the remainder of the properties which are assumed to contain RAAC. The report will detail associated risks, remedial actions, cost, and any routine monitoring suggestions for all RAAC planks identified with a Red or Amber RAG rating. This information will be in the form of a report for each Board.

NMcC added that, of the buildings surveyed to date, Discovery Surveys have identified that two of the buildings have no RAAC and one of the buildings has RAAC. For the time being, this has not been highlighted as a major concern, and it has been proposed that one part of the building is checked on a three-yearly basis and the remaining part of the building is checked on a yearly basis. Whilst the building was identified as containing RAAC, there is no evidence that this is failing.

The remaining 20+ reports should be received within the next 10 days.

To summarise, no evacuations or rendering buildings out of use has been identified, however, it is unclear as to what the government response will be moving forward.

	The Sub-Committee took **assurance** from the update and **noted** that an update will be given at the next H&S Sub-Committee when it meets on 8 December 2023.	**Andrea for the Agenda**
9	**Date & Time of Next Meeting** Friday 8 December 2023 at 12.30 pm on Teams	

Infection Control Committee

INFECTION CONTROL COMMITTEE (Meeting on 9 August 2023)
No issues were raised for escalation to the Clinical Governance Committee.

Fife Health & Social Care Partnership

NHS Fife

Infection Prevention and Control Team

Infection Control Committee Minutes (unconfirmed

09th August 2023 at 1400 via Teams

Item No	Subject
1	**Attendees** Janette Keenan, Director of Nursing (Chair) **JK** Julia Cook, Infection Control Manager **JC** Keith Morris, Infection Control Doctor and Microbiologist **KM** Lizzy Dunstan, Senior Infection Prevention & Control Nurse **ED** Suzanne Watson, Senior Infection Prevention & Control Nurse **SW** Mirka Barclay, Senior Infection Prevention & Control Nurse **MB** Paul Bishop, Head of Estates **PB** Midge Rotherham, Support Services Manager **MR** Fiona Bellamy, Senior Health Protection Nurse Specialist **FB** Jamie Gunn, Health Protection Nurse Specialist **JG** Claire Connor, Dental Practice Co-Ordinator **CC** Pauline Cummings, Risk Manager **PC** **Apologies** David Griffith, Neil McCormick , Norma Beveridge, Jim Rotheram, Aileen Lawrie, Pryia Venkatesh, Beverley Young
2	**Minute of Previous Meeting** Group approved previous minute as an accurate reflection.
3	**Action List** Action list shared and updated by members of the meeting.
4	**Standing Items**
4.1	**Risk Register** PC advised members of the meeting current 15 risks, one risk closed and another opened since last ICC. No high risk to report. Flexible hose risk has been closed. ICNET contract renewal added to risk register. Hand hygiene governance to be added as a risk. Discussion around QMH TH modular ceiling, PB to investigate. Off site area sterilisation unit, deep dive review is being presented to the next Clinical Governance Committee in September and Decontamination Group. The water safety deep dive review shall be presented after the decontamination deep dive.
4.2	**HAIRT Board Report** ED & JC presented the HAIRT report, which covers validated data for Quarter 1, and locally validated up to June 2023. **ECB:** Continues to be challenging, however reduction in cases reported. **CDI:** Increase in cases reported from January to end of June. **SAB:** Moderate risk of 9, challenges discussed (Dialysis and PWIDs). **SSI:** Programme still on hold and local teams are supported. **COVID 19:** Weekly ARHAI Scotland nosocomial report now ceased. Locally less outbreaks during this reporting period. **MRSA & CPE Screening:** April-June 2023 sitting at 98% compliance for MRSA and 100% CPE screening. **PWID** & **UCIG:** update **Hand Hygiene:** currently no robust digital systems for recording hand hygiene compliance, meetings held with eHealth with discussions of exploring a commercial audit package such as MEG. Action - further discussion with JK, JC and ADoN **Outbreaks:** Since last reporting period, 0 norovirus to report, 0 outbreaks of flu and 8 COVID-19

	ECB Annual Report - KM updated the committee on the 3 main contributing factors- urosepsis, CAUTIs and hepatobiliary. Hepatobiliary is diet related and possibly a public health issue. Catheters challenge is to reduce the number being used. The number of ECBs is reducing, particularly in the community (people with catheters are HCAI) could be related to prescribing: GP and pharmacies for UTIs, people receiving abx quickly and not developing bacteraemia.
4.3	**Care Home Update** SW updated on the IPC Care Home Team proactive programme with focus on the good engagement: monthly contact with all care homes and annual assurance walk rounds. Discussed the education report and training provided to care homes during 2022. The team are promoting the NES/SSSC app for Care Homes just launched July 2023. CAUTI work in care homes – SW presented at the last UCIG and now engaging with the bladder and bowel team. FB – raised the advanced notification from SG advising on upcoming changes to COVID-19 testing
4.4	**NHSS National Cleaning Services Specification** MR advised NHS Fife is above national average for cleaning scores and achieving green status. Discussed Quality Assurance audit methodology, in line with the Facilities Monitoring Tool, that a random sample of the rooms in an audit area are audited each month but over 12 months, every room on the Quality Assurance system will be audited. Following the HIS Inspection of MH services in February, in addition to the annual facilities services satisfaction survey a further questionnaire has been developed and is now in use, whereby during monthly Peer Audits, a patient or carer are asked to provide feedback on cleaning, environment and other facilities services. The NCSS report presented to ICC does capture a number of areas below 90%, MR assured that areas scoring below 90% are actioned and usually the score improves the next audit, if it still falls below 90% in second audit, this will be scrutinised to see what the issue is and what resources need to be considered to bring the area back to standard JK raised with committee members following recent HIS Inspection, concerns resulting from audits if not resolved at local level can be raised at ICC.
4.5	**Learning Summary** PC provided an overview of learning summary 44 – SAB associated with a midline; ward staff training on VADs and escalation identified as part of key learning. KM added as more midlines are being used, training is essential. PVCs insertion and maintenance is recorded electronically via Patientrack, however other VADs are not. No timeframe as yet to be added to Patientrack (other D&I programmes taking priority). JC added similar issue with significant time delay in development of eCatherter bundle, ED advised this has been raised at UCIG also.
4.6	**National Guidance** JC updated to recent changes to the NIPCM and the *Candida auris* briefing paper – further discussions with senior lab staff before recommendations can be implemented
4.7	**HEI Inspections Fife** JC shared feedback to the group, on the February MH HIS Inspection, monthly group chaired by HoN Tanya Lonergan. JK shared with the committee a high level update on the recent HIS Safe Delivery of Care Inspection, VHK 31st July – 2nd August, report expected in 10 weeks. A number of actions all ready implemented.
4.8	**Quality Improvement Programmes** **PWID** MB updated, the pathway is being finalised and almost ready to roll out, the clinical team have taken out requirement to swab suspected infected injection sites, JC has raised this as a concern with HoN Sally O`Brien. JK will discuss further with Lynn Barker. A treatment room for Addiction Services is being developed. **UCIG** ED advised the last meeting was held 23rd June, CCR for each CAUTI reviewed and lessons learned shared, continuing drive on education/training and QI. Following a pilot, changes to Patientrack electronic insertion and maintenance bundle update still awaited, unable to rollout further at this time.
4.9	**Education** ED advised IPC training programme continues. Supporting all NHS Fife HCWs and volunteers, teams sessions, face-to-face. IPC education programme up to March 2024, now bookable via TURAS Learn topics include:

	CDI, CPE and water safety. JC added NES have recently developed a new poster (shared with the WSG) and awaiting animation around best practice of sinks. MR to share link to animation.
4.10	**Infection Prevention & Control Audit Programme Update** ED advised audits have a dedicated IPC audit nurse and most inpatient and outpatient wards are largely up to date, with very little slippage for the 2 yearly rolling audit programme. HH compliance and technique is also incorporated within this. CC asked if audits were unannounced, advised typically yes. JC raised challenges with current IPC audit tool raised and IPCT exploring other options such as MEG to improve governance. The IPCT shall escalate concerns from audit programme to ICC
4.11	**HAI-SCRIBE** MB – updated the committee on current projects: project hydra, QMH TH reception treatment room, MH refurbishment **Levendale:** JC raised concerns with the environment in Levendale and the delay in patients transferring to Fife Council care.
	JK – had to leave the meeting, JC chaired the remainder of the ICC
4.12	**Capital Planning** JC advised the update from Ben Johnston- Health centres project currently on hold, Phase 1 VHK and Mental Health redesign at planning stage with MB to support from IPC.
4.13	**Infection Prevention and Control Annual Work Programme Update** For noting
5	**New Business**
5.1	**Incidents/Outbreaks/Triggers** **COVID-19 ASD** – reports noted **COVID 19 HCSP** – reports noted **CDI V22** An increase in CDI cases in V22 was identified, following ribotyping that showed no link to the 4 cases, the clinical team were thanked for their support during the review
5.2	**The HCAI Interim Strategy Development** JC provided a verbal report, the strategy launch on the 19th of June, Year 1 – deliverables for national level (SG, ARHAI and NES etc) Year 2 – focus on delivering locally at Board level Progress update to follow to the committee.
5.3	**The IPC Workforce Strategy 2022-24** JC advised an Oversight Board is being commissioned and paper (ToR and action plan) has been shared with the committee.
5.4	**ICNET AND LIMS** ED updated the group ICNET is an essential IPC electronic reporting system. A new Lab information management system (LIMS) is being rolled out nationally, to replace LabCentre, LIMS is required to be integrated with ICNet to ensure it is fully functional, as well as multiple other systems in Fife. Weekly LIMS meetings, chaired by NHS Fife Digital Services are held to provide a progress report of this integration and to discuss this challenging development, with a further extension required. JC advised members of the meeting that this ICNet risk is required to be added to the risk register.
5.5	**ICNET CONTRACT** JC advised members of the meeting the ICNET contract negotiations, it was raised previously Scottish Government was to develop a business case for an eSurveillance system for Scotland as a whole. The current national contract ends December 2023. ICMs have taken forward negotiations with national procurement. Currently cost pressures are indicating an increase of 34%. Next meeting planned 23rd August. There are number of risk associated which have been added to the risk register (risk 2532).
6	**Infection Control Committee's Sub Groups – Minutes/notes of meetings**
6.1	**Infection Prevention & Control Team** Members **noted** the notes of the meeting
6.2	**NHS Fife Decontamination Steering Group**

	Members **noted** the notes of the meeting
6.3	**NHS Fife Antimicrobial Management Team** Members **noted** the last meeting was held 2022
6.4	**NHS Fife Water Safety Management Group** Members **noted** the notes of the meeting
6.5	**NHS Fife Ventilation Group** Members **noted** the notes of the meeting
6.6	**NHS Fife HAI Scribe Planning Group** Members **noted** the notes of the meeting
6.7	**Quality Reports** Members **noted** the notes of the meeting
7	**Any Other Business**
	Hand Hygiene - This was discussed with members of the team earlier in the meeting and it was decided it will be added to the risk register and JK/JC to take forward discussions with ADoNs. **SSI Surveillance** – carried forward to next meeting as no ASD representation. **Renal Dialysis HBV UKHSA**- KM raised renal team have processes, clinical side would have to give assurance these are in place, SB noted a slight error in the document around requirement for renal staff vaccination and screening for HBV infectivity. JC& SB to raise with ARHAI Scotland. **PHS UCI Cycling World Championship** – no PH incidents reported. **IPC Framework 2023-25** – PC to provided JC a few minor suggested changes in an appendix, final paper to be brought back October ICC**.**
8	**Date of Next Meeting**
	ICC meeting schedule 2022-2023.

4th October 2023	1400-1600	Via Ms teams

Infection Control Committee

INFECTION CONTROL COMMITTEE (Meeting on 4 October 2023)
No issues were raised for escalation to the Clinical Governance Committee.

Fife Health & Social Care Partnership | NHS Fife

Infection Prevention and Control Team

Infection Control Committee Minutes (unconfirmed)

04th October 2023 at 1400 via Teams

Item No	Subject
1	**Attendees** Julia Cook, Infection Control Manager (Chair) **JC** Stephen Wilson, Consultant Microbiologist & Lead for Decontamination & Builds **SW** David Griffith, Consultant Microbiologist & Lead for Antimicrobials **DG** Elizabeth Dunstan, Senior Infection Prevention & Control Nurse **ED** Mirka Barclay, Senior Infection Prevention & Control Nurse **MB** Midge Rotherham, Support Services Manager **MR** Fiona Bellamy, Senior Health Protection Nurse Specialist **FB** Claire Connor, Dental Practice Co-Ordinator **CC** Yvonne Chapman (deputising for Pauline Cumming), Risk management **YC** Jim Rotherham (deputising for Paul Bishop), Facilities Manager **JR** Nykoma Hamilton, Infection Prevention and Control Nurse (notes of meeting) **NH** **Apologies** Janette Keenan, Keith Morris; Priya Venkatesh; Norma Beveridge; Pauline Cumming; Neil McCormack; Paul Bishop; Aileen Lawrie; Suzanne Watson
2	**Minute of Previous Meeting** Group approved previous minute as an accurate reflection.
3	**Action List** Action list shared and updated by members of the meeting.
4	**Standing Items**
4.1	**Risk Register** YC advised members of the meeting current 17 risks, 15 of these are moderate and previously reported and no changes to risk rating. Two further risks have been added since last ICC, one is a high level risk and another is low level. Both relate to Phase 1 of VHK. Timescales for review are being met. A few risks have actually reached target level. Risk scoping template presented by JC, 1st for awareness regarding IPC staffing. Starting from September for next 6 months in IPC specialist workforce due to vacancy and recruitment challenges with significant loss of experienced staff in a short space of time. All new IPCNs require support for job support, specialist study and development; in addition we have the challenges for winter that places pressure on system. IPC have a new Band 8A experienced Lead Nurse starting in November, new band 6 nurse starting in next 4-8 weeks and a further post out to advert. Hand Hygiene audit governance Scoping template. Until 2022, each ward or department who deliver patient care undertake hand hygiene opportunity audits of 20 a month. Decision made in October 2022 to cease the use of Lanqip as “not supported”, resulting in loss of a digital record of audits across NHS Fife, IPCT have met with Digital Information colleagues regarding this to explore options including external software.

	At next meeting new risk being added regarding ICNet and LIMS project and JC has had meetings regarding scoping template for this risk. Off site area sterilisation unit, deep dive review is being presented to the next Clinical Governance Committee and Decontamination Group. JR was asked to speak to this. NHS Tayside CSDU: weak SLA regarding decontamination, the building and plant is old with activity increased. NHS Fife has some resilience work to support. There are two plans for long and medium term and national group has been set for this. The water safety deep dive review shall be presented after the decontamination deep dive – meeting organised.
4.2	**HAIRT Board Report** ED & JC presented the HAIRT report, which covers validated data for Quarter 1, and locally validated up to August 2023. **SAB:** Below rate nationally for HCAI; Q2- NHS Fife below national rate for HCAI and above for CAI. VAD & PWIDs associated SABs remain a challenge **PWID**: ongoing improvement work supporting the Addictions team. Up to end of August 2023 there were 6 SABs associated with PWIDs. **SAB Dialysis Line:** all have been Datixed. **CDI:** for Q1 equal to HCAI national rate; Q2- above national for HCAI and below for CAI. HCAI CDI has increased and target extended to end of March 2024. CDI Risk is moderate and no new initiatives. **ECB:** Below the national rate for Q1 and Q2 in both HCAI and CAI. Biggest risk remains catheters, addressed by the NHS Fife Urinary Catheter Improvement Group. Q2 catheter related ECBs are 22% HCAI and 12.5% HAI. Marked improvement in those associated with trauma. ECB current risk is Moderate- 12 and aim is for risk level of 6. **SSI:** Programme still on hold and local teams are supported. **COVID 19:** Weekly ARHAI Scotland nosocomial report now ceased. Locally less outbreaks during this reporting period. **MRSA & CPE Screening:** Q2- 2023 sitting at 98% compliance for MRSA and 100% CPE screening. Well above national average **Outbreaks:** Since last reporting period, 0 norovirus to report, 0 outbreaks of flu and 10 COVID-19 (8 in HSCP and 2 VHK) **Hand Hygiene Audits**: no electronic capture of compliance **National Cleaning**: Q1 95.9% **Estates:** Q1 96.3% Hospital Inspection team: Mental health inspected earlier this year and monthly meetings continue. 18week report has just been submitted. In VHK unannounced inspection 31.07.23 and follow up on 14.08.23, factual accuracy report received.
4.3	**Care Home Update** Proactive work highlighted in report with positive interest in education. IPC Care Home team have been named NHS Fife Team of the Year!
4.4	**NHSS National Cleaning Services Specification** MR report circulated. Q1 NHS Fife above Scottish average compliance at 95.9%. April 2022 to March 2023 slightly above Scottish average with no areas of concern. Teams are busy with regular audits undertaken and some areas have two audits a month supported by Quality Assurance team. Mental Health audit- continuing to progress through actions from report. Should we display the domestic scores on SPSP area? CG raised the boards raised to discuss with Heads of Nursing for standardised approach.
4.5	**Learning Summary** YC updated the 1 learning summary - Review highlighted area for improvement, PVC checks undertaken.
4.6	**National Guidance** JC updated that the Scottish Government has paused most routine asymptomatic COVID testing, including NHS staff. Local guidance was shared for committee's awareness. NIPCM – the COVID-19 appendix has now been archived.
4.7	**HEI Inspections Fife** JC shared to the group the VHK 31st July to 2nd August. Factual accuracy report received yesterday. Issues raised regarding phase 1 environment: V5 planned refurbishment has been brought forward, leading to the

	ENT ward temporarily being moved to V10. HAI-SCRIBE meetings are now taking place weekly with Estates and IPC as well as Executive walk arounds recommenced.
4.8	**Quality Improvement Programmes** **PWID** IPC supporting the addictions team. There are plans for a treatment room in Cameron Hospital site for the service. Removed wound swabbing from the care plan and risk assessment completed. **UCIG** CG advised that the last meeting was September. Sally O'Brien is now taking the group further. Awaiting CAUTI bundle to be added to patientrak system.
4.9	**Education** ED advised IPC training programme continues. Supporting all NHS Fife HCWs and volunteers, teams sessions, face-to-face. IPC education programme up to March 2024, now bookable via TURAS Learn topics include: CDI, CPE and water safety. Winter education training programme to start soon for all staff online and in person. HCID training has been undertaken in V51 and A&E were also invited.
4.10	**Infection Prevention & Control Audit Programme Update** ED advised audits have a dedicated IPC audit nurse and most inpatient and outpatient wards are largely up to date, with very little slippage for the 2 yearly rolling audit programme. HH compliance and technique is also incorporated within this. Approximately a total of 62 undertaken since January and includes re-audits approx. 4 weeks later.
4.11	**HAI-SCRIBE** MB – updated the committee on current projects all listed in the report and the HAI-SCRIBE weekly meeting. One note of concerns is that there is not always full sector representation at these meetings. Preliminary meetings have begun for HAI-SCRIBE generic templates i.e sanitary ware/sinks Levendale: IPC had been highlighted issues, following notification in a further delay in the closure of this ward, lead to a walk around in August 2023, IPC only informed then about air sampling issues. Urgent PAGs held and patients now in Daleview/Fife Council
4.12	**Capital Planning** QMH theatre reception suite redevelopment- complete and open. Phase 1 Oversight Group VHK- V5 now into V10 and refurbishment ongoing. Stage 2 and Stage 3 HAI-SCRIBE completed but detailed plans for fixtures and fittings have not yet been shared with IPC or clinical teams. V6 had planned to have maintenance work commence in October with 9 week closure but due to bed pressures the work has been paused. Concerns raised by IPC about level of work required and missing components not accommodated for in scope of works. Mental health- rolling programme of the mental health wards in NHS Fife. Commencing in ward Q3 which is currently closed and several plans have been shared and discussed. Monthly project team meeting. Ben Johnston organised a 'Lessons Learned meeting' for NTC and details will be shared in due course.
4.13	**Infection Prevention and Control Annual Work Programme Update** For noting and updated for ICC
5	**New Business**
5.1	**Incidents/Outbreaks/Triggers** **COVID-19 ASD** – reports noted **COVID 19 HCSP** – reports noted **Lessons learned from COVID;** HSCP with unwell visitor in ward; testing changes caused some confusion. Patients had been incubating on admission to wards. Staff been working well with IPC but hindered by lack of isolation facilities in older estate in HSCP. Some bays have been closed and spread prevented. Acute: 2 bay closures, 1 linked to a relative. Clinical teams worked with IPC well. Newer facilities including side rooms and bay doors in phase 3 wards has facilitated avoiding whole ward closure. CDI Trigger in V22: Report confirmed that the cases were not linked through ribotyping.

	Endophthalmitis: surgical record noted that patient jumped in procedure and likely own flora caused infection.
5.2	**The HCAI Interim Strategy Development** JC provided a verbal report, the strategy launch on the 19th of June; Year 1 – deliverables for national level (SG, ARHAI and NES etc) Year 2 – focus on delivering locally at Board level
5.3	**The IPC Workforce Strategy 2022-24** JC advised an Oversight Board is being commissioned and paper (ToR and action plan) has been shared with the committee. Workforce collaboration event on 30th October and will update. Ongoing piece of work.
5.4	**ICNET AND LIMS** ED updated the group ICNET is an essential IPC electronic reporting system. A new Lab information management system (LIMS) is being rolled out nationally, to replace LabCentre, LIMS is required to be integrated with ICNet to ensure it is fully functional, as well as multiple other systems in Fife. Weekly LIMS meetings, chaired by NHS Fife Digital Services are held to provide a progress report of this integration and to discuss this challenging development, with a further extension required. Deadline now extended to end of December 2023. JC advised members of the meeting that this ICNet risk is required to be added to the risk register.
5.5	**ICNET CONTRACT** JC advised members of the meeting the ICNET contract negotiations, it was raised previously Scottish Government was to develop a business case for an eSurveillance system for Scotland as a whole. The current national contract ends December 2023. ICMs have taken forward negotiations with national procurement. Currently cost pressures are indicating an increase of 34%. Next meeting planned 23rd August. There are number of risk associated which have been added to the risk register (risk 2532).
6	**Infection Control Committee's Sub Groups – Minutes/notes of meetings**
6.1	**Infection Prevention & Control Team** Nil new to escalate. Dates are now out for the next year.
6.2	**NHS Fife Decontamination Steering Group** Nil to raise at ICC. Next meeting 10th November 2023.
6.3	**NHS Fife Antimicrobial Management Team** Members **noted** the last meeting was held 2022. NHS Fife has no Antimicrobial Pharmacist. Work undertaken moving guidance from one app to another after contract changes.
6.4	**NHS Fife Water Safety Management Group** Meets 9th October and water flushing will be raised.
6.5	**NHS Fife Ventilation Group** **Minutes to be circulated when received**
6.6	**NHS Fife HAI Scribe Planning Group** Now meets weekly and minuted meeting once a month
6.7	**Quality Reports** Members **noted** the notes of the meeting
7	**Any Other Business**
	SSI Surveillance For aware that audit support has been given to orthopaedic and maternity re SSI. Nationally SSI surveillance programme remains paused. ED raised that the IPCT have 1 part-time surveillance member of staff and limited capacity. JC working with HR for new job description and hope to advertise soon to provide resilience in the team and prepare for the possible recommencement of the SSI programme. IPC Framework 2023-2025. Feedback received from Pauline Cummings and with suggestions for terms of reference to sub groups, these shall be shared with the respective groups. In the interest of having an up-to-date IPC Framework the committee agreed the document to be a live document and the sub groups ToRs update accordingly when they are reviewed.

	ARHAI Annual Report for awareness of group.
8	**Date of Next Meeting**
	ICC meeting schedule 2022-2023.

6th December 2023	1400-1600	Via Ms teams

MEDICAL DEVICES GROUP

(Meeting on 13 September 2023)

No issues were raised for escalation to the Clinical Governance Committee.

Medical Devices Group

Minute Medical Device Group
Wednesday 13 September 2023 at 2 pm on Teams

Present

Neil McCormick, Director of Property & Asset Management (NMcC) (Deputy Chair)
Maxine Michie, Deputy Director of Finance (MM)
Iain Forrest, Medical Physics Manager (IF)
Julia Cook, Infection Control Manager (JC)
Robyn Gunn, Head of Laboratory Services (RG)
Alistair Graham, Associate Director of D&I (AG)
Richard Scharff, Radiology Clinical Activity Manager (RS)
Amanda Wong, Director of Allied Health Professionals (AW)
Kevin Booth, Head of Financial Services, Procurement (KB)
Shirley-Anne Savage, Director of Quality & Clinical Governance (S-AS)

In Attendance

Andrea Barker, Note Taker

The meeting was recorded on Teams
The order of the minute does not necessarily reflect that of the discussion

		Action
1	**WELCOME & APOLOGIES** Apologies were received from Iain MacLeod, Claire Steele, John Brown, Paul Smith, Murray Cross, Aylene Kelman, Elizabeth Muir and Satheesh Yalamarthi.	
2	**MINUTE OF LAST MEETING/MATTERS ARISING** The Minute of 14 June 2023 had the following text amendments and was updated accordingly: **Item 3.4** - GP/I4 Digital Solutions Procurement Policy - Work continues on the Digital Solutions Procurement Policy before it is submitted to the General Policies Group. **Item 4.1** - A discussion followed on eQuip database which is to be implemented as the new Medical Equipment Management System (MEMS) for NHS Fife which link to a centralized NHS Scotland system:	

	• Existing equipment asset and maintenance data will be transferred over from Micad to ~~Equip~~ eQuip. • Each piece of medical equipment will have a unique identifier prefix added for each NHS Board to avoid confusion with duplicate numbers in the central system. National Services Scotland (NSS) and other Scottish Government Agencies will have the ability to view data across all Boards. • Currently awaiting Digital & Information (D&I) to implement the local server then the system can be deployed. • All existing users will have the latest client software installed on computers and laptops. • The new client software will require user training to be carried out. • This will eventually link to the RFID system allowing us to share and track equipment (VHK only). <u>Scan for Safety</u> MEMS will be an integral part of an ongoing overarching national project "Scan for Safety" being implemented in the longer-term. <u>Post Meeting Note</u> Update (IF): Bullet point line 1 - Completed, but some catch up will be needed between cease of data input into MICAD and now. Also significant data tidying required. Bullet point line 3 - Successfully completed and server connection to two client PC/Laptops confirmed. Bullet point line 4 - Delayed due to staff shortage issue in D&I. Ongoing. Bullet point line 5 - Training done via TEAMS demonstrations for first key users. Recorded and available for cascade training.	
3	**<u>GOVERNANCE</u>** There were no governance matters to report.	
4	**<u>FOR DISCUSSION</u>** 4.1 <u>Suppliers Transmitting Data Policy</u> (deferred from the June meeting) AG advised that in relation to the IPO elements of the Policy, it has been picked up on how clear the data processing arrangements were in the contract documents. **<u>Action</u>** - AG to provide an update at the next meeting. 4.2 <u>Post Stroke Study - Modified Nasogastric Tube Device</u> (Frances Quirk)	**AG**

	The NHS Fife R&D Ref 23-023 Pharyngeal Electrical Stimulation for Acute Stroke Dysphagia Trial (PhEAST) SBAR and appendix papers were circulated and **noted** by the group. NMcC presented the Post Stroke Study - Modified Nasogastric Tube Device paper and asked if the group was comfortable to support the Study (NHS Fife R&D Ref 23-023 Pharyngeal Electrical Stimulation for Acute Stroke Dysphagia Trial (PhEAST) in NHS Fife prior to the paper going to the Clinical Governance Committee. The equipment is part of a trial and has not previously been used in Fife and will be supplied by the University of Nottingham. (a) It was noted that the device has a CE marking indicating that a product has been assessed by the manufacturer and deemed to meet EU safety, health and environmental protection requirements and that it had been used widely throughout the world. (b) AW noted that the paper contained several errors which she agreed to pick up directly with Frances Quirk. (c) In terms of the loan equipment, KB agreed to check with Paula Lee, Procurement to see if the Indemnity Form (covering equipment supplied by a manufacturer) has been received? **Action** - KB **agreed** to liaise with Paula Lee, Procurement to progress. (d) IF commented on the fact that the form may not cover a university as a supplier? **Action** - IF agreed to check this detail with Paula Lee, Procurement. The Medical Devices Group **agreed** that subject to the receipt of the relevant paperwork, it had no objections and was happy to **support** the Study if it is taken forward by the organisation. 4.3 Medical Devices & Equipment Internal Audit Report (B21/21) Key Performance Indicators (KPIs) for Medical Equipment within Annex 2 of CEL 35(2010) for consideration NMcC advised the group that there was an outstanding Internal Audit issue around Medical Device Key Performance Indicators (KPIs) in terms of which group they should sit. He added that the Capital Equipment Management Group (CEMG) had questioned whether they are the correct group for it to go to. Following discussions with the Internal Auditors, they believed that the Medical Devices Group was the right group for the KPIs to come to. The Medical Devices Group **agreed** to take on the role of receiving the KPI information.	**KB** **IF**

	NMcC suggested then that the SAFR return with Medical Devices KPIs report be circulated to the group for review to identify any potential gaps. He added that the SAFR return with Medical Devices KPIs contains an outdated set of indicators which have been around for many years and that once the equipment database is up and running effectively within NHS Fife, then this will provide a lot of this information going forward. As it stands, the SAFR Return with Medical Devices KPIs report is updated annually, however, it would be helpful to receive the information more regularly ie on a 6-monthly basis. NMcC advised that the requirement from the Scottish Government (SG) is around the usage of major equipment eg endoscopes and such like. He added that the SG are not asking about MRI Scanners or CT Scanners, however, this may be worth considering as a group. **Action** - Review of the SAFR return with Medical Devices KPIs report at the next Medical Devices meeting on 13 December 2023 in terms of the information we currently hold and what the gaps may be. 4.4 IRIC Safety Alert Process - Verbal Update (IF) The GP/E5 Policy for Processing Hazard & Safety Notices & Alerts was circulated and **noted** by the group. NMcC added that Safety Action Notices (SANs) are circulated through Datix the Safety Alert System and handed over to IF, as Incident Safety Alerts Officer for the organization, who gave a verbal update on the process to the group. One concern he had was the closing of the loop ie to identify if the correct actions had been undertaken or were valid. NMcC questioned whether an amendment should be made to the Policy to reflect this? IF advised that when the Policy was being discussed, an agreement could not be reached in terms of who would be responsible for carrying this out. To summarise, the group agreed to take forward for **assurance** to the wider organisation the question of is there something more we can do to ensure that SANs are being appropriately actioned? 4.5 MHRA National Patient Safety Alerts - Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from entrapment or falls The MHRA National Patient Safety Alert on Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices – risk of death from entrapment or falls was circulated and **noted** by the group. NMcC presented the National Patient Safety Alert to the group and advised that it was important to see that the items fall into the broad description of Medical Devices. He added that as much of the maintenance of beds and	**ALL**

	trolleys is carried out by the Estates Department. Therefore, he agreed to take forward the action. NMcC agreed to discuss the process around regular maintenance and checks of these pieces of equipment with Estates colleagues and Mike McAdams, Estates Compliance Manager. He added that these checks require to be carried out in conjunction with Clinical and Estates colleagues. **Action** - NMcC **agreed** to bring an update to the next Medical Devices Group when it meets on 13 December 2023.	**NMcC**
5	**FOR INFORMATION** There were no items to report.	
6	**MINUTES FOR NOTING** (a) CEMG Minute of 1 June 2023 The CEMG Minute of 1 June 2023 was distributed and **noted** by the group. (b) CEMG Minute of 6 July 2023 The CEMG Minute of 6 July 2023 was distributed and **noted** by the group.	
7	**ANY OTHER BUSINESS** 7.1 The Registration of the Laboratory Information Management System Software as a Medical Device RG raised the question of identifying the Laboratory Information Management System (LIMS) software as a medical device as there has been National discussions around whether the LIMS system requires to be registered as a Medical Device as there are certain aspects of what we do will require to be registered. NHS Fife will be the first Board to go live with LIMS who implement certain calculations and algorithms. Following a group discussion, AG and RG will discuss in finer detail out with the meeting. **Action** - RG and AG **agreed** to provide an update to the Medical Devices Group when it meets on 13 December 2023.	**RG & AG**

	NMcC added that this is an excellent example of a specific question that throws up a generic risk around how we deal with software as a medical device within the organization. The group **agreed** to add the item to our Risk Register as a generic risk. **Action** - NMcC to take forward. The group **agreed** for the item to be added to the next Medical Device Group Agenda for the meeting on 13 December 2023. **Action** - Andrea to add to the agenda. 7.2 NHS Fife Representation at Commodity Advisory Panel Meetings IF attended the Commodity Advisory Panel Meeting today which covered patient monitoring, anesthetic machines and ventilators and representation from NHS Fife was low. **Action** - KB **agreed** to gather details on the Commodity Advisory Panel meeting and feedback to the group at the next Medical Devices meeting on 13 December 2023. Equipment specifications are received by IF from the group and these are then passed over to the relevant Clinical Leads for review - details required on who they are? **Action** - Discuss at next Medical Devices Committee meeting on 13 December 2023 following feedback from KB.	**NMcC** **Andrea** **KB** **IF**
8	**DATE & TIME OF NEXT MEETING** Wednesday 13 December 2023 at 2 pm on Teams	

RESEARCH, INNOVATION & KNOWLEDGE GROUP

(Meeting on 3 October 2023)

No issues were raised for escalation to the Clinical Governance Committee.

NHS Fife

NHS Fife Research, Innovation and Knowledge

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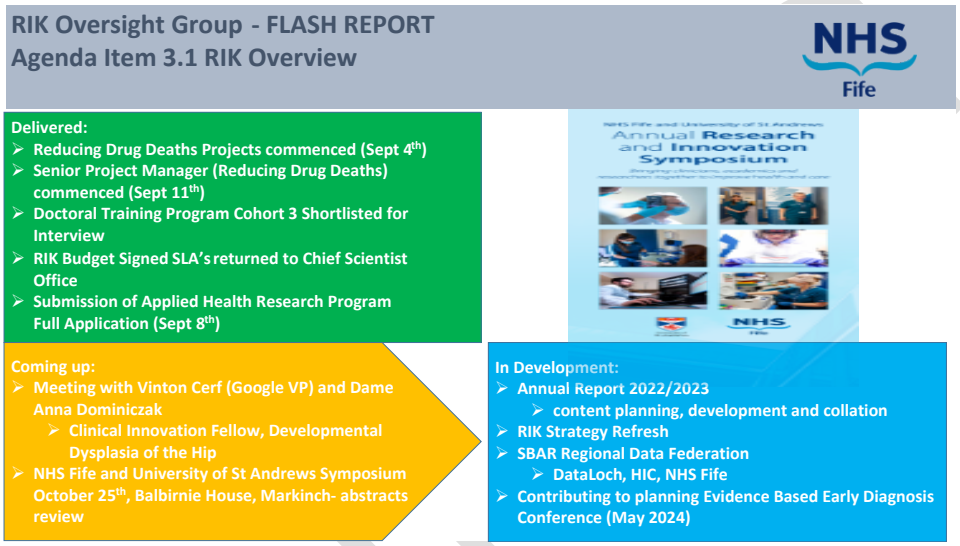
RESEARCH, INNOVATION & KNOWLEDGE OVERSIGHT GROUP MEETING
MINUTES
Microsoft TEAMS,

03 OCTOBER 2023 deferred from 19 SEPTEMBER (13.00 – 14.00)

		ACTION
	Present: Dr Chris McKenna, Medical Director, Executive Lead for Research, Innovation & Knowledge (CMcK) Prof. Frances Quirk, RIK Assistant Director (FQ) Neil Mitchell, Innovation Manager (NM) Anne Haddow, Lay Advisor (AH) Karen Gray, Lead Nurse (KG) Prof. Colin McCowan, Head of Population Health and Behavioural Science Division, University of St. Andrews (CMcC) Doreen Young, Head of Practice & Professional Development (DY) - representing Nicola Robertson Shirley-Anne Savage, Associate Director of Quality and Clinical Governance (S-AS) Ramsay Khadeir, Senior Project Manager, Reducing Drugs Death programme (RK) Sally Tyson, Head of Pharmacy, Development & Innovation (ST) - representing Ben Hannan In Attendance: Roy Halliday, R&D Support Officer – minutes (RH) Anna Borkowska, R&D Nursing Support Officer – observer (AB)	
1.0	**CHAIRPERSON'S WELCOME/APOLOGIES AND OPENING REMARKS** **Apologies;** Prof. Frank Sullivan, Director of Research, University of St. Andrews Dr Grant Syme, Physiotherapist Consultant Alistair Graham, Associate Director, Digital & Information	
2.0	**STANDING ITEMS**	
2.1	**OVERSIGHT OF R, I K OVERSIGHT GROUP MINUTE** CMcK welcomed all to the meeting. NM introduced Ramsay Khadeir, the new Senior Project Manager for the Reducing Drugs Death programme, all introduced themselves to Ramsay. The RIK Oversight Group Minutes were accepted with no amendments. **Actions:**	

	Action.5.2 Innovation Scout proposal – NM advised this is still ongoing but has been overtaken by the high workload with the Reducing Drugs Death Challenge with RK now in place, NM will be able to focus on this a bit more.	
2.2	**OVERSIGHT OF RIK OPERATIONAL GROUP MINUTE AND ACTION LIST** For noting - Nothing from this meeting required escalation.	
3.0	**STRATEGIC PRIORITIES/INITIATIVES**	
3.1	**RIK OVERVIEW**	



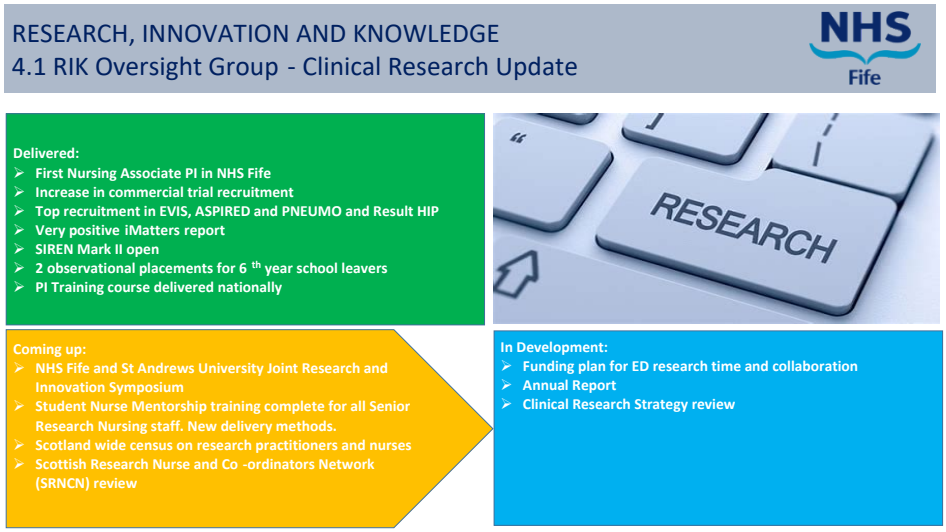
FQ advised that the Reducing Drugs Death programme commenced on 04th September, NM will give further information in his update.

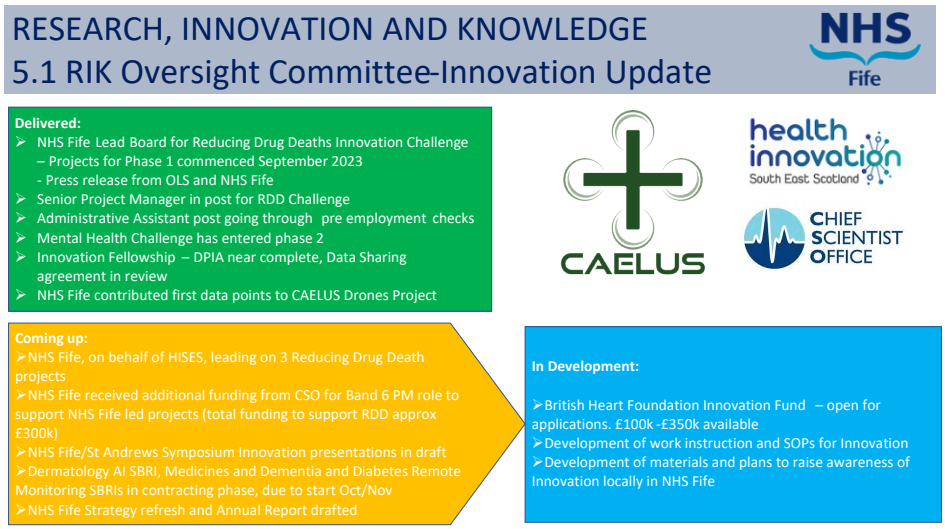
FQ also noted that interviews for the Doctoral Training Programme are taking place this week, four candidates have been shortlisted for interview for St Andrews projects.

FQ confirmed that the CSO budget for RIK has been agreed and was slightly higher than anticipated.

FQ has worked with St. Andrews colleagues to support submission of an Applied Health Research programme application to the CSO, this was submitted on 08th September.

FQ attended a meeting with Vinton Cerf, (Google Vice President, Chief Internet Evangelist) and Dame Anna Dominiczak from the Chief Scientist Office, discussing Clinical Innovation Fellow Joyce Henderson's Development of Displacement of the Hip (DDH) project looking at using the use of AI in the diagnostic assessment (DDH), this was a very productive discussion with recommendations from Vinton for connections

	to be made in his wider network. Discussion also took place with regard to supporting the wider innovation agenda in Scotland. The 2nd joint NHS Fife/University of St. Andrews Symposium will take place on 25th October, submitted abstracts are currently being reviewed, successful applicants will be notified on 6th October. FQ advised that the Leadership Team are currently finalising the 22/23 Annual Report and RIK Strategy, drafts will come to this meeting in December for approval. FQ added that a Development Session with the Clinical Governance Committee will be taking place on October 18th with a focus on the research and innovation partnership between NHS Fife and the University of St. Andrews.	
4.0	**RESEARCH AND DEVELOPMENT**	
4.1	**CLINICAL RESEARCH UPDATE**  KG advised that we now have the first Nursing Associate Principal Investigator's in NHS Fife, a Senior Nurse in the Emergency Department who will be supervised by a current PI. The department was the top recruiter in four UK studies for September. The team has also recently completed the placement of two sixth year school leavers intending to study medicine at university each spent a week in the department spending time with the clinical team. KG and members of the team will be delivering the first PI training sessions tomorrow.	

	KG advised that student mentorship training will be completed by all the Senior Research Nurse team within the next few weeks. As discussed in the last meeting KG advised that as part of her role within the Scottish Research Nurse Coordinating Network, the team are looking into performing a Scottish Research Nurse workforce census, this will be ongoing. KG advised that work is underway to introduce research studies with the Emergency Department and some of the staff recently visited the EMERGE study team in Edinburgh, KG is currently looking at funding plans with the Service Manager to free up time for the ED staff to undertake research, with the plan to look at some commercial trials which will generate income for the ED.	
5.0	**INNOVATION**	
5.1	**INNOVATION UPDATE**  NM advised that all eleven of the Reducing Drugs Death programme Phase 1 projects have now commenced, a press release has been issued by the Office of Life Science and CSO promoting this project. NHS Fife also issued a media release promoting NHS Fife's role supporting this national program NM noted that as well as the Senior Project Manager, Ramsay Khadeir (RK) a full-time administration assistant will be joining soon. The Metal Health Innovation challenge which is being led by NHS Lothian has now entered phase II, one of the two companies HISES has been working with has been successful for this, they will be looking at mental	

	health in school children and attempting to reduce the waiting time of CAMHS appointments. NHS Fife will be leading on three Reducing Drug Deaths projects and have received funding from the CSO to recruit a Band 6 Project Manager to support these projects. NM noted that innovation will have a major role at the joint symposium on 25th October and he is currently working on presentations. NM advised that the British Heart Foundation innovation fund is now open for applications with funding of between £100,000 to £350,000 being available. Development is ongoing for SOPs and WIs for Innovation along with the production of materials for raising awareness of innovation within NHS Fife.	
5.2	**REDUCING DRUG DEATHS CHALLENGE** Small Business Research Initiative (SBRI) funded by SHIP Scottish Health and Industry Partnership / Office for Life Sciences **5.2 ReducingDrug Deaths InnovationChallenge** ➢ 11 feasibility companies contracted for 01 September start date ➢3 companies working with HISES, focussing in NHS Fife initially ➢1 Demonstration company contract under review, due to commence 01 October ➢Senior Project Manager, Ramsay Khadeir, commenced in September with responsibility for the National Challenge ➢Administrative assistant role under pre-employment checks ➢1st milestone report due from companies and Challenge Steering group meeting in October ➢Webinar for all companies to present and meet being organised for October/November	

	Small Business Research Initiative (SBRI) funded by SHIP Scottish Health and Industry Partnership / Office for Life Sciences  NM advised that as previously noted, eleven companies have commenced the Phase 1 contracting stage and projects have begun. A webinar will be set up for all companies to present their products and will take place late October/early November. Three of these projects will be led by NHS Fife, NM will be working with Susanna Galea-Singer, Addictions Clinical Lead and Clinical Innovation Champion to connect with Clinicians to co-develop products with the companies involved. The three projects are: • AI overdose monitoring system to enable both self and responder digital alerts. To repurpose mental health screening and digital wearable technologies. • Rescue Patch - Transdermal controlled release combination patch naloxone and flumazenil • Handheld biosensor benzodiazepine detections and notification to user / responders	
6.0	**LIBRARY & KNOWLEDGE SERVICES**	
6.1	**LIBRARY STAFFING REVIEW** FQ advised that there had been some progress with the recruitment of a new Library & Knowledge Services Manager, A job description has been submitted and is being evaluated, the LK&S team had a visit last week from Catherine McLeod who is the new principal lead for knowledge management and discovery at NES, she has kindly offered to support our recruitment process and has volunteered to be on the interview panel.	
7.0	**PARTNERSHIP UPDATES**	
7.1	**DOCTORAL TRAINING PROGRAMME**	

	CMcC advised that the two students in cohort one have been in post for a year and are due their review soon. The two candidates for cohort two started in August and are settling in. Interviews for cohort three take place later this week with four candidates, with there being the option to appoint two. A meeting with other DTP Leads will take place in London in November.	
7.2	**JOINT RESEARCH OFFICE** CMcC noted that as mentioned earlier by FQ, an Applied Health Research programme application to the CSO was submitted in September, the topic is identifying people in the last year of life using Emergency Care services looking to create referral pathways to existing services that might better meet the patient's needs, interviews will be taking place during December, with outcome by the end of the year.	
7.3	**NHS FIFE & UNIVERSITY OF ST. ANDREWS PARTNERSHIP** CMcC advised that there is a new Professor of Infectious Diseases, Nick Feasey who will also be working as a Consultant at NHS Fife. CMcC discussed the SCREDS lectures being offered by NES, this is for doctors in training who have a PhD, they are allocated to a university one day per week, paid for by NES to allow them to develop a Clinical Academic career, an agreement with NES allows doctors who go through the DTP programme to become SCREDS lecturers for at least one year after they finish the programme, two NHS Fife appointments have been made lecturers, Dr Sinan Khadhouri and Mr Andrew Hall.	
7.4	**R&D/FIFE COMMUNITY ADVISORY GROUP**. AH updated from her report (attached to the Agenda) and wished to draw attention to the fact that members have been involved in planning meetings for the Inaugural Evidence Based Early Diagnosis (EBED) Conference to be held in St Andrews at the end of May 2024. The conference aims to help create an international community of practice and enquiry in the area of evidence based early diagnostics with the purpose of ensuring that individuals, societies, and health systems benefit from, rather than are harmed by the wave of new diagnostic options soon to commence in primary care and community settings. Evidence Based Early Diagnosis – Conference 2024 | Mackenzie Institute for Early Diagnosis (st-andrews.ac.uk)	
7.0	**AOCB** FQ reminded everyone of the need to register for the joint NHS Fife/University of St. Andrews Symposium if they were planning to attend. CMcK commended all on the great work that is taking place.	
8.0	**DATE AND TIME OF NEXT MEETING** Monday 11th December, 14.00 – 15.00	