NHS Fife Clinical Governance Committee

Fri 08 September 2023, 10:00 - 12:30

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 7 July 2023

Enclosed *Arlene Wood*

Item 3 - Draft Clinical Governance Committee Minutes (unconfirmed) 20230707 GM.pdf (11 pages)

10:00 - 10:10
10 min

4. Matters Arising / Action List

Enclosed *Arlene Wood*

Item 4 - Clinical Governance Committee Action List - 20230908.pdf (2 pages)

4.1. Central Sterilisation Decontamination Units Update

Verbal *Neil McCormick*

10:10 - 10:30
20 min

5. ACTIVE OR EMERGING ISSUES

5.1. Health Improvement Scotland (HIS) Inspection Update

Enclosed *Janette Keenan*

Item 5.1 - SBAR Health Improvement Scotland (HIS) Inspection Update.pdf (4 pages)

5.2. Computerised Tomography (CT) Scanner Update and Next Steps

Verbal *Claire Dobson / Iain MacLeod*

10:30 - 10:50
20 min

6. GOVERNANCE MATTERS

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

Enclosed *Janette Keenan / Neil McCormick*

Item 6.1 - SBAR Corporate Risks Aligned to Clinical Governance Committee.pdf (5 pages)

- Item 6.1 - Appendix 1 Summary of Corporate Risks Aligned to the CGC as at 31 08 23.pdf (5 pages)
- Item 6.1 - Appendix 2 Deep Dive Review Off-Site Area Sterilisation and Disinfection Unit Service.pdf (5 pages)
- Item 6.1 - Appendix 3 Assurance Principles.pdf (1 pages)
- Item 6.1 - Appendix 4 Risk Matrix.pdf (2 pages)

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

Enclosed *Gillian MacIntosh*

- Item 6.2 - Proposed Clinical Governance Committee Meeting Dates 2024-25.pdf (1 pages)

6.3. Delivery of Annual Workplan 2023/24

Enclosed *Shirley-Anne Savage*

- Item 6.3 - Delivery of Annual Workplan 2023-24.pdf (7 pages)

10:50 - 11:15
25 min

7. STRATEGY / PLANNING

7.1. Annual Delivery Plan 2023/24

Enclosed *Margo McGurk*

- Item 7.1 - SBAR Annual Delivery Plan 2023-24.pdf (3 pages)
- Item 7.1 - Appendix 1 Annual Delivery Plan 2023-24.pdf (63 pages)
- Item 7.1 - Appendix 2 Annual Delivery Plan Sign Off Letter from Scottish Government.pdf (30 pages)

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

Enclosed *Janette Keenan*

- Item 7.2 - SBAR Scottish Healthcare Associated Infection (HCAI) Strategy 2023-25.pdf (4 pages)
- Item 7.2 - Appendix 1 Scottish Healthcare Associated Infection (HCAI) Strategy 2023-25.pdf (32 pages)

7.3. The Infection Prevention Workforce: Strategic Plan 2022-24

Enclosed *Janette Keenan*

- Item 7.3 - SBAR The Infection Prevention Workforce Strategic Plan 2022-24.pdf (4 pages)
- Item 7.3 - Appendix 1 The Infection Prevention Workforce Strategic Plan 2022-24.pdf (41 pages)
- Item 7.3 - Appendix 2 Local Integrated Service Delivery Plan Steering Group.pdf (9 pages)
- Item 7.3 - Appendix 3 Local Integrated Service Delivery Plan.pdf (12 pages)

11:15 - 11:45
30 min

8. QUALITY / PERFORMANCE

8.1. Integrated Performance & Quality Report, including Deep Dive: Pressure Ulcers

Enclosed *Shirley-Anne Savage / Janette Keenan*

- Item 8.1 - SBAR Integrated Performance & Quality Report.pdf (4 pages)
- Item 8.1 - Appendix 1 Integrated Performance & Quality Report.pdf (16 pages)
- Item 8.1 - Appendix 2 Deep Dive - Pressure Ulcers.pdf (10 pages)

8.2. Healthcare Associated Infection Report (HAIRT)

Enclosed *Janette Keenan*

- Item 8.2 - SBAR Healthcare Associated Infection Report (HAIRT).pdf (6 pages)
- Item 8.2 - Appendix 1 Healthcare Associated Infection Report (HAIRT).pdf (26 pages)
- Item 8.2 - Appendix 2 E. Coli Bacteraemia Report.pdf (6 pages)

8.3. Deteriorating Patient Improvement Project Update

Enclosed *Janette Keenan*

- Item 8.3 - SBAR Deteriorating Patient Improvement Project Update.pdf (4 pages)
- Item 8.3 - Appendix 1 Deteriorating Patient Project Brief.pdf (15 pages)

11:45 - 11:55
10 min

9. DIGITAL / INFORMATION

9.1. Information Governance and Security Steering Group Update

Enclosed *Margo McGurk / Alastair Graham*

- Item 9.1 - SBAR Information Governance and Security Steering Group Update + Appendix 1.pdf (9 pages)
- Item 9.1 - Appendix 2 IGS Accountability and Assurance Framework - Exec Summary.pdf (9 pages)

11:55 - 12:25
30 min

10. ANNUAL REPORTS / OTHER REPORTS

10.1. Patient Experience & Feedback Report Q1

Enclosed *Janette Keenan*

- Item 10.1 - Patient Experience & Feedback Report Q1.pdf (14 pages)

10.2. Care Opinion Report

Enclosed *Janette Keenan*

- Item 10.2 - SBAR Care Opinion Report.pdf (10 pages)
- Item 10.2 - Appendix 1 Annual Review of Stories Told.pdf (38 pages)

10.3. Allied Health Professional Assurance Frameworks

Enclosed *Janette Keenan*

- Item 10.3 - SBAR Allied Health Professional Assurance Frameworks.pdf (3 pages)
- Item 10.3 - Appendix 1 AHP Professional Assurance and Governance Framework.pdf (20 pages)
- Item 10.3 - Appendix 2 AHP Learning and Development Framework 2023-26.pdf (15 pages)
- Item 10.3 - Appendix 3 AHP Research, Innovation and Knowledge Strategic Framework 2023-26.pdf (10 pages)

10.4. Controlled Drug Accountable Officer Annual Report

Enclosed *Ben Hannan*

- Item 10.4 - SBAR Controlled Drug Accountable Officer Annual Report.pdf (3 pages)
- Item 10.4 - Appendix 1 Controlled Drug Accountable Officer Annual Report.pdf (19 pages)

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

Enclosed *Ben Hannan*

- Item 10.5 - SBAR High Risk Pain Medicines + Appendix 1 & 2.pdf (11 pages)
- Item 10.5 - Appendix 3 High Risk Pain Medicine Patient Safety Programme Year One Report.pdf (97 pages)

10.6. Occupational Health Annual Report 2022/23

Enclosed *Sue Ponton*

- Item 10.6 - Occupational Health and Wellbeing Service Annual Report 2022-23.pdf (17 pages)

12:25 - 12:30
5 min

11. LINKED COMMITTEE MINUTES

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

Enclosed

- Item 11.1 - Minute Cover Paper.pdf (1 pages)
- Item 11.1 - Area Clinical Forum Minutes (unconfirmed) 20230803.pdf (3 pages)

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

Enclosed

- Item 11.2 - Minute Cover Paper.pdf (1 pages)
- Item 11.2 - Area Medical Committee (confirmed) 20230627.pdf (5 pages)

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

Enclosed

- Item 11.3 - Minute Cover Paper.pdf (1 pages)
- Item 11.3 - Clinical Governance Oversight Group (unconfirmed) 20230620.pdf (11 pages)

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

Enclosed

- Item 11.4 - Minute Cover Paper.pdf (1 pages)
- Item 11.4 - Digital & Information Board (unconfirmed) 20230719.pdf (7 pages)

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

Enclosed

- Item 11.5 - Minute Cover Paper.pdf (1 pages)
- Item 11.5 - Fife Area Drugs & Therapeutic Committee (confirmed) 20230621.pdf (7 pages)

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

Enclosed

- Item 11.6 - Minute Cover Paper.pdf (1 pages)
- Item 11.6 - Fife IJB Quality & Communities Committee (confirmed) 20230503.pdf (10 pages)

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

Enclosed

- Item 11.7 - Minute Cover Paper.pdf (1 pages)
- Item 11.7 - Information Governance & Security Steering Group (unconfirmed) 20230713.pdf (4 pages)

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

Enclosed

- Item 11.8 - Minute Cover Paper.pdf (1 pages)
- Item 11.8 - Medical Devices Group (unconfirmed) 20230614.pdf (5 pages)

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

Enclosed

- Item 11.9 - Minute Cover Paper.pdf (1 pages)
- Item 11.9 - Research, Innovation & Knowledge Oversight Group (unconfirmed) 20230621.pdf (7 pages)

11.10. Resilience Forum held on 8 June 2023 (unconfirmed)

Enclosed

- Item 11.10 - Minute Cover Paper.pdf (1 pages)

Item 11.10 - Resilience Forum (unconfirmed) 20230608.pdf (6 pages)

12:30 - 12:30
0 min

12. ESCALATION OF ISSUES TO NHS FIFE BOARD

12.1. To the Board in the IPQR Summary

Verbal *Arlene Wood*

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

Verbal *Arlene Wood*

12:30 - 12:30
0 min

13. ANY OTHER BUSINESS

12:30 - 12:30
0 min

14. DATE OF NEXT MEETING - FRIDAY 3 NOVEMBER 2023 FROM 10AM - 1PM VIA MS TEAMS

Fife NHS Board

Unconfirmed

MINUTE OF THE NHS FIFE CLINICAL GOVERNANCE COMMITTEE MEETING HELD ON FRIDAY 7 JULY 2023 AT 10AM VIA MS TEAMS

Present:
Arlene Wood, Non-Executive Member (Chair)
Colin Grieve, Non-Executive Member
Anne Haston, Non-Executive Member
Kirstie MacDonald, Non-Executive Whistleblowing Champion
Simon Fevre, Area Partnership Forum Representative
Janette Keenan, Director of Nursing
Aileen Lawrie, Area Clinical Forum Representative
Chris McKenna, Medical Director
Carol Potter, Chief Executive
Joy Tomlinson, Director of Public Health

In Attendance:
Nicky Connor, Director of Health & Social Care
Shirley Cowie, Senior Nurse/Excellence in Care Lead *(item 8.3 only)*
Claire Dobson, Director of Acute Services
Alistair Graham, Associate Director of Digital & Information
Ben Hannan, Director of Pharmacy & Medicines
Helen Hellewell, Deputy Medical Director, Health & Social Care Partnership
Gillian Malone, Clinical Nurse Manager *(deputising for Norma Beveridge)*
Gillian MacIntosh, Head of Corporate Governance & Board Secretary
Maxine Michie, Deputy Director of Finance *(deputising for Margo McGurk)*
Elizabeth Muir, Clinical Effectiveness Manager
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 Sinead Braiden (Non-Executive Member) and routine attendees Iain MacLeod (Deputy Medical Director, Acute Services Division), 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 5 May 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.

A Haston, Non-Executive Member, gave a warm thanks to Jane Anderson, Head of Radiology, who had met with her and took time to answer her questions and provide direct assurance around in-patient safety and radiology.

4.1 Four Pillars of Advanced Practice within Pharmacy

The Director of Pharmacy & Medicine provided a verbal update and advised that a research manuscript was carried out locally on behalf of the East Region. The manuscript had been circulated to those members who requested a copy, and further updates will be provided, in terms of development, to the Committee.

It was agreed to share by circulation the research manuscript with the full Committee.
Action: Director of Pharmacy & Medicine

5. ACTIVE OR EMERGING ISSUES

The Medical Director updated the Committee on the preparation within services in relation to the Junior Doctors strike, which is planned from 12 – 14 July 2023, should it go ahead.

Following a question from C Grieve, Non-Executive Member, the Medical Director advised that if the strike goes ahead, the impact on the number of Junior Doctors involved in the strike, and number of clinics cancelled, will be documented.

6. GOVERNANCE MATTERS

6.1 Annual Statement of Assurance for Clinical Governance Oversight Group

The Associate Director of Quality & Clinical Governance reported that the Annual Statement of Assurance provides the Committee with assurance that the Clinical Governance Oversight Group has fulfilled its remit during 2022/23. The key areas within the statement were highlighted, and it was noted that timings for discussing issues at the Group will be reviewed, to allow for full and in-depth discussions on specific topics.

It was noted that the vision for the following year is to bring the statement to the May 2024 meeting, which is in line with the reporting of the other Committee & Groups Annual Statements of Assurance.

The Committee took **assurance** from the Annual Statement of Assurance.

6.2 Annual Internal Audit Report 2022/23

The Deputy Director of Finance advised that the report was presented and approved by the Audit & Risk Committee at their meeting on 23 June 2023. The report provides outcomes on the 2022/23 internal audit work plan and outlines the Chief Internal Auditor's positive opinion on the Board's internal control framework for 2022/23. Positive progress in a number of areas were outlined. It was noted that the report highlights challenges in terms of deliverable performance targets and financial sustainability, however it also acknowledges the common challenges and issues being faced across all NHS Scotland Health Boards.

The Medical Director noted that the report highlights the improvement programmes, in terms of clinical governance, that have been carried out, and that the report also includes actions that have been addressed from the Internal Control Evaluation Report. Following a question from the Chair, the Board Secretary explained that it is the role of the Audit & Risk Committee to review the ongoing work in relation to any outstanding actions, and that these are captured to completion within the Internal Audit Follow Up process.

The Committee **considered** the narrative within the corporate governance section and took **assurance** from this finalised report.

6.3 Corporate Risks Aligned to Clinical Governance Committee, Including Deep Dive on Quality & Safety

The Medical Director introduced this item and noted that the Deep Dive on Access to Outpatient, Diagnostic and Treatment Services paper, which was presented to the Finance, Performance & Resources Committee, has been included within the papers to provide further assurance, due to the clinical impacts to the delays to treatment which are currently being experienced.

The Associate Director of Quality & Clinical Governance advised that the deep dive on quality & safety was presented to the Clinical Governance Oversight Group and Executive Directors' Group, and comments from both groups have been considered. It was reported that the level of risk assurance has been added to the deep dive, with a reasonable level of assurance for the quality & safety risk. It was highlighted that there are some management actions that require significant work, which are aligned to the implementation of the Clinical Governance Strategic Framework. The Associate Director of Quality & Clinical Governance spoke to the management actions which have a significant level of delivery challenge, as detailed in the paper.

Following a query from C Grieve, Non-Executive Member, it was agreed that the risk scores required to be reviewed given the likelihood of occurrence was scored very high, despite number of completed mitigating actions. The Chair requested that the tool that outlines the detail of the risk ratings be included within the report.

Action: Associate Director of Quality & Clinical Governance

Discussion took place on the deep dive on Access to Outpatient, Diagnostic and Treatment Services that was presented to the Finance, Performance & Resources Committee at their March 2023 meeting. It was highlighted that the risk ratings differ from the Clinical Governance Committee deep dive, and it was explained that this was due to timings, and the format had since been changed. A request was made to add actions relating to keeping patients safe whilst waiting for treatment, on the associated management actions relating to that particular risk.

Action: Associate Director of Quality & Clinical Governance

Assurance was provided that work is underway to support these individuals, and that this is monitored through the Planned Care Programme Board. It was confirmed that the Finance, Performance & Resources deep dive was presented in March 2023, and that some of the information is now out-of-date.

The Committee took **assurance** from the Deep Dive on Quality & Assurance.

6.4 Delivery of Annual Workplan 2023/24

The Associate Director of Quality & Clinical Governance highlighted updates to the workplan since the previous meeting.

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

7. STRATEGY / PLANNING

7.1 Annual Delivery Plan 2023/24

The Chief Executive explained that the Annual Delivery Plan addresses specific expectations and priorities of the Scottish Government. It was reported that templates have been adapted to suit NHS Fife's requirements and mapped to the new organisational strategy and our four strategic priorities. It was noted the plan is high level and does not encompass all the actions and work that will be undertaken throughout the organisation. The Annual Delivery Plan will be utilised for performance monitoring.

The Chief Executive advised that following submission of the plan to the Scottish Government at the beginning of June 2023, and following feedback, no further iterations of the plan are required to be submitted, however clarity has been requested around some of the detailed templates.

The Chair questioned where the impact assessment for capacity and delivery would sit. It was advised that this would sit under the planned care template, however it was noted that trajectories and projections have been carried out for 2023/24 and the position is unlikely to improve due to the demand on services and the capacity available. It was noted that the Scottish Government have requested an additional plan in terms of accessing further financial resource to support demand and capacity, and that this would be discussed in due course through the Finance, Performance & Resources Committee.

The Committee **endorsed** the draft Annual Delivery Plan 2023/24 and **recommended** approval from the NHS Fife Board.

7.2 Clinical Governance Strategic Framework Delivery Plan 2023-24

The Associate Director of Quality & Clinical Governance provided background detail and welcomed comments or additions to be included within the plan. It was agreed to add to the plan that any emerging issues would come to the Committee by exception, in addition to the regular reporting schedule.

Action: Associate Director of Quality & Clinical Governance

The Committee took **assurance** from the Clinical Governance Strategic Delivery Plan 2023-24.

8. QUALITY/PERFORMANCE

8.1 Integrated Performance and Quality Report

The Director of Nursing advised that discussions have been taking place on enhancing the narrative within the IPQR, particularly in relation to in-patient falls, pressure ulcers and complaints, and that this will be reflected in the next iteration of the IPQR. The Chair thanked all involved.

It was reported the number of in-patient falls continues to fluctuate and is below target, however, there had been some improvement within the Health & Social Care Partnership. It was noted that the majority of in-patient falls over the last quarter resulted in either no harm or minor harm, and the major or extreme falls were less than 3% of total in-patient falls. It was highlighted that NHS Fife is one of the better performing Health Boards in Scotland.

An update was provided on pressure ulcers, and it was reported that significant work has been undertaken. An overview on the work carried out by the Tissue Viability Team was provided. It was advised that the rate of pressure ulcers reduced in April 2023 for the third successive month. Following a question from the Chair, it was confirmed that learning has been shared from the Health & Social Care Partnership across to the Acute Services and other areas of the Partnership. It was also noted that the quality improvement work carried out within the Partnership has been beneficial and an update will be provided at the next meeting.

Action: Director of Nursing/Medical Director

The Director of Nursing also provided an overview on SAB, C Diff and E Coli Bacteraemia, as detailed in the report. An update on complaints was provided at agenda item 10.1. A Haston, Non-Executive Member, queried the increase in C Diff and was advised that work is ongoing with the Infection Control Doctors and Teams to identify the risk. She also questioned the learnings from the potential cross transmission to avoid future occurrences and was advised that the Infection Control Team are carrying out a review, and to date, nothing specific has been identified.

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 highlighted that NHS Fife achieved a green status for the Cleaning and the Healthcare Environment compliance.

The Director of Nursing also highlighted the Healthcare Improvement Scotland (HIS) unannounced Infection Prevention and Control Inspections of Mental Health Units at Queen Margaret Hospital and Whyteman's Brae Hospital. Further detail was provided under agenda item 8.4.

It was reported that hand hygiene audit work is ongoing, and the issues with electronic recording was explained. The timescales for a new electronic system being implemented and the back up in the interim was questioned. In response, the Director of Nursing explained that solutions are being explored between the Infection Control Team and the Digital & Information Team, and an update will be provided at the next Committee meeting.

Action: Director of Nursing

Following questions from the Chair, it was advised that there are no concerns around surgical site programmes locally, and that no guidance has been received from the Scottish Government on when the programmes will restart. It was also reported that there are no concerns around Clostridioides Difficile Infection (CDI).

The Committee welcomed a deep dive on specific items within the report.

Action: Director of Nursing

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

8.3 Excellence in Care Presentation

The Director of Nursing introduced this item and welcomed S Cowie, Senior Nurse/Excellence in Care Lead, to the meeting. A presentation on Excellence in Care was provided to the Committee.

Following a query from A Haston, Non-Executive Member, it was confirmed that Excellence in Care is a national care assurance programme, and it was advised that it is anticipated that all Health Boards will have to submit a report. It was noted that NHS Fife has submitted its first report to the Scottish Government.

It was agreed to hold a future Committee Development Session on Excellence in Care. Progress reports would also be submitted to the Committee as part of the regular cycle of business.

Action: Director of Nursing/Board Committee Support Officer

The Chair thanked S Cowie for an informative presentation.

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

8.4 Infection Control Inspection by Health Improvement Scotland Report

The Director of Nursing reported that there was an unannounced Healthcare Improvement Scotland (HIS) Infection Prevention and Control Inspection of Mental Health Services at Queen Margaret Hospital and Whyteman's Brae Hospital. The areas inspected, areas of good practice, requirements and recommendations were outlined, and it was noted than an action plan to address the requirements has been developed. Following a question, it was explained that the minimum bed space requirements are being met and that they vary between new and old buildings.

A Haston, Non-Executive Member, queried the link to a representative of patient public involvement being involved in the production of the improvement action plan. The Director of Nursing agreed to provide a response outwith the meeting.

Action: Director of Nursing

Assurance was provided that the backlog of minor repairs is being addressed.

C Grieve, Non-Executive Member, commented that the inspection is timely in terms of the development of the Board's Mental Health Strategy.

The Committee **noted** the very positive feedback around areas of good practice.

The Committee took **assurance** from the report that actions have been taken to address the requirements and recommendations from the Inspection.

8.5 NHS Response to Fatal Accident Inquiry (Linda Allan) & Recommendations

The Medical Director outlined to the Committee the Fatal Accident Inquiry (FAI) and NHS Fife's response to the recommendations. It was advised that the action plan will sit with the Acute Services Clinical Governance Committee for reporting and review, for completion. C Grieve, Non-Executive Member, requested clarity on the target dates in the action plan, noting that some dates had passed. It was advised that this was due to timings of the paper coming to Committee, and that the plan will have since been updated.

Following a question from K MacDonald, Non-Executive Member, around learning and disseminating back to teams, it was advised that the Organisational Learning Group is being rejuvenated, and that the action plan from this FAI is on the agenda to take forward. It was noted that there is an opportunity to take learning and share across the organisation. The Director of Pharmacy & Medicines added that learning in terms of medicines is shared across teams on a regular basis.

The Chair questioned what will be put in place to ensure the improvements are sustained, including compliance. The Medical Director highlighted the challenges and plans to take forward.

The Committee took **assurance** that the Fatal Accident Inquiry for Ms Linda Allan has been appropriately responded to and that organisational learning has taken place.

9. DIGITAL / INFORMATION

9.1 Digital and Information Strategy 2019-24 Update

The Associate Director of Digital & Information reported that the Digital Strategy has been refreshed, and a review of the deliverables is being undertaken with a focus on optimising the outpatient capacity. It was noted that the Digital Strategy is aligned to the priorities within the Population Health & Wellbeing Strategy.

An overview on the Digital Strategy Ambitions was provided.

Following questions from A Haston, Non-Executive Member, it was advised that governance groups are looking to formulise our approach to accelerate an adoption of the electronic health record, supported by electronic patient records. It was also advised a strategic review of progress will be carried out, which will support identifying areas for change or carrying forward.

The Chair highlighted that within the Internal Audit Report there is a recommendation that the Committee need to be made aware of elements of the Digital Strategy that will not meet the 2024 deadline. It was agreed that the High Level Delivery Plan will be streamlined to become a one-page document highlighting what will be delivered, or not delivered, and will include deadline dates and risks. The document will be brought back to the next Committee meeting.

Action: Associate Director of Digital & Information

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

10. PERSON CENTRED CARE / PARTICIPATION / ENGAGEMENT

10.1 Patient Experience & Feedback Report

The Director of Nursing advised that there were 42 stage 2 complaints received in April 2023, and 23 stage 2 complaints were closed, which is a more positive rate of performance. It was noted that work addressing the backlog of complaints continues.

The level of detail for stage 2 complaints, which clarifies where each complaint is in the process, was highlighted and an overview provided. An overview on the key points from the report was provided. It was noted that new processes that are being put in place will help sustain improved performance.

Following questions from C Grieve, Non-Executive Member, regarding the process for improvement and addressing the backlog, the Director of Nursing advised that there had been challenges for senior staff to write statements due to their busy work schedules, and that a Patient Experience Officer is now in place to support. The Associate Director of Nursing added that the MSForms questionnaire returns were very comprehensive in terms of reasons for delays in responding to complaints, and it was advised a report on the outcomes is being drafted.

The Director of Nursing advised that the complaints improvement plan is being updated and will be replaced within the report. It was reported that a milestone plan is being explored for the long delay complaints.

The Chief Executive acknowledged the challenges and difficulties for senior staff in responding to complaints and noted that there is priority to deliver care to patients. She also acknowledged that the position for responding to complaints is currently not at an acceptable level and work is ongoing through improvement plans.

The Chair questioned if there would be an opportunity to change the 20 day standard response time, through discussions nationally, due to the challenges and complexities of meeting this target faced across all health boards. It was noted that the complexity of complaint responses often means a 20 day response time is not realistic in order to support robust investigation of the issues. The Director of Nursing advised that the 20 day response time is set for all public services by the Scottish Public Service Ombudsman (SPSO) and is unlikely to be changed.

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

11. ANNUAL REPORTS

11.1 Clinical Advisory Panel Annual Report

The Medical Director advised that the report is presented to the Committee on a yearly basis to provide assurance on the activities of the Clinical Advisory Panel and to assure the Committee that a reasonable and well governed process is in place. Assurance is also provided, to ensure that patients requiring treatment outwith the options available from NHS Fife and Service Level Agreements (SLAs) from surrounding Health Boards, receive equity in access to treatments.

Following a question from A Haston, Non-Executive Member, the Medical Director advised that there is an appeal process in place, which sits outwith the Clinical Advisory Panel, for any cases that are declined. The Medical Director agreed to add detail on the appeal process to the report.

Action: Medical Director

It was advised that the report is only presented to the Clinical Governance Committee, however, any financial issues or pressure that may arise would be included within reports that go to the Finance, Performance & Resources Committee.

Following a question from the Chair, the Medical Director explained that opportunities to deliver services more locally, rather than externally, are discussed at the Clinical Advisory Panel.

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

11.2 Director of Public Health Annual Report

The Director of Public Health noted that the report is a text only version presented to the Committee (images will be added before publication), and she explained the change of approach to the report, noting that there is a single topic approach on child health for the 2023 report, which is an emerging national priority.

The Director of Public Health highlighted the United Nations Convention on the Rights of the Child (Incorporation) (Scotland) Bill (UNCRC), which will support decision making for our services.

A Haston, Non-Executive Member, highlighted the maternal smoking rates and queried the work that is being undertaken for improving the rates. In response, it was advised that the Smoking Cessation Team are aware of the high rates and are taking improvement work forward. It was advised that different approaches have been trialled to reduce the barriers for patients. The disruption to the service due to the pandemic was highlighted. The Director of Health & Social Care advised that a report went to the Public Health & Wellbeing Committee around the work that is underway for the Smoking Cessation Service in terms of smoking cessation, prevention, and protection. It was noted discussions are ongoing in relation to the Prevention and Early Intervention Strategy and an overview was provided on some of the preventative work and opportunities for the promotion of health & wellbeing.

A Haston, Non-Executive Member, requested more detail on the examples of good practice for perinatal mental health. The Director of Public Health agreed to respond to A Haston outwith the meeting.

Action: Director of Public Health

Following a question from A Haston, Non-Executive Member, regarding the results of the Fife Children & Young People Health & Wellbeing Survey, it was advised that once the report is published, a hyperlink will be added directing the reader to the results.

It was reported that quality evidence around areas of inequality has been shared with the Chair of the Fife Health Charity Board of Trustees.

It was advised that the report will be shared with the NHS Fife Board and discussed further at a forthcoming Development Session.

The Committee **discussed**, **examined** and **considered** the Director of Public Health Annual Report for 2023.

11.3 Fife Child Protection Annual Report

The Director of Nursing advised that the report was also presented to the Public Health & Wellbeing Committee at their July 2023 meeting.

The Director of Nursing spoke to the report and highlighted the key points, including the challenges and successes.

An explanation was provided on accessing the child protection advice line out of hours.

The Director of Nursing and Director of Health & Social Care thanked Lindsay Douglas, Lead Nurse Child Protection, Heather Bett, Senior Manager, and Lisa Cooper, Head of Service, for the in-depth report.

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

12. LINKED COMMITTEE MINUTES

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

12.1 Area Clinical Forum dated 8 June 2023 (unconfirmed)

12.2 Area Medical Committee dated 2 May 2023 (unconfirmed)

12.3 Cancer Governance & Strategy Group dated 31 May 2023 (unconfirmed)

12.4 Clinical Governance Oversight Group dated 18 April 2023 (confirmed)

12.5 Fife Area Drugs & Therapeutic Committee dated 26 April 2023 (unconfirmed)

12.6 Health & Safety Subcommittee dated 9 June 2023 (unconfirmed)

12.7 Infection Control Committee dated 7 June 2023 (unconfirmed)

13. ESCALATION OF ISSUES TO NHS FIFE BOARD

13.1 To the Board in the IPQR Summary

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

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

There were no matters to escalate to the Board.

It was agreed to highlight to the Board the work underway on complaints and IPQR developments.

14. ANY OTHER BUSINESS

There was no other business.

Date of Next Meeting – Friday 8 September 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 September 2023

NO.	DATE OF MEETING	AGENDA ITEM / TOPIC	ACTION	LEAD	TIMESCALE	COMMENTS / PROGRESS	RAG
1.	05/05/23	**Development Sessions**	A Development Session to be arranged on Optimal Clinical Outcomes.	**CM/HT**	TBC		In progress
2.	07/07/23		A Development Session to be arranged on Excellence in Care.	**JK/HT**	TBC		In progress
3.	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	This work will be completed and presented to the Digital & Information Board, then the Executive Directors' Group, before being presented to the Committee at the November 2023 meeting.	Deadline not reached
4.	05/05/23	**Central Sterilisation Decontamination Units**	A briefing paper to be provided to the Committee, with further detail and timing for the national report to be added to the workplan.	**NM**	September 2023	On agenda.	Closed
5.	07/07/23	**Four Pillars of Advanced Practice within Pharmacy**	To share by circulation the research manuscript.	**BH**	July 2023	Circulated.	Closed
6.	07/07/23	**Integrated Performance and Quality Report**	To provide an update at the next meeting on the quality improvement work carried out within the Partnership.	**JK/CM**	September 2023	A paper will be presented at the September meeting on the quality improvement work in reducing pressure ulcers and will complement the IPQR.	Closed
7.	07/07/23	**Healthcare Associated Infection Report (HAIRT)**	To provide an update at the next meeting, on the solutions that are being explored in terms of a new electronic system for hand hygiene, between the Infection Control Team and the Digital & Information Team.	**JK**	September 2023	A verbal update will be provided at the September meeting on the Medical E-Governance system, under the HAIRT agenda item	Closed

NO.	DATE OF MEETING	AGENDA ITEM / TOPIC	ACTION	LEAD	TIMESCALE	COMMENTS / PROGRESS	RAG
8.	07/07/23	**Healthcare Associated Infection Report (HAIRT) – Deep Dive**	To carry out a deep dive on specific items within the report.	**JK**	September 2023	A deep dive paper will be presented at the September meeting on E Coli Bacteraemia.	Closed
9.	07/07/23	**Clinical Advisory Panel Annual Report**	To add detail on the appeal process to the report.	**CM**	September 2023	Complete.	Closed
10.	07/07/23	**Director of Public Health Annual Report**	To respond to A Haston outwith the meeting regarding more detail on the examples of good practice for perinatal mental health.	**JT**	September 2023	Complete.	Closed
11.	12/01/23	**Development Sessions**	A Development Session to be arranged on the relationship between NHS Fife and the University of St Andrews.	**HT**	October 2023	Arranged for 18 October 2023.	Closed
12.	07/07/23	**Corporate Risks Aligned to Clinical Governance Committee, Including Deep Dive on Quality & Safety**	To include within the report, the tool that outlines the detail of the risk ratings.	**SAS**	September 2023	Complete.	Closed
13.	07/07/23	**Clinical Governance Strategic Framework Delivery Plan 2023-24**	To add to the plan that any emerging issues would come to the Committee by exception.	**SAS**	September 2023	Complete.	Closed
14.	07/07/23	**Infection Control Inspection by Health Improvement Scotland Report**	To provide a response to A Haston regarding the link to a representative of patient public involvement being involved in the production of the improvement action plan.	**JK**	September 2023	Complete.	Closed

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**8 September 2023**
Title:	**Health Improvement Scotland (HIS) Inspection Update**
Responsible Executive:	**Janette Keenan, Executive Director of Nursing**
Report Author:	**Janette Keenan, Executive Director of Nursing**

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Emerging issue
- Government policy / directive

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

Healthcare Improvement Scotland (HIS) carried out a Safe Delivery of Care (SDoC) Inspection in Victoria Hospital between 31 July and 2 August. This report has been prepared to provide the Clinical Governance Committee with an overview of the inspection, pending receipt of the HIS report.

2.2 Background

In November 2021, taking account of the changing risk considerations and sustained service pressures, the Cabinet Secretary for Health and Social Care approved adaptations to the inspections of acute hospitals across NHS Scotland to focus on the **safe delivery of care**.

The inspections consider the factors that contribute to the safe delivery of care. To achieve this, inspectors:

- observe the delivery of care within the clinical areas in line with current standards and best practice.
- attend hospital safety huddles.
- engage with staff where possible, being mindful not to impact on the delivery of care.
- engage with management to understand current pressures and assess the compliance with the NHS board policies and procedures, best practice statements or national standards.
- report on the standards achieved on the day of our inspection and ensure the NHS board produces an action plan to address the areas for improvement identified.

To support preparation for an inspection and following a letter from HIS Director of Quality Assurance in November 2022 highlighting concerns raised via SDoC Inspections in other Boards, the Acute Services Division (ASD) considered the guidance in the letter regarding aspects of safety and quality. The ASD Senior Leadership Team (SLT) reviewed practice, policies and procedures to assure NHS Fife of learning regarding the issues highlighted in relation to the impact that ongoing system pressures were having on acute care delivery. There was a specific focus on:

- Oversight and supportive leadership
- Collegiate planning
- Overcrowding
- Supplementary staffing
- Staff wellbeing
- Medicines Governance

2.3 Assessment

There were a number of positive aspects of care highlighted during the inspection, including the compassionate interaction between staff and patients, medicines governance.

The Lead Inspectors commented on good and excellent communication between staff and patients. Positive comments were also shared on MDT working and the delivery of care interactions. Medicines management in front door areas was reported as generally good.

A number of issues were raised and included the absence of an exit button for patients and relatives on Ward 24 and the potential for this being perceived as an infringement of human rights. This was immediately rectified by the clinical leadership team with support from Estates.

There were a number of wards in Phase 3 where the Arjo baths had been recently removed by Equans to create additional storage space and HIS identified that the work was incomplete. This was raised immediately with estates and work is now completed.

Significant issues were highlighted in relation to the fabric of ward 5 (ENT) in the ageing phase 1 estate. This highlighted issues with routine and reactive maintenance and escalation processes between the service, infection control and estates. Action plans were provided to HIS for immediate rectification and an internal review is being commissioned.

A planned programme of refurbishment for ward 5 was in place, but the ASD SLT took an immediate decision to relocate the ENT ward to another area of the hospital and to bring forward the programme of work, ensuring that the area could be improved as quickly and safely as possible.

HIS Inspectors have held further discussions with the Director of Acute Services, Director of Nursing - Acute, Director of Property and Asset Management and Executive Director of Nursing.

HIS will send a copy of the draft report for factual accuracy checking week commencing 25th September. There will then be five working days to review the report then an additional five working days provided to develop the required action plan that accompanies the report.

HIS will aim to publish the final report with the action plan on Thursday 19th October.

2.3.1 Quality / Patient Care

Focus of the inspection is on the Safe Delivery of Care

2.3.2 Workforce

The inspectors consider staffing levels, escalation and staff well-being as part of the inspection.

2.3.3 Financial

By delivering safe and effective care we will maximise the sustainable and effective use of the services available to the division and across the wider health and social care system.

2.3.4 Risk Assessment / Management

The Executive Directors are considering processes which will be put in place to ensure appropriate escalation of risks and issues.

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

The actions and plans are focused on safe, effective, quality healthcare for all and are undertaken with consideration of addressing barriers to access and inequalities associated with personal and community characteristics.

2.3.6 Climate Emergency & Sustainability Impact

The focus is on assuring a safe acute system and thereby avoiding duplication and additionality that may otherwise stem from errors and require additional resources.

2.3.7 Communication, involvement, engagement and consultation

Involvement of EDG members and ASD SLT

2.3.8 Route to the Meeting

Discussion at EDG

2.4 Recommendation

- **Noting** – Note the information in relation to the Inspection, pending receipt of the draft report.
- **Assurance** – The Committee is asked to take assurance that immediate remedial work has taken place and a review of issues highlighted in Ward 5 is being taken forward. A full report will be provided to the Committee when the HIS report is recievd.

Report Contact
Janette Keenan
Executive Director of Nursing
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NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**8 September 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 7 July 2023. It includes a Deep Dive review into Risk 16 - Off-Site Area Sterilisation and Disinfection Unit Service.

The Committee is invited to:

- note the corporate risks detail as at 17 August 2023 at Appendix 1;
- consider the Deep Dive Review provided at Appendix 2;
- review the information provided against the Assurance Principles at Appendix 3, and the Risk Matrix at Appendix 4;
- consider and be assured of the mitigating actions to improve the risk levels;
- conclude and comment on the assurance derived from the report; and
- confirm the deep dive review to be provided for the next Committee

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

2.3 Assessment

As previously reported, the overall Strategic Risk Profile contains 18 risks.

- No risks have been closed.
- No new risks have been identified.
- Risk 3 - COVID 19 - has reduced its current rating within risk level

The updated Strategic Risk Profile is provided at Table 1 below.

Strategic Risk Profile

Table 1

Strategic Priority	Total Risks	Current Strategic Risk Profile				Risk Movement	Risk Appetite
To improve health and wellbeing	5	2	3	-	-	▲ (rating reduced within level)	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.

The Committee is asked to note that the majority of corporate risks remain outwith the Board's risk appetite; this reflects the current organisational context and the ongoing challenges across all areas of service delivery.

The risks aligned to this Committee are summarised in Table 2 below and set out at Appendix 1.

Strategic Priority	Overview of Risk Level	Risk Movement	Corporate Risks	Assessment Summary of Key Changes
To improve health and wellbeing	1 1 - -	▲ (rating)	• 3 - COVID 19 Pandemic • 5 - Optimal Clinical Outcomes	Risk 3 - COVID 19 Pandemic. Mitigations updated. Risk rating reduced within moderate level.
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	Mitigations updated and target date added for Risk 16. Mitigations updated for risks 17 and 18.

Key Risk Updates

Risk 3 - COVID 19

The Public Health Assurance Committee (PHAC) reviewed this risk on 2 August 2023. Members agreed that the risk rating should be lowered from Moderate 12 (L- 3 x C- 4 to Moderate 9 (L- 3 x C- 3) in light of the continued effectiveness of vaccination and the reduced impact of illness in the population.

Proposed next steps are to revisit the deep dive review carried out in March 2023. Based on that assessment, a decision will be taken through the appropriate governance routes to retain or close as a corporate risk.

The Committee is advised that there is recognition of a longer term risk around preparedness for future biological threats (including pandemics). This will require to be considered for inclusion in the Corporate Risk Register. A risk scoping exercise led by a Consultant in Public Health has started. The risk will be presented In due course to EDG and the appropriate governance groups and committees for a decision.

Risk Target Date

It was previously reported, that an indicative target date, rather than a date fixed at year end, should be set for each risk. All risks aligned to this Committee now have an indicative target date.

Deep Dive Reviews

Deep dive reviews will continue to be commissioned by the governance committees, or via a recommendation from EDG or the Risks & Opportunities Group. Going forward, generally, though not exclusively, these will be carried out on deteriorating corporate risks, associated with the committee's remit.

The current Deep Dive review schedule is as follows:

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

The Associate Director of Digital & Information has proposed that the schedule is altered to consider Risk 18 - Digital & Information, at the November meeting, and then take Risk 17 - Cyber Resilience, at the January meeting. This would allow the presentation of evidence to satisfy the Internal Audit action B08/23 -11- relating to the D&I Workforce Plan as a component of the D&I Strategy, and an assessment of its implementation and effectiveness.

Next Steps

The revised Assurance Levels model introduced in July 2023, will continue to be embedded in the corporate risk papers and deep dive reviews, and implementation monitored. Supporting guidance is being developed.

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

The format and content of the Register and corporate risk reports will continue to evolve; feedback from Committees and other stakeholders will be used to inform a consensus on priority areas for further development and / or improvement in terms of assurance.

Connecting to Key Strategic Workstreams

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

Effective management of financial risks will support delivery of our strategic priorities including delivering value and sustainability.

2.3.4 Risk Assessment / Management

The management of the corporate risks aligned to this committee continues to be maintained, with risk reporting provided to the Clinical Governance Oversight Group, the Digital and Information Board, the Infection Control Committee and the Public Health Assurance Committee as applicable, to show that all actions, within the control of the organisation, are being taken to mitigate the risks as far as it is possible to do so.

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

- This paper reflects a range of communication and engagement including with the Executive Director's Group on 17 August 2023.

2.3.8 Route to the Meeting

- NHS Fife Clinical Governance Oversight Group on 22 June 2023
- Alistair Graham, Associate Director of Digital & Information on 29 August 2023
- Neil McCormick, Director of Property & Asset Management on 29 August 2023
- Dr Chris McKenna, Medical Director on 29 August 2023
- Dr Shirley - Anne Savage, Associate Director of Quality & Clinical Governance on 29 August 2023
- Dr Joy Tomlinson, Director of Public Health on 29 August 2023

2.4 Recommendation

- Assurance

3 List of appendices

The following appendices are included with this report:

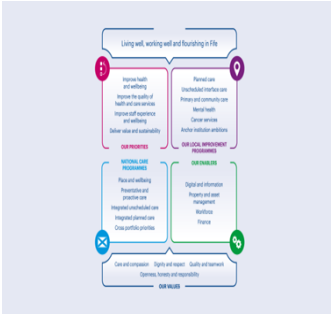
- Appendix No. 1, Summary of Corporate Risks Aligned to the Clinical Governance Committee as at 31 August 2023
- Appendix No. 2, Deep Dive Review - Off Site Area Sterilisation and Disinfection Unit Service
- Appendix No. 3, Assurance Principles
- Appendix No. 4, Risk Matrix

Report Contact
Pauline Cumming Risk Manager, NHS Fife Email: pauline.cumming@nhs.scot

Appendix 1

Summary of Corporate Risks Aligned to the Clinical Governance Committee as at 31 August 2023

	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 are no variants currently under investigation. 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. A deep dive was presented to CGC in March 2023 and will be updated in October 2023.	Mod 9 (3x3)	Mod 12 (4x3) by October 2023	◄►	Below	Director of Public Health

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.  A deep dive was presented to the CGC in May 2023. Following discussion, a Clinical Governance Committee Development Session on Optimal Clinical Outcomes is to be held to discuss this risk in more detail. A date for the session is to be identified.	High 15 (5x3)	Mod 10 (5x2) by 31/03/24	◀ ▶	Within	Medical Director

	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. A deep dive review was presented to the CGC in July 2023. This resulted in an agreement to review the risk scores given that several actions had been completed reducing the risk likelihood. The review is underway.	High 15 (5x3)	Mod 10 (5x2) by 31/03/24	◄►	Above	Medical Director

	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. A Deep Dive review on this risk will be presented to the CGC on 08/09/23.	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 primary mechanism for prioritising items is the response to the Network Information Systems Directive (NISD) review report May 2022. Next audit due July 2023, with final report made available by 1 September 2023.	High 16 (4x4)	Mod12 (4x3) by Sept 2024	◄►	Above	Medical Director
18	**Digital & Information (D&I)**	Consistent alignment of the D&I Strategy with the NHS Fife Corporate	High 15	Mod 8 (4x2)	◄►	Above	Medical Director

	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.	Objectives and developing Health & Wellbeing Strategy. Active review of the Strategy deliverables against current strategic objectives. This includes financial and workforce planning. Digital & Information Board Governance established and supporting prioritisation with ongoing review.	(3x5)	by April 2025			

Risk Movement Key

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

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**8 September 2023**
Title:	**Corporate Risk - Deep Dive: Off-Site Area Sterilisation and Disinfection Unit Service**
Responsible Executive:	**Neil McCormick, Director of Property & Asset Management**
Report Author:	**Neil McCormick, Director of Property & Asset Management**

1 Purpose

This report is presented for:

- Assurance
- Discussion

This report relates to:

- Local policy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This paper is brought to the Committee as part of the reporting to the Governance Committees on the corporate risks and provides a Deep Dive into the Risk - Off-Site Area Sterilisation and Disinfection Unit Service.

The Committee is invited to:

- Consider the Deep Dive Review

2.2 Background

The Corporate Risk Register aligns to the four 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

2.3 Assessment

Deep Dive Review of Corporate Risks

It is essential to provide assurance on the management of our corporate risks. To contribute to this aim, Deep Dive reviews have been commissioned for specific risks via the following routes:

- Governance Committees
- Executive Directors' Group (EDG)
- Risks & Opportunities Group (ROG) with recommendations into EDG

A Deep Dive on the following risk has been prepared for members' attention:

Risk Title	Aligned Committee
Off-Site Area Sterilisation and Disinfection Unit Service	Clinical Governance (CGC)

Corporate Risk Selected for "Deep Dive"

Deep Dive Review on Corporate Risk 9 - Quality and Safety

Corporate Risk Title	**Off-Site Area Sterilisation and Disinfection Unit Service**			
Strategic Priority	**To Deliver Value & Sustainability**			
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 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.			
Root Cause (s)	NHS Fife have been experiencing quality issues with the service provided from Sterile Services in Tayside since April 2021. These manifest as damaged trays, holes in drapes, foreign matter, wrong parts, missing parts and labelling issues. There has been a total number of 263 Datix incidents generated between 1st April 2021 to 25th May 2023. While the majority of events are recorded as having no harm in terms of impact, there are multiple impacts on quality & safety, resource utilisation, cost of reprocessing, business continuity, and workforce including rework. There have been instances where procedures have had to be postponed affecting the patient experience.			

	NHS Tayside have experienced two major incidents in the past two years, once in April 2021 and another in March 2023; on both occasions there has been a significant impact on the service, resulting in no tray deliveries for up to 6 days. Furthermore, the provider's contingency plans are not robust and, on both occasions, have not been activated, putting our emergency, obstetric and trauma services at risk. The problems are caused by: - • The ageing plant and lack of resilience in the Central Decontamination Unit (CDU) in Tayside. • The increasing demand due to elective workloads from Tayside and Fife meaning that the unit is working at full capacity with little down time. • Unsatisfactory contractual arrangements through a Service Level Agreement (SLA) with Tayside. • A lack of a proper track and trace system which causes significant problems during periods of disruption.		
Current Risk Rating ([LxC] & Level (e.g. High Moderate, Low)	**Likelihood -** Likely 4	**Consequence -** Moderate 3	**Level -** Moderate 12
Target Risk Rating([LxC] & Level (e.g. High, Moderate, Low)	**Likelihood -** Unlikely 2	**Consequence -** Moderate 3	**Level -** Low 6

Management Actions (current)

Action	Status	Impact on Likelihood/ Consequence
Ensure that mitigations are in place to ensure that no trays are damaged while they are handled and stored in NHS Fife to include new racking and training • Staff have received training in the safe handling of trays. Training is being repeated on a yearly basis. • Staff must inspect each tray prior to loading on to storage system. • New racking system installed early March 2022 costing £27,000 and prevents the stacking of trays. • Tins have been purchased to protect our heavy trauma and orthopaedic trays in early 2022 costing £29,000. • A trial of foam corners has been instigated by Tayside	Complete	Reduced Likelihood
Ensure that contingency stock has been procured to mitigate the effects of any down-time on the service to include: - • At least 3 Days of Trauma trays • At least 3 days of obstetric trays	Complete	Reduced Consequence
Consideration being given to increasing stock to 7 days for Trauma and Obstetric trays.	On Track ongoing	Reduced Consequence
Manage the SLA appropriately and consider changes to allow quality issues to be identified and treated seriously and in a timely mannner. • Regular Liaison meetings to discuss issues with the service have been taking place since 2021 • Discussions are taking place about changing some of the terms in the SLA to allow defective trays to be identified at point of use rather than at point of delivery (July 2023)	On Track ongoing	Reduced Consequence
Consider alternative providers to determine whether value for money is being provided and whether increased resilience can be provided.(work	On Track ongoing	Reduced Likelihood

has been undertaken by Theatres over the last 6 months)		
Involvement and influencing the National group looking at capacity and resilience in CDU provision across Scotland. This group, facilitated by National Services Scotland (NSS) will make recommendations to the Scottish Government (SG) about how best to increase capacity and resilience within NHS Scotland. This Group was convened in 2021.	On Track ongoing	Reduced Likelihood
Work with Regional partners to identify synergies in service delivery including the developing business plan for reprovision of CDU capacity within NHS Lothian (raised in regional meetings over the last 2 years)	On Track ongoing	Reduced Likelihood
Raise the profile of this issue at National Estates and Facilities Fora including National Strategic Facilities Group which includes key representatives from NSS and SG (most recently raised at Risk Workshop in June 2023)	On Track ongoing	Reduced Likelihood
Management Actions (future)		
Action	**Status**	**Impact on Likelihood/ Consequence**
Develop a business case to consider the options of re-provision with another provider and the long term aim of the provision of a CDU within Fife which could provide resilience to the East Region and NHS Scotland	Significant level of delivery challenge	Reduced Likelihood

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

2.3.1 Quality / Patient Care

Effective management of risks will support delivery of our strategic priorities, to improve the value and sustainability of our services.

2.3.2 Workforce

There are major workforce implications of changing the delivery of CDU services from the current provision that will need to be considered as part of any proposal for change.

2.3.3 Financial

There are significant costs involved in the delivery of decontamination services and these need to be considered in line with the requirement for robustness and quality of service. Any proposals for change will have to clearly identify the costs and benefits as part of a cost benefit appraisal.

2.3.4 Risk Assessment / Management

Subject of the paper.

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

No Assessment has been carried out.

2.3.6 Climate Emergency & Sustainability Impact

This paper does not raise, directly, issues relating to climate emergency and sustainability.

2.3.7 Communication, involvement, engagement and consultation

This paper reflects a range of communication and engagement over time.

2.3.8 Route to the Meeting

- NHS Fife Decontamination Group, 11 August 2023
- Executive Director's Group, 17 August 2023
- NHS Fife Clinical Governance Oversight Group on 22 August 2023

2.4 Recommendation

The Committee is invited to:

- Discuss and take assurance from the Deep Dive Review

3 List of appendices

The following appendices are included with this report:

None

Report Contact
Neil McCormick
Director of Property & Asset Management
Email neil.mccormick@nhs.scot

Assurance Principles

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

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

CLINICAL GOVERNANCE COMMITTEE

DATES FOR FUTURE MEETINGS

Date
Friday 3 May 2024
Monday 8 July 2024
Friday 6 September 2024
Monday 4 November 2024
Monday 6 January 2025
Friday 7 March 2025

Please note that all meetings take place via **MS Teams** / in the **Staff Club** (TBC) and start at **10am**

A pre-meeting of Non-Executive Members is routinely held, beginning at **9.15am**

* * * * *

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**			✓			
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**		✓				
Annual Statement of Assurance for Clinical Governance Oversight Group	**Medical Director / Associate Director of Quality & Clinical Governance**		✓				**To be included in Ass. Statements in May 2024**
Committee Self-Assessment Report	**Board Secretary**						✓
Corporate Calendar / Committee Dates	**Board Secretary**			✓			

Governance Matters (cont.)							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
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**	✓ **Cyber Resilience**	✓ **Digital & Information**	✓
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 2023/24	**Director of Finance & Strategy / Associate Director of Planning & Performance**	**Deferred to July**	✓	✓	✓	✓	✓
Cancer Strategic Framework	**Medical Director**				✓		
Clinical Governance Strategic Framework	**Medical Director / Associate Director of Quality & Clinical Governance**						✓
Clinical Governance Delivery Plan	**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**		
Development Assistant Practitioner Role	**Director of Nursing**	✓					

Strategy / Planning (cont.)							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Integrated Unscheduled Care	**Medical Director**	✓			✓		✓
Medium Term Plan	**Director of Finance & Strategy**				✓		✓
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**				
Safer Management of Controlled Drugs	**Director of Pharmacy & Medicines**				✓		
Nursing & Midwifery Professional Assurance Framework	**Director of Nursing**	**2 yearly report – due September 2024**					
Covid Mortality Report	**Medical Director**	**TBC**					
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 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**			✓

Digital / Information (cont.)							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
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**	✓	✓	✓	✓	✓	✓
Volunteering Report	**Director of Nursing**				✓		
Annual 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 *(also goes to PHWC)*	**Director of Nursing**	✓					
Allied Health Professional Assurance Framework	**Director of Nursing**	**Deferred to July**	**Deferred to Sept.**	✓			
Annual Resilience Report	**Director of Public Health**	**Partial Assurance Statement**			✓ **Mid-year Assurance Report**		✓ **Annual Report**
Clinical Advisory Panel Annual Report	**Medical Director**		✓				
Controlled Drug Accountable Officer Annual Report	**Director of Pharmacy & Medicines**			✓			
Director of Public Health Annual Report *(also goes to PHWC)*	**Director of Public Health**		✓				
Equality Outcomes Progress Report	**Director of Nursing**					✓	
Fife Child Protection Annual Report *(also goes to PHWC)*	**Director of Nursing**	**Deferred to July**	✓				
Hospital Standardised Mortality Ratio (HSMR) Update Report	**Medical Director**				✓		

Annual Reports (cont.)							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Integrated Screening Annual Report	**Director of Public Health**	**Will be presented to the Public Health & Wellbeing Committee only**					
Medical Education Report	**Medical Director**				✓		
Medical Appraisal and Revalidation Annual Report	**Medical Director**				✓		
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 *(also goes to PHWC)*	**Director of Nursing**				✓		
Prevention & Control of Infection Annual Report	**Director of Nursing**				✓		
Radiation Protection Annual Report	**Medical Director**	✓					
Research & Development Progress Report & Strategy Review	**Medical Director**					✓	
Research, Innovation and Knowledge Annual Report	**Medical Director**					✓	
Review of Deaths of Children & Young People	**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			TBC	TBC	TBC

Linked Committee Minutes (cont.)							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Cancer Governance & Strategy Group	**Medical Director**	✓ 30/03	✓ 31/05		✓ 17/08	✓ 02/11	
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	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	✓ 07/09	✓ 07/12	
Mental Health Estates Initial Agreement	**Medical Director**	**Deferred to July**	**Deferred – date tbc**				
Medical Devices	**Director of Property & Asset Management**	✓					

Ad Hoc Items							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
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**			✓			
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	**Medical Director**	**TBC**					

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**8 September 2023**
Title:	**Annual Delivery Plan 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:

- Assurance

This report relates to:

- Annual Delivery Plan 2023/24

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, following request for further information, on 26 June.

This paper provides the committee with assurance that the ADP has now been agreed with the Scottish Government.

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.

The ADP is focussed on planning for the 10 Scottish Government recovery drivers:

1. Primary and Community Care
2. Urgent and Unscheduled Care
3. Mental Health
4. Planned Care
5. Cancer
6. Health Inequalities
7. Innovative healthcare and technologies
8. Workforce
9. Digital
10. Climate Change

2.3 Assessment

Following submission of the ADP documents on 8 June, formal feedback from Scottish Government policy departments was received on 28 June 2023.

NHS Fife responded to the feedback and submitted a formal response to the feedback on 26 July 2023. Our response includes a revised version of the ADP1 with additional information in the dental and diabetes sections.

Formal sign off of the ADP from Scottish Government was received on 11 August 2023 and the revised ADP and sign off letter from the Scottish Government has been attached for formal approval.

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

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

- Executive Directors' Group 17 August 2023
- Public Health & Wellbeing Committee 4 September 2023

2.4 Recommendation

The committee is asked to:

- Take **assurance** from the Annual Delivery Plan 2023/24
- **Note** the ADP Review Feedback for 2023/24

3. List of appendices

1. Annual Delivery Plan 2023/34
2. Annual Delivery Plan Sign Off letter from Scottish Government

Report Contact

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Associate Director of Planning and Performance

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NHS Fife

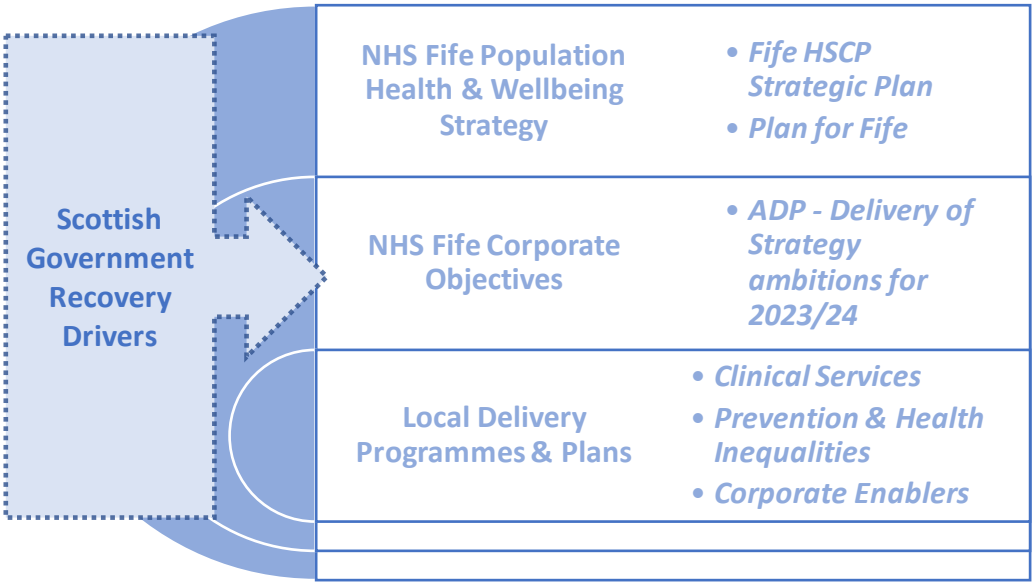
Population Health & Wellbeing Strategy

Annual Delivery Plan 1 2023/24

Table of Contents

Planning Context

This Annual Delivery Plan sits as part of the overall planning context for NHS Fife. The newly approved NHS Fife Population Health and Wellbeing Strategy has established the strategic priorities for our organisation, this Annual Delivery Plan describes our key areas of focus for the first chapter of the strategy in 2023/24.



The plan confirms the alignment across our strategic priorities and corporate objectives for 2023/24 to the Scottish Government Recovery Drivers. The sections below illustrate this alignment and also highlights additional corporate objectives identified by NHS Fife.

	Strategic Priority 1: To improve health and wellbeing	Recovery Driver
1	Progress the business case for the mental health services programme	3. Mental Health
2	Support the ADP in the delivery of MAT standards	6. Health Inequalities
3	Develop a prevention and early intervention strategy, and delivery plan, to support health improvement and address inequalities	1. Primary & Comm Care 6. Health Inequalities
4	Develop a primary care strategy and supporting delivery plan	1. Primary & Comm Care
5	Develop and deliver a system wide medicines safety programme	Local Priority

	**Strategic Priority 2:** **Improve quality of health and care services**	**Recovery Driver**
1	Implement redesign and quality improvement to support mental health services	3. Mental Health
2	Review and redesign the Front Door model of care to support improvements in performance	2. Urgent & Unsch Care
3	Deliver an ambulatory care model supporting admission avoidance and early appropriate discharge	2. Urgent & Unsch Care
4	Further develop Queen Margaret Hospital as centre of excellence for ambulatory care and day surgery	4. Planned Care 5. Cancer Care
5	Develop and deliver an improved patient experience response process to support a culture of person-centred care	Local Priority
6	Delivery year 1 of Planned Care Recovery Plan	4. Planned Care 5. Cancer Care

	**Strategic Priority 3:** **Improves staff health and wellbeing**	**Recovery Driver**
1	Collaborate with University of St Andrews to develop the ScotCOM medical school	7. Innovation
2	Develop and deliver an action plan to support safe staffing legislation	8. Workforce
3	Develop and deliver a sustainability plan for the nursing and midwifery workforce	8. Workforce
4	Deliver specific actions from the workforce strategy to support both patient care and staff wellbeing	8. Workforce
5	Develop and deliver a leadership framework to increase team performance	8. Workforce

	Strategic Priority 4: Deliver value and sustainability	Recovery Driver
1	Deliver year one actions of the financial improvement and sustainability programme	B. Finance & Sustainability
2	Implement actions to support climate emergency	10. Climate
3	Develop the digital medicines programme	9. Digital

	Cross-cutting actions	Recovery Driver
1	Develop a corporate communications and engagement plan	Local Priority
2	Develop the strategic plan to secure teaching health board status	Local Priority
3	Deliver Anchors ambitions working collaboratively with partners	6. Health Inequalities

Section A: Recovery Drivers

1. Primary & Community Care

NHS Fife Corporate Objectives 2023/24 mapped to this Recovery Driver are:

To improve health and wellbeing

- *Develop a prevention and early intervention strategy, and delivery plan, to support health improvement and address inequalities*
- *Develop a primary care strategy and supporting delivery plan*

1.1 Care in the Community and enhancing a focus on Preventive Care

Following a period of review and extensive engagement, Fife HSCP are currently refreshing our Primary Care Improvement Plan (PCIP) to make sure plans will provide the best opportunity for General Practitioners to fulfil their crucial role as Expert Medical Generalists. This refreshed plan will focus on stabilising and creating consistency in terms of multi-disciplinary support for Practices across Fife, in particular with regards to services which haven't been fully implemented.

In line with MOU (Memorandum of Understanding) 2, we have been carrying out a focused piece of work to develop our CTAC (Community Treatment and Care) services to both create a level of consistency in service provision across Practices, whilst allowing for the enhancement of services across Primary Care. This has already seen the commencement of the following initiatives:

- Working with Podiatry to bring all Low-Risk foot screening under the responsibility of CTAC Services
- Working with ENT and Audiology services to develop joint Ear Care strategy
- Leg ulcer specialist clinics

In line with a wider review of Leadership and Governance, Primary Care Contracting services and associated services, work is ongoing to review the integration of Primary Care nursing teams, to provide more sustainable workforces but also equitable provision of Immunisation, CTAC and Chronic Disease Management.

This work will be brought together in a Primary Care Strategy and Delivery Plan which underpins both the Population Health and Wellbeing Strategy and Health and Social Care Strategic Plan and focuses on the important role of all Primary Care Providers supporting:

- Recovery of Primary Care
- Quality within Primary Care
- Sustainability across Primary Care services

Another shared commitment in the Population Health and Wellbeing Strategy and HSCP Strategic plan focuses prevention and early intervention aligned to the national health and wellbeing outcome and Public Health priorities. We will demonstrate through the Prevention and Early Intervention strategy and delivery plan the steps we can take in the next few years to address health inequalities to enable everyone living in Fife to have the same chance of getting the best care or support they need. This will follow a life course approach, preventing, or limiting

problems arising so people's lives will be healthy and people can remain independent for longer. To achieve this our mission is to build a culture of prevention, involving all partners across Fife, including communities and individuals, to make sure we are as good at preventing health and social care problems as we are at treating them.

1.2 Delivery of a sustainable Out of Hours service

To support our strategic ambition of sustainable and accessible Primary urgent care services, we are expanding our current system wide Urgent Care Infrastructure. This will further integrate 24/7 urgent care models across Primary care. This work will focus on the continuation of developing urgent care pathways within Out of Hours Primary Care, integrating staffing models in and Out of Hours to develop a resilient and sustainable workforce. The overall ambition is to develop plans for 24/7 'Urgent Care Hubs', interfacing between Primary and Secondary care, create sustainable workforces across Urgent Care Services and create consistent Urgent Care support to Primary Care.

1.3 Aligning Primary Care with Mental Health and Wellbeing resources

In line with the Scottish Government vision for the future of primary care services, we are enabling multidisciplinary working to support people in the community and to free up GPs to spend more time with patients in specific need of their expertise.

The approach focuses on multidisciplinary working to reduce pressures on services and ensure improved outcomes for patients with access to the right professional, at the right time, as near to home as possible.

The key goal of the project is to develop and plan for the establishment of multidisciplinary Mental Health and Wellbeing in Primary Care and Community Services (MHWPCS) within GP clusters or localities, which will include:

- An Integrated Community Based System
- The Promotion of Fife Population Mental Health and Wellbeing
- Strengthening and Improving Formal and Informal Mental Health Care Provision
- Placing service users at the heart of design and planning

We have identified three initial test sites for this work to take learning across different localities within Fife who each have different needs including Cowdenbeath, North East Fife and Levenmouth. A critical part of this process is enabling co-production which is underway with the locality planning groups to shape the design and range of supports that need to be available in the mental health and wellbeing hubs and inform the future roll out across the 7 localities of Fife.

1.4 Early detection of key cardiovascular conditions

The delivery plan supporting this strategy will inform the actions being taken including:

- Working closely with the Heart Disease Managed Clinical Network in Fife and will also link to the Women's Health Plan which aims to reduce cardiovascular risk in women in particular.
- We will continue integrated service improvement plans to increase capacity for early intervention and implementation which will support, empower and enable people to prevent, reduce and/or improve cardiac health risks working across services and with our partners in local authority and third sector.

- Developing low risk chest pain pathways to ensure care in the right place and right time.
- Work collectively to improve service capacity for early detection and anticipatory care planning for cardiovascular risk factors including for example Community Treatment and Care (CTAC) in line with national planning and direction.

Specific projects are under way and ongoing in Fife in relation to diabetes prevention and weight management services:

- Health Promotion Dietitians obtained additional funding from Scottish Government, to build local capacity and strengthen support around childhood obesity prevention in the early years. The bid was in partnership with Fife Council Early Years team and NHS Lothian to implement the HENRY core training train the trainer (TTT) package to produce 8 HENRY trained facilitators (4 in Fife). HENRY core training builds the skills, confidence, and knowledge of the early years workforce to support families to lead healthy lifestyles by providing practical support on healthy eating, physical activity and parenting strategies around food and behaviour. Core training, as part of TTT model, took place across Fife and was offered to the early year's workforce: To date Fife has trained 92 members of the early years' workforce in this approach with more scheduled to be trained.
- Family focused sessions, relating to Child Health Weight, are supporting being active as a family and working together to make small healthy changes.
- Diabetes Prevention Programme 'Let's Prevent Diabetes' is a six-hour course that empowers individuals to make positive lifestyle changes to prevent or delay the onset of type 2 diabetes. This is delivered face to face, online or digitally. This programme forms part of the national Diabetes Education and Self-Management for Ongoing and Newly Diagnosed (DESMOND) package of support, designed by the NHS and Leicester Diabetes Centre. All individuals are invited to a weight management programme, where appropriate.
- Operationalised pathway supporting diet and lifestyle management of gestational diabetes to help achieve optimal blood glucose control to reduce associated complications for both mother and baby. Let's Prevent Diabetes programme offered post-partum to reduce risk of developing type 2 diabetes. Weight management support offered post-partum as appropriate.
- A two-year intensive weight loss programme which aims to help those living with type 2 diabetes to achieve and maintain remission. Involves total diet replacement, food reintroduction and maintenance phases. Based on evidence from the Diabetes Remission Clinical Trial (DiRECT).
- Various Weight Management Programmes supporting diet and behaviour changes which can lead to the improved management of the key cardiovascular risk factor conditions.
- Operationalised pathway supporting individuals before and after bariatric surgery. Sustained diet and behaviour changes along with significant weight loss can result in improved management of the key cardiovascular risk factor conditions.

1.5 Frailty in Primary Care

Approach adopted will be to:

- Build the capacity of the existing MCN service to include an MCN for Frailty

to ensure that people with frailty in the community can be cared for utilising recognised national approaches placed into a local framework.

- Reduce the need for double up packages of care whilst utilising a variety of techniques and equipment to achieve better outcomes for people, to use resources more efficiently and effectively, reduce delays, release capacity, improve flow and provide a more flexible service.
- Review and redesign of Assessment and Rehabilitation Centre model to achieve better outcomes for people, early intervention, and prevention to manage those at most risk of admission, use resources more efficiently and effectively, increase capacity and provide a more flexible service.
- All Fife Care Home residents will have an anticipatory care plan in place. The ACP will be shared with MDT including GPs to anticipate any decompensation in long term condition and pro-actively manage symptoms and offer support to avoid admission to hospital. ANPs are in the process of being recruited and will be aligned to locality care homes to facilitate a first point of contact for care home staff to redirect and offer support to avoid admission.

1.6 Dental Care

Much like the rest of Scotland there are ongoing challenges with recruiting and retaining NHS Dentists across Fife, with many dental practices having very limited cover and access arrangements in place for NHS patients registered with them or capacity to register new patients.

Dental practitioners are independent contractors and own their own businesses, with many providing NHS care along with private practice. There are a number of complex reasons why dental services are experiencing significant challenges including the backlog created during the pandemic along with issues of recruitment and retention and the impact of Brexit.

National indicators to measure access are being developed and will include number of dentists resigning from dental list and joining dental list. This will be a useful measure of workforce but will not accurately capture WTE and hours working on NHS dental care versus private care. This level of data is not available. Independent dental contractors advertise for posts and NHS Fife only has responsibility for recruiting to the Public Dental Service (PDS). NHS Fife, like other NHS Boards, are experiencing challenges recruiting.

The Dental Management Team are proactively working with Dental Practices across Fife to explore ways to facilitate and improve patient access. Our NHS Fife Dental Advice line links in with practices on a fortnightly basis to monitor and evaluate capacity for registering new NHS patients. Currently the position in Fife is that no practices are in a position to register new NHS patients although a few practices are offering a waiting list with the expectation of new patients being able to access appointments in the autumn/winter.

The current guidance for people in Fife who are experiencing acute dental pain, and are not registered with a dentist, is to call the Dental Advice Line which is staffed by members of our NHS Fife Public Dental Service (PDS) (Monday to Friday, 8.30am – 5.00pm) with a commitment that they will receive dental care within 24 hours.

The PDS also offers a short course of care to get people dentally ‘stable’, and currently we have 5 sites (Randolph Wemyss Memorial Hospital, Rosyth,

Cowdenbeath, Cardenden and Kirkcaldy access) across Fife where we are able to provide this service.

The PDS in Fife is committed to providing support, access and treatment to patients who are non-registered or de-registered as a result of the reduction of NHS GDS provision. The PDS are having to see registered General Dental Practitioner (GDP) patients as a number of practices can't recruit and have limited capacity to see their own patients. This is in addition to the pressures of the backlog in core services due to the pandemic.

The Scottish Government recently advised NHS Boards of a further revision of the Scottish Dental Access Initiative (SDAI) capital scheme to include four areas in Fife- Tayport, Newburgh, Leslie and Auchtermuchty which will take effect from 26 April 2023. It is hoped that this initiative will attract interest from dental practices.

In Q1 of 2023/24, we will explore ways to maximise capacity to increase access to dental care to get people dentally stable e.g., evening clinics. We will aim by Q2 to recruit to small test of change sites to deliver extended day time service to meet urgent needs of unregistered/deregistered patients.

Test of change proposal from Q2 is a pilot initiative being developed to provide short courses of targeted care in order to ‘stabilise’ patients’ oral health. This service will be provided out of hours to reduce the impact on the PDS in-hours. Control measures will include ensuring the patients are signposted to the correct service. An options appraisal has been worked through and a preferred model is being worked up. The success of the pilot will be reliant on dentists and dental nurses and administrative staff coming forward to work in the service, which will be in addition to their normal contracted hours. The Dental SMT are very aware of potential unintended consequences and reducing risks so as not to destabilise current services, particularly the OOH dental service. Successes from these tests of change will used to spread and sustain service from Q3.

The HSCP Primary Care Strategy 2023/2024 will focus on recovery, quality, and sustainability across all of primary care including GDS and PDS. Implementation of this will commence from August 2023. A delivery plan will ensure a focus on developing a sustainable workforce within dental services working collectively with independent contractors and the PDS to improve access to service across Fife.

Primary Care will explore innovative ways to maximise current workforce capacity to deliver dental care and optimise outcomes.

1.7 Delivery of hospital-based eyecare in a primary care setting

Optometry has been assisting colleagues within secondary care through shared care schemes since the COVID pandemic focusing mainly on emergency and glaucoma eyecare. This has allowed upskilling of optometrists for future national schemes meaning optometrists can undertake more specialist work on behalf of the hospital through such qualifications as independent prescribing and Glaucoma (NESGAT).

To alleviate the burden of glaucoma care on the hospital eye clinic, plans are well underway with the aim of ‘going live’ in April 2024, recognising that locally within Fife we have a well-established Shared Care arrangements in place for eye care, including emerging eye care and Glaucoma.

Review of current Shared Care provision will take place in collaboration with Secondary Care during Q1 2023/24 with development of local plans in Q2 to

transition to National Shared Care model. There will be ongoing support throughout 2023/24 to enhance qualifications for Optometrists.

1.8 Infection, Prevention and Control (IPC) support to Primary Care

We are implementing the IPC Workforce Strategy 2022-24 with the goal of having an appropriately skilled, resilient, sustainable, and confident workforce working in an integrated way. Delivering evidence-based advice, guidance and interventions appropriate to localised need in both acute and community settings.

An oversight board is currently being convened to develop a Local Integrated Service Delivery Plan (LIDP) in response to implementing the IPC Workforce Strategy 2022-24.

The oversight board is being led by the Director of Nursing and HAI Executive and supported by the Infection Control Manager to review current service provisions and focusing on how the AMS, HP and IPC workforce could be strengthened in the short term whilst planning for a more sustainable long-term position.

The oversight board will link in with professional groups and the Primary Care workforce specialists in these areas when undertaking the review and prepare an action plan considering what additional roles and resources are required.

2. Urgent & Unscheduled Care

NHS Fife Corporate Objectives 2023/24 mapped to this Recovery Driver are:

To improve quality of health and care services

- *Review and redesign the Front Door model of care to support improvements in performance*
- *Deliver an ambulatory care model supporting admission avoidance and early appropriate discharge*

2.1 Reducing Attendances: Phase 2 Redesign Urgent Care

2.1.1 Review and Further Development of Flow and Navigation Centre

Access will be improved through the development and optimisation of pathways, scheduling and virtual capacity pathways to deliver care closer to home and provide the right care in the right place.

We will appraise the current established workforce model for the Flow Navigation Centre (FNC) and develop this further to ensure the model adds value ensuring a whole system approach to accessible pathways in line with national and local strategic direction and that we remain financially effective. We will also continue our progression to further develop our virtual triage (RTU) and scheduling to Minor Injury Units (MIU) including paediatrics, with a review of resource and capacity across the three sites, in addition to testing a scheduling model to our Rapid Triage Unit (RTU). By focussing on our model of virtual triage from NHS 24 flow we have increased our redirection rate by 29% from ED to QMH MIU.

To reduce unscheduled admissions and keep care closer to home, we will also be reviewing and developing further pathways in social care, respiratory, heart failure and mental health. We are also looking to scale up from earlier TOCs around Call Before Convery (CBC) embedding the learning from these to become a business-as-usual model.

Connections to national best practice and learning opportunities will continue.

2.1.2 'Scheduling' unscheduled care

We are planning to improve scheduling processes within FNC increasing the use of NearMe, where appropriate and further utilise the Rapid Triage Unit (RTU) and ambulatory models of care as a means of scheduling patients to ensure patients are directed to the right place. As examples we have increased our capacity for patient's requiring access to DVT and OPAT pathways with concurrent increases in nurse numbers and skill mix to develop nurse led approaches for these services.

2.1.3 An integrated approach to all urgent care services

We will expand on the current system-wide Urgent Care Infrastructure to develop more integrated, 24/7 urgent care models, sustainable workforce across Urgent Care Services and consistent Urgent Care support to Primary Care in hours.

We will expand on the current system-wide Urgent Care Infrastructure to develop more integrated, 24/7 urgent care models, a sustainable workforce across Urgent

Care Services and consistent Urgent Care support to Primary Care in hours. This will align with the continued implementation of the Primary Care Improvement plan 2023/24 and national planning and direction as the model of 24/7 urgent care evolves.

We will implement year 1 of the delivery plan underpinning the HSCP Primary Care Strategy 2023/2026 with a strategic focus on recovery, quality improvement and sustainability.

We will work collectively to develop, refine and embed a performance framework with clear and consistent data and defined KPIs to provide assurance regarding delivery and target improvement.

We will deliver a refreshed communication plan to support, enable and empower people to access care in the right place with the right person first time.

As part of an integrated approach, we are committed to improving our ED 4-hour performance target and have an agreed action plan covering the following improvements.

- Improve virtual triage at Queen Margaret Hospital to redirect patients from VHK
- Review ENT/OMFS protocols to support in-reach and faster transfers to ward
- Review orthopaedic assessment protocols to achieve faster transfers to assessment
- Evaluate Push Model to avoid patients breaching in ED and reduce overcrowding
- Evaluate ED call before you convey outcomes comparing to FNC Call before you Convey
- Stroke Thrombolysis review – earlier moves to MHDU to support stroke bundle performance
- Reduce Ambulance Waits and improve turnaround times to 30 mins max.
- Optimise triage further – expand nursing workforce to support with agreed escalations for 1st assessment breaches
- Improve use of data –performance/bed waits/site capacity- development of dashboard and visibility within the dept
- Review all ED protocols to ensure tests and results can be undertaken and completed within 4 hours
- Further improve minors performance and sustain at above 95%
- Improve night and weekend medical cover at senior clinical decision-making level
- Reintroduce frailty practitioner with direct moves to RAD/RADU
- Redirection protocols with primary care/OOH/AU1/community teams to be adhered to
- Closer links with mental health and potential of co-location with UCAT on site
- Agreement of medical model redesign

Figure 1 – Victoria Hospital ED 4-hour Performance Trajectory

	Week Ending									
	25-Jun	30-Jul	27-Aug	24-Sep	29-Oct	26-Nov	31-Dec	28-Jan	25-Feb	31-Mar
VHK ED 4 hour %	70.3%	71.8%	73.1%	74.3%	75.8%	77.0%	78.5%	79.8%	81.0%	82.5%

2.2 Reducing Admissions: Alternatives to inpatient care

2.2.1 Further develop OPAT, Respiratory and Hospital at Home pathways.

Our OPAT service is a 5-day service however we recognise a 7-day model would support a greater number of clinically appropriate patients who do not require hospitalisation over the weekend but who currently remain/become in-patients. We are increasing our skill mix through specialist nursing developments to implement a full 7-day model with Consultant oversight.

We are planning to enhance integration and collaboration with Hospital at Home (H@H) and Acute Services to ensure early supported discharge of step-down referrals are facilitated in a timely manner.

By testing this model of care, H@H Service aims to facilitate timely and safe discharge to H@H and support the front door model. Ensure smoother, more timely and appropriate discharges to the service with clear intervention plans. Commencing H@H assessments for step down patients in the acute environment and supporting the front door team will positively impact admission, assessment and documentation time required in the community, and this will result in increased capacity and resilience across H@H and the system.

Currently H@H teams are informed of step-down patients planned for that day however, for numerous reasons; including complex planning and assessment these do not always happen. Recent data demonstrates that a third of step-down referrals do not progress to a discharge. This results in inefficiencies due to these places being held therefore some admissions to H@H are being declined. Introducing In-Reach Nurse Practitioner (NP) posts will ensure smoother, more timely and appropriate discharges to the service with clear intervention plans 7 days per week. In addition, having H@H assessments for step down patients commencing in the acute environment and supporting the front door team, will positively impact admission, assessment and documentation time required in the community and this would result in increased capacity and resilience across H@H and the system by:

- Accepting more referrals
- Offering 7 day a week in reach
- Accepting later step-down admissions i.e., from a 5pm cut off to a 8pm cut off if treatment is required or if no treatment is required admission at any time with review the following day
- Reducing the number of occasions that H@H reach maximum capacity and are unable to take new referrals
- Increasing caseloads
- Improving patient experience
- Supporting the front door model

We will increase the capacity for IV antibiotics to be delivered in the community at a patient's home by diversifying the clinical services that can support the existing H@H service. This will ensure that we are able to stratify complexity appropriately amongst other services, e.g., community nursing, and increase the available options for people requiring this approach at home.

2.2.2 Development of new pathways including paediatrics and heart failure

Fife Health and Social Care Partnership has a well-established specialist nurse-led heart failure service in the community offering a Fife-Wide service for those suffering from heart failure. Currently accepting referrals from across primary care,

secondary care and external boards they have a proven model of care for patients in the community, assisting in preventing unnecessary admissions and offering timely, efficient and person-centred care at home. Further work to reduced unscheduled admissions remains a crucial part of their role and they are continually reviewing their model of care to meet the needs of people in Fife. Work is underway to enhance pathways between acute cardiac services and the community heart failure team, and new pathways are being considered and devised to utilise the expertise of this service with the wider community nursing team, with a view to preventing unnecessary admissions and promoting earlier, safe discharge.

To increase access and keep paediatric care closer to home, several services are provided on an out-reach model, including Specialist Nursing Care for children with complex and chronic illnesses including diabetes and epilepsy. Paediatrician in-reach to the Emergency Department for children presenting urgently aims to reduce delay and minimise the need for hospital admission where possible. Increasingly NearMe and telephone appointments are used to facilitate access to Community Paediatric services. We are also exploring potential opportunities to implement virtual pathways in Paediatrics using NearMe for Rapid Review clinics where it is clinically safe to do so.

2.3 Reducing Length of Stay: Rapid assessment and streaming

2.3.1 Increasing assessment capacity

Early supported discharge and admission prevention will be achieved by developing ambulatory models of care to improve person-centred outcomes including admission avoidance, decreasing length of stay by 10% to 4.5 days and reducing readmission rates. This can also support chronic disease management clinics with rapid access slots where appropriate and improving bed availability by providing ambulatory treatments in a Clinical Intervention Unit to avoid overnight stay requirement. We are currently monitoring repeat admissions within 12 weeks and linking with the HSCP to support patients where alternative pathways are appropriate.

2.3.2 Optimise Flow to align discharge and admission patterns

There are a number of plans in place to deliver effective discharge planning:

- Maximise models of care and pathways to prevent presentations and support more timely discharges from ED using a targeted MDT approach. As the model embeds, admission avoidance will increase through an outreach model which will be developed to support people at home.
- Develop additional models of care within Admissions and the supporting services to also accommodate the increase in admissions whilst maintaining a Respiratory Viral pathway. Reduction in length of stay for patients requiring ongoing IV antibiotic treatment.
- Improve flow within the VHK site, reducing length of stay and number of patients boarding. Accurate PDD to inform planning for discharge from point of admission, coordinated with the Discharge Hub.
- Continue to reduce delayed discharge by taking a coordinated person-centred approach to discharge planning, ensuring the patient is at the centre of any decision making and planned with the patient /carer & family and not on the availability of care, equipment, or long-term care placement.

- Increase capacity of Fife Equipment Loan Store Service (FELS) to deliver and collect community equipment on behalf of Fife residents in a timely manner.
- 7 Day Pharmacy Provision of clinical and supply services across hospital care settings, reviewing the current position and additional need.
- Support and embed a criteria led discharge model to reduce boarding and improve flow.
- Further embed the front door model, continuing to work over 7-days, to enable early intervention and assessment resulting in discharge planning commencing as soon as the individual presents to hospital. This is available for patients presenting to Accident & Emergency Department, Acute Medical Unit and the Rapid Assessment Discharge Ward 9 (RAD) at the Victoria Hospital Kirkcaldy.

Fife Health & Social Care Partnership hold multidisciplinary 'verification' meetings to ensure continuous review of patients clinically fit for next stage of care with confirmed pathways of care in place and identified Planned Dates of Discharge. Daily and Weekly verification meetings feed into the weekly Whole System verification meeting where assurance at a senior level (Head of Service chairs) is provided covering patients in all aspects of delay. Any patients who can be discharged at the weekend are identified through this process.

Currently, there is a commitment to have no more than 48 Standard delays across Acute Services and Community Hospitals on any given day with goal of reducing this to 44 by end of 2023/24.

2.4 Best Start Maternity and Neonatal Plan

2.4.1 Delivery of The Best Start programme

We will continue to implement our Best Start Plan which is aligned to the 4 strategic priorities of the NHS Fife Population Health and Wellbeing Strategy.

The local lead is the Director of Midwifery supported by the Executive Nurse Director with Clinical Leaders from across Maternity Services supporting the range of recommendations currently in place and underway.

Data analysis and user feedback will contribute to planning and decision making. There is a continuous process of audit undertaken within the service which directs planning focus.

The following planning assumptions are being given careful consideration.

- The ongoing significant impact of COVID-19 on the Health and Care System including Maternity Services. Maternity Services will also require to adapt to any future effects of COVID-19.

- Balancing the capacity to maintain current service provision and implement the recommendations of Best Start whilst we are “recovering” from COVID-19 alongside seasonal demands (Winter Planning).
- Significant continuous registrant vacancy factor (due to national shortage of Midwives). There is also challenge in recruiting to some medical posts.
- Continuation of the vaccination programme for influenza delivered by the Midwifery Team and the new request for the Midwifery Teams to deliver for COVID-19 vaccination programme.
- The time out allocation of 21.5% is no longer sufficient to enable safe roster cover. This is due in part to the requirement for all Midwives to complete Core Mandatory Training (CMT), alongside local mandatory training. There is also an increasing part-time workforce (the need for CMT calculation to be per head and not per wte) a mainly young, female workforce with high demand for maternity leave.
- Recognition of the need to ensure staff health, wellbeing and resilience when implementing significant change to working practice within the service.

This plan will continue to be subject to review and updating as the clinical picture demands.

3. Mental Health

NHS Fife Corporate Objectives 2023/24 mapped to this Recovery Driver are:

 *To improve health and wellbeing*	• *Progress the business case for the mental health services programme*
 *To improve quality of health and care services*	• *Implement redesign and quality improvement to support mental health services*

3.1 Improving Access to Services

Fife CAMHS are engaged in and will continue to focus on a number of initiatives in order to sustainably deliver, achieve and maintain the 18-week referral to treatment standard and increase capacity with our services.

Fife Psychology Service leads on the delivery of PT 18-week referral to treatment target. On-going recruitment activity is a key component of building capacity. Demand-capacity data is collated and interrogated routinely and is used to inform improvement actions. The service has a detailed plan of improvement actions which relate to both the waiting times target and improving access to PTs.

- Service redesign and delivery options
- Service development and establishment of new services in response to investment and creation of new tiers of service and/or clinical pathways within established services
- Staff training within wider mental services and with 3rd sector partners and CPD to increase the skill set of specific groups of psychology staff
- Workforce skill mix and other efficiency measures including the introduction of Enhanced Psychological Practitioners
- Developing and supporting provision delivered by other services through clinical supervision and with 3rd sector partners.

PTs and PIs are delivered in 32 clinical services within Fife. Alongside delivery of specialist and highly specialist PTs, service provision includes a suite of PT and PI options which are low intensity in terms of therapist time. People can self-refer to many of these PT options via the Access Therapies Fife website. There are no capacity issues within the low intensity delivery options.

Figure 2 – CAMHS RTT Trajectories

If 90% of patients starting treatment within 18 weeks of referral has not been achieved by March 2023, when do you project that 90% of all patients will start treatment within 18 weeks of referral	Mar-24

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Projected Patients Starting Treatment total	60	82.8	70.8	69	60	67.8	91.2	92.8	123	107	131	120
Projected patients starting treatment within 18 weeks	51	70.38	60.18	58.65	51	47.46	63.84	64.96	73.8	64.2	91.7	108
Projected Performance Against Standard (Auto Populates)	0.85	0.85	0.85	0.85	0.85	0.7	0.7	0.7	0.6	0.6	0.7	0.9

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Projected Waiting list ≤ 18 weeks	213	209	216	230	218	228	232	257	235	222	201	200
Projected Waiting list >18 weeks	71	89	116	113	133	98	77	86	42	39	15	0
Projected Waiting list >52 weeks	0	0	0	0	0	0	0	0	0	0	0	0

Comments (please include here any asssumptions caveats or other information that you feel is relevant).	longest waits whilst ensuring the waiting list does not grow over 35 weeks in the next 6-8 months. Trajectory reflects service capacity as recruitment progresses and optimum functioning is recovered. Trajectory is based on referral rates remaining stable with no increase in acuity/severity or presentation

Figure 3 – Psychological Therapies RTT Trajectories

If 90% of patients starting treatment within 18 weeks of referral has not been achieved by March 2023, when do you project that 90% of all patients will start treatment within 18 weeks of referral	Dec-24

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Projected Patients Starting Treatment total	200	288	280	207	215	215	176	236	155	272	276	259
Projected patients starting treatment within 18 weeks	135	200	185	135	140	158	122	161	110	185	200	180
Projected Performance Against Standard (Auto Populates)	0.675	0.694444	0.660714	0.652174	0.651163	0.734884	0.693182	0.682203	0.709677	0.680147	0.724638	0.694981

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Projected Waiting list ≤ 18 weeks	888	888	888	888	888	888	888	888	888	888	888	888
Projected Waiting list >18 weeks	1394	1575	1660	1625	1591	1569	1609	1596	1680	1739	1691	1604
Projected Waiting list >52 weeks	255	237	219	201	183	165	147	129	111	93	75	57

Comments (please include here any asssumptions caveats or other information that you feel is relevant).	Our target for the coming year remains to reduce longest waits to under 52 weeks and maintain the current under 18 week list size. Trajectory is based on the following – retaining current staff; recruitment to vacancy; no change in demand ; access to clinic space; and plans to increase capacity in the wider mental health system.

3.2 To deliver services that meet standards

A summary of the plan to build capacity is outlined below:

- Recruitment is ongoing and under continual review to ensure workforce is at full capacity.
- CAMHS Early Intervention Service is in place to ensure the right support is delivered at the right time by the right services to enable young people who require specialist CAMHS intervention to achieve timely access.
- Caseload management is implemented to ensure throughput, reduce bottlenecks and maintain capacity.

In addition, pathways to clinical services provided by CAMHS, informed by the CAMHS National Service Specification are in place or in development to ensure mental health support is accessible for those with the greatest need and are most vulnerable.

3.3 Engagement with PHS to improve quality of data

Fife CAMHS have robust data collection processes in place that supports the delivery of local priorities and aligns to national standards. Engagement with CAPTND Clinical Reference Group and NHS Fife Information Services will ensure that Fife CAMHS systems for data collection have the capability to support and adapt to future data collection requirements.

The Psychology Service is currently working with NHS Fife Digital & Information team to introduce a new patient appointment system and also an electronic patient record system. Timelines dictate that the service will be better placed to achieve full compliance with CAPTND data set during 2023/24.

3.4 Mental Health Services

The vision as detailed in the Mental Health Strategy 'Let's really raise the bar' is: 'We will live in mentally healthy communities; free from stigma and discrimination, where mental health is understood. Where support is required, it will be personalised, responsive and accessible'. This strategy is currently being refreshed and will be mapped against the soon to published national Mental Health and Wellbeing strategy to support alignment of priorities against to priorities to 'Prevent, Promote and Provide'. This work will inform any changes or refinement to the 5 key priorities within Fife Mental Health Redesign Programme including:

- Data and Quality Indicators: to develop a dashboard of quality indicators aligned to the Public Health Scotland quality indicators.
- Inpatient Redesign and the development of the initial agreement and business cases required to support capital investment to improve our inpatient estate in line with consultation and the mental health model in Fife including the development of our community mental health teams.
- Distress Brief Intervention (DBI) service across both front-line health services commissioned through third sector services.
- Urgent and Unscheduled Care to ensure access to mental health support is fit for purpose.
- Mental Health and Wellbeing in Primary Care and Community settings which can be found more fully earlier within this delivery plan.

4. Planned Care

NHS Fife Corporate Objectives 2023/24 mapped to this Recovery Driver are:

To improve quality of health and care services

- *Further develop Queen Margaret Hospital as centre of excellence for ambulatory care and day surgery*
- *Delivery year 1 of Planned Care Recovery Plan*

4.1 Enabling a "hospital within a hospital"

The opening of the National Treatment Centre - Fife Orthopaedics continues to provide protected capacity for elective Orthopaedics in a fit for purpose facility. This will also provide capacity for the East region neighbouring boards.

Capital work in Ward 24 has been completed to optimise the Gynaecology model. Beds are now available for unscheduled activity based on specified criteria with one bed available for emergency admission. The ward reconfiguration has increased the bed base to support the capacity required for elective activity.

Improvement support locally directed to support high volume nationally and locally identified specialties to adopt and spread ACRT (Active Clinical Referral Triage) and PIR (Patient Initiated Return). Currently there is engagement and adoption of ACRT for five specialties with further exploration required for robust recording of enhanced vetting where guidance is sent directly back referrer and not to the patient. Ten specialties are engaged and adopting PIR and we are continuing to receive support for scale up and spread to other specialty cohorts.

ERAS (Enhanced Recovery After Surgery) is business as usual but requires visibility and development of robust mechanisms for reporting in Orthopaedics and General Surgery. There are plans to implement in Gynaecology following completion of capital works.

Fife's Integrated Planned Care Programme Board (IPCPB) has oversight of all elective improvement work including CfSD (Centre for Sustainable Delivery) work and is directing next steps aligning to CfSD and local drivers.

Figure 5 below illustrates the projected capacity available to deliver New Outpatients and TTG activity in 2023/24.

Figure 5 – New Outpatient and TTG Capacity Projections

New Outpatient Capacity Projections by Specialty can be found in Appendix A whilst similar for TTG can be found in Appendix B.

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
New Outpatients	7573	7372	7364	7565	7340	7432	7421	7432	7421	7436	7436	7436
TTG	1138	1139	1139	1144	1144	1145	1162	1162	1163	1164	1164	1164

4.2 Extending the scope of day surgery and 23-hour surgery

We are creating a procedure room in our day surgery facility at the Queen Margaret Hospital (QMH) to release theatre capacity through capital investment to increase procedures which can be conducted under local anaesthetic. Work is underway and due for completion June 2023. This will generate ten additional sessions per week and will allow transfer of lists from VHK to QMH, freeing up theatre capacity at VHK.

We continue to provide same day hip and knee arthroplasty where appropriate in line with the British Association of Day Surgery (BADS) guidance via the NTC facility.

Figure 6 – Same Day Knee and Hip Replacement Projections

		QE Jul-23 Plan	QE Sep-23 Plan	QE Dec-23 Plan	QE Mar-24 Plan
KNEE Arthroplasty	Number of same day procedures	3	3	3	3
	Total number of procedures	162	162	162	162
	Percentage Same Day	1.9%	1.9%	1.9%	1.9%
HIP Arthroplasty	Number of same day procedures	8	8	8	8
	Total number of procedures	185	185	185	185
	Percentage Same Day	4.3%	4.3%	4.3%	4.3%

Project commenced with all specialties to identify and remove barriers to optimise BADS procedures within a day case setting in QMH. Plans to recruit Clinical Lead for Day Surgery as per BADS recommendations.

Ongoing review of IP/DC activity to maximise capacity on QMH site where theatre resources allow.

4.3 Reducing unwarranted variation

There is a focus on specialities to reduce variation aligning to ATLAS of variation; theatre work in planning to look at variation.

We are participating and engaging with the national drive toward standard high volume same procedure lists such as Cataracts.

We encourage continued clinical engagement with CfSD SDG (Speciality Delivery Group) and support implementation of national pathways including Endometriosis for Gynaecology and develop an NHS Fife sustainable model including training for local consultants.

Figure 7 – Unwarranted Variation Projections (Cataracts & 4 Joint Sessions)

	QE Jul-23 Plan	QE Sep-23 Plan	QE Dec-23 Plan	QE Mar-24 Plan
Average Cataracts per 1/2 day session (Cataract only session)	4.5	4.5	4.5	4.5
% of 4 joint sessions (of all full day sessions with at least 1 joint)	25.0%	25.0%	25.0%	25.0%

4.4 Validation of waiting lists

In order to support the full adoption of National Elective Co-ordination Unit (NECU) within NHS Fife, Digital & Information are procuring a digital solution (NETCALL) within patient hub. This will digitise the current paper process with benefits identified in service efficiencies within Health Records and improved patient experience through better communications with those experiencing long waiting times. Digital & Information will look to implement by the end of 2023 and will be engaging with NECU shortly.

Figure 8 describes the waiting lists will continue to increase despite the improvement work that is being undertaken in 2023/24. The capacity described in Figure 5 is based on the current funding available.

Figure 8 – New Outpatient and TTG Long Wait Projections

Expected Number Waiting at:	30th June 2023	30th Sept 2023	31st Dec 2023	31st March 2024
New Outpatients (NOP)				
Over 104 Weeks	0	74	212	352
Over 78 Weeks	150	339	849	1358
Over 52 Weeks	1646	2275	2902	3497
Total List Size	27101	28764	30429	32094
InPatient / Day Cases (TTG)				
Over 104 Weeks	16	67	173	351
Over 78 Weeks	159	305	547	893
Over 52 Weeks	688	1157	1718	2593
Total List Size	7126	7816	8506	9196

5. Cancer Care

NHS Fife Corporate Objectives 2023/24 mapped to this Recovery Driver are:

To improve quality of health and care services

- *Further develop Queen Margaret Hospital as centre of excellence for ambulatory care and day surgery*
- *Delivery year 1 of Planned Care Recovery Plan*

5.1 Diagnostic capacity and workforce

We have identified a number of actions to increase diagnostic capacity and workforce,

- Development of project team within Endoscopy to identify tests of change for more efficient booking processes and to book patients with longer lead time to ensure routine and surveillance waiting times are reduced, filling every slot where possible.
- Readjustment timings within new Endoscopy Management System will explore if this improves efficiency and provide good data on turnaround times and duration of endoscopies and will be used for list planning to improve efficiency and explore text messaging system to reduce DNA.
- NHS Fife pool of Nurse Endoscopists available to backfill short notice cancellation.
- Regular audits and target improvement measures are in place.
- Recruitment of full-time education co-ordinator and introduction of monthly training session for all Endoscopy staff. This will be focused on improvement in quality measures as well as upskilling of trained and untrained staff that includes nurses trained in trans-nasal endoscopy and investment in other specialist roles including scrub training for HCSW (Healthcare Support Workers).
- Within Radiology, every effort will be made to fill every slot and activities to promote this include accurate measurement of performance, introduction of text reminder service, improve processes for utilisation of patient cancellations, monitor performance in utilisation of unused slots, resourcing and training in the department and ensure awareness of available funding streams.
- Continue to protect and prioritise urgent and cancer requests by managing appointing system to ensure sufficient slots available for urgent and planned follow up appointments.
- Match Ultrasound rooms with sonographer availability, this may require additional local footprint or adapting existing resources.
- Minimise the impact of acute service pressures on planned care CT and MRI service by redesigning of out of hours acute CT staffing to smooth acute demand and continue with extended day and weekend MRI service.
- Use funding from cancer pathway projects to use weekend CT capacity.

Figure 9 below illustrates the projected capacity available to deliver endoscopy and radiology activity in 2023/24. Figure 10 demonstrates the impact of the capacity on the different diagnostic waiting lists.

Figure 9 – Diagnostic Capacity Projections

Diagnostic Capacity by Key Test can be found in Appendix C.

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
All Endoscopy	899	899	899	899	899	899	899	899	899	899	899	899
All Radiology	4222	4222	4222	4222	4222	4222	4222	4222	4222	4222	4222	4222

Figure 10 – Diagnostic Long Wait Projections

Expected Number Waiting at:	30th June 2023	30th Sept 2023	31st Dec 2023	31st March 2024
Endoscopy 4 key diagnostic tests				
Over 52 Weeks	3	0	0	0
Over 26 Weeks	109	63	10	0
Over 6 Weeks	373	250	140	10
Total List Size	755	785	795	795
Radiology 4 key diagnostic tests				
Over 52 Weeks	0	0	0	0
Over 26 Weeks	0	0	0	0
Over 6 Weeks	4966	6577	8188	9799
Total List Size	9107	10718	12329	13940

5.2 Roll out of RCDSs

The principles of RCDS (Rapid Cancer Diagnosis Service) will continue to be rolled out following the success of the pathfinder in Fife. We are looking to expand the service into additional tumour specific sites. Upper GI (Gastrointestinal) and (HPB) Hepatobiliary pathways have commenced with further implementation expected in the Colorectal service during 2023.

5.3 Adoption of Framework for Effective Cancer Management

The Cancer Framework 2022-2025 has eight key commitments with high level actions noted below:

1. To reduce cancer incidence, mortality and inequalities for our population through effective prevention, screening and early detection initiatives.
2. The patients will be at the heart of how services are designed with excellent patient experience as a priority.
3. Patients will receive the right treatment at the right time in the right place by the right person.
4. Research, innovation and knowledge is central to the delivery of high-quality sustainable cancer services for our patients and population.
5. Collaborative strategies and programmes to deliver service change that is focussed on improved patient care through digital transformation.
6. Recognise workforce challenges and identify system-wide approaches to support in relation to recruitment, wellbeing, education and training to ensure our cancer patients receive the best care.

7. To ensure our healthcare environments are designed to deliver optimum patient care the current cancer estate will be reviewed.
8. To make best use of available information sources to assure patients are receiving timely, high quality, effective care.

The Fife action plan describes various actions to prevent cancer, diagnose early and treat effectively, underpinned by the principles of realistic medicine and person-centred care. New national optimal cancer pathway and clinical management pathways will set clear standards for all, and a new oncology transformation programme will create a new vision and, ultimately, new service for oncology.

Figure 11 – Cancer 31-day DTT Projections

Percentage treated within 31 days of decision to treat	Quarter ending 30 June 2023	Quarter ending 30 September 2023	Quarter ending 31 December 2023	Quarter ending 31 March 2024
Breast	95.0%	95.0%	95.0%	95.0%
Cervical	95.0%	95.0%	95.0%	95.0%
Colorectal	95.0%	95.0%	95.0%	95.0%
Head & Neck	95.0%	95.0%	95.0%	95.0%
Lung	95.0%	95.0%	95.0%	95.0%
Lymphoma	95.0%	95.0%	95.0%	95.0%
Melanoma	95.0%	95.0%	95.0%	95.0%
Ovarian	95.0%	95.0%	95.0%	95.0%
Upper GI	95.0%	95.0%	95.0%	95.0%
Urological	82.7%	86.0%	88.3%	90.0%
All Cancer types combined	**93.8%**	**94.1%**	**94.3%**	**94.5%**

Figure 12 – Cancer 62-day RTT Projections

Percentage treated within 62 days of urgent referral with a suspicion of cancer	Quarter ending 30 June 2023	Quarter ending 30 September 2023	Quarter ending 31 December 2023	Quarter ending 31 March 2024
Breast	93.0%	93.3%	94.0%	94.0%
Cervical	50.0%	50.0%	53.0%	53.0%
Colorectal	87.0%	87.0%	90.0%	92.0%
Head & Neck	83.0%	87.0%	90.0%	90.0%
Lung	90.0%	90.0%	92.0%	93.0%
Lymphoma	80.0%	85.0%	90.0%	90.0%
Melanoma	95.0%	95.0%	95.0%	95.0%
Ovarian	85.0%	85.0%	87.0%	87.0%
Upper GI	93.5%	94.0%	94.0%	94.0%
Urological	62.0%	62.0%	65.0%	66.0%
All Cancer types combined	**81.9%**	**82.8%**	**85.0%**	**85.4%**

5.4 Improving cancer staging data

The following plans are in place:

- Staging data collection for Prostate will be further improved by ensuring that this information is provided for or at multidisciplinary team (MDT) meetings.
- For renal, consideration is given to include the staging field in the outcomes of the MDT. Valid staging must be assigned in review preparation notes for all patients with suspected renal cancer. The outcomes to be published on the appropriate patient administration system.
- For bladder, record pathological T staging prior to each TURBT (Trans Urethral Resection of Bladder Tumour) procedure and pathological TNM staging prior to cystectomy.

5.5 Further Plans

There will be full participation to support delivery of the upcoming national oncology transformation programme. The following are currently under way:

- A Single Point of Contact Hub has been implemented to support patients who are referred USC or diagnosed with a urological or colorectal cancer. Introduction of this service will be rolled out to the lung cancer service to support the Optimal Lung Cancer Pathway in 2023
- Many services have a dedicated Pathway Navigator (Urology, HPB, RCDS, UGI) to support patients or applications for this resource is being explored (Breast).
- Maggie's Prehabilitation service has been implemented offering universal sessions for anyone with a cancer diagnosis.
- A project group has been set up to implement the Optimal Lung Cancer Pathway.
- Psychological support is already embedded within our cancer services. RCDS and other services complete Holistic Needs Assessments and make referrals to Maggie's Centre for Prehabilitation and other support, to Improving the Cancer Journey (ICJ) routinely, and to Clinical Psychology, spiritual care and counselling as required. Training on aspects of emotional wellbeing is undertaken by Pathway Navigators and Cancer Nurse Specialists for example through Good Conversations and Sage and Thyme training, and case consultation with clinical psychology. Through the recently published Psychological Therapies and Support Framework there will be a continued focus to ensure equitable access to psychological support across Fife and tumour groups and identify areas for further development.
- All patients diagnosed with cancer are referred to Macmillan Improved Cancer Journey (ICJ).

6. Health Inequalities

NHS Fife Corporate Objectives 2023/24 mapped to this Recovery Driver are:

To improve health and wellbeing

- *Support the ADP in the delivery of MAT standards*
- *Develop a prevention and early intervention strategy, and delivery plan, to support health improvement and address inequalities*

Cross cutting actions

- *Deliver Anchor's ambitions working collaboratively with partners*

6.1 Reducing health inequalities

Poverty is a significant driver of poor health outcomes and health inequalities. It is likely that the current cost-of-living crisis will exacerbate health inequalities because it will lead to a deterioration in living conditions which will inevitably impact on individual and population health. NHS Fife recognises the importance of developing and implementing an effective strategic approach to address avoidable health inequalities and their root causes. Without deliberate effort the current cost-of-living crisis will widen the gap in health outcomes which already exists between people living areas most affected by deprivation and those living in areas with less financial pressures. It will also result in greater pressures on NHS services.

Our ambition to tackle health inequalities is set out in the recently published Population Health and Wellbeing Strategy for NHS Fife. The response that is required involves deliberate long-term efforts in collaboration with other statutory agencies in Fife. Preparatory work for the strategy included an evidence-based review of the role the NHS has in preventing illness and reducing health inequalities. The strategy also utilised information within the Director of Public Health annual report for 2020/2021, which contains the most recently collated information describing the health of the local population and the factors that are important for creating and maintaining health.

The review we conducted noted that the risk factors which contribute most to poor health and wider conditions where people live, and work are all experienced unequally in our society. The result is worse health outcomes and reduced life expectancy amongst those living in areas most affected by deprivation in Fife.

The review identified six key areas for action which NHS Fife should progress:

- Mainstreaming the process of supporting patients to maximise health and wellbeing
- Focus on staff health and wellbeing
- Maximise staff and patient income
- Reduce inequalities in access to services
- Ensure organisational policies / service planning prevents and mitigates health inequalities

- Work to address poverty and inequality as part of the Plan for Fife and development as an anchor institution

Given the current cost of living crisis and service pressures there is a risk that health inequalities may worsen. This risk has been added to our corporate risk register, to appropriate management actions are in place and regularly reviewed.

6.2 Delivery of healthcare in police custody and prison

In NHS Fife, the Executive Lead is shared from prison healthcare – Director of HSCP and those in custody - Director of Acute Services.

Healthcare in custody is led by Acute Services in collaboration with police based locally whilst HSCP is involved in pathways on release from prison back to community which includes links to forensic service and there is involvement from Perth Prison on the Alcohol and Drugs Partnership Board.

We have a commissioned hospital liaison service and third sector provision, this includes Near Fatal Overdose service, Custody Navigation, and In-reach/Outreach peer mentoring service in prisons.

6.3 Implementation of MAT (Medication Assisted Treatment) Standards

The standards provide a framework to ensure that the system and services responsible for MAT delivery are sufficiently safe, effective, accessible and person centred to enable people to benefit from treatment and support for as long as they need. The Alcohol and Drugs Partnership is leading the multi-agency response and NHS Fife services are well engaged and represented in this work.

There are two ADP subgroups focused on

MAT 1 to 5 to be delivered in 2023/24:

1. All people accessing services have the option to start MAT from the same day of presentation
2. All people are supported to make an informed choice on what medication to use for MAT and the appropriate dose
3. All people at high risk of drug-related harm are proactively identified and offered support to commence or continue MAT
4. All people can access evidence-based harm reduction at the point of MAT delivery
5. All people receive support to remain in treatment for as long as requested

MAT 6 to 10 to be delivered in 2024/25:

6. The system that provides MAT is psychologically informed (tier 1); routinely delivers evidence-based low intensity psychosocial interventions (tier 2); and supports individuals to grow social connections
7. All people have the option of MAT shared with Primary Care
8. All people have access to independent advocacy as well as support for housing, welfare and income needs
9. All people with co-occurring drug use and mental health difficulties can receive mental health care at the point of MAT delivery
10. All people receive trauma informed care

All of the subgroup's report into the Alcohol and Drugs Partnership Committee at each meeting with quarterly reports that are submitted to Scottish Government.

Examples of work being progressed to support delivery of the MAT standards are:

- Enhanced Performance reporting including MAT standards and referral to treatment targets, this includes quarterly progress reports to the Scottish Government and compliance with the evidence submitted at the end of year assessment conducted by Public Health Scotland.
- Working towards evidencing of all 4 harm reduction service aspects to be available at the point of care, sustainably, across all 3 locations where NHS addictions services are delivered.
- There is access to access to long-acting injectable buprenorphine across the full NHS Addictions Service.
- Established a same day prescribing one stop shop in Methil as a partnership between third sector, NHS Addictions Service, housing and foodbank partners, plans are underway to extend this into the Kirkcaldy and Cowdenbeath localities.
- The MAT 6 & 10 psychological interventions and trauma informed workforce development plan is complete with all services (NHS and third sector) committed to embedding decider skills and advanced motivational interviewing into their operation practice. This work will commence in 2023/24 and places Fife Alcohol and Drug Partnership ahead of its implementation plan for 2022/23 in addition mapping for MAT 10 work has been completed this year and a small subgroup is established to enhance coordination of recovery communities.
- For MAT 7, enhancing a MAT Standards compliant approach within primary care implementation group is in the planning phase. This will encompass locality-based work in specific areas of Fife where prevalence of harm and substance related deaths are highest and engagement and demand for treatment and support services is lower. Primary care is also currently involved in the planning of the one stop shops.
- An independent advocacy service has been commissioned in relation to MAT 8 and is in place with people with lived experience as part of the service workforce. This is linked to both the ADP lived experience panel and living experience group.
- Multi-agency work is being progressed to support people to remain in treatment and is a defined risk that we are working with the APD to mitigate.
- Further multi-agency work is ongoing with Mental Health Services including work to implement the four recommendations made by the Mental Welfare Commission on their “Ending the Exclusion” Report September 2022. The clinical director is chairing a group to support delivery of MAT 9.
- Fife ADP is now in the second year of supporting the delivery of the distribution of naloxone, through the peer-to-peer model, across Fife.
- We are embedding decider skills and advanced motivational interviewing into their operation practice to support trauma informed practice.

6.4 Delivery of the Women’s Health Plan

The aim of the Women’s Health Plan is to improve health outcomes and health services for all women and girls in Scotland. It is underpinned by the acknowledgement that women face particular health inequalities and, in some cases, disadvantages because they are women.

The HSCP (Associate Medical Director) is leading along with Public Health on reducing health inequalities on women’s general health.

The plan includes:

- Collaborating with acute colleagues in improving access to menopausal treatment. One of our sexual health doctors has completed British Menopausal training and is working with vulnerable populations and those with more complex menopausal needs due to co-morbidities. Over the next year we are planning to roll out training with the aim of having a lead GP in each locality.
- Training GPs to be more confident to initiate more complex HRT and therefore allow quicker access to treatment for women with menopausal symptoms and also decrease waiting times.
- Training to non-healthcare staff over the next year to allow them to have conversations with women about health and health care services available for them to access.
- Working with acute colleagues on early referral for patients with possible endometriosis.

Over the next year, work will be undertaken to scope what access there is in primary care teams to a Healthcare Professionals (HCPs) who have a specialist knowledge in menstrual health including awareness of the symptoms of PMS, PMDD, heavy menstrual bleeding, endometriosis and their treatment options. With a view to increase this overall and to identify any gaps which would require further training provision.

We are looking at improving women's heart health by providing more information on heart health to women via our media channels and also raising awareness in health professionals. We are planning to run education sessions for primary care. We are also seeking views on rehabilitation programmes from users to ensure women's views are taken into account.

6.5 Anchor strategic plan

As a large organisation connected to our local area and community, we recognise we can make a positive contribution to benefit the population of Fife, not only through service delivery but also by developing our Anchor ambitions.

We have worked with our third sector partner (Fife Voluntary Action) to establish a local website interface which aims to enhance community benefits within Fife. Fife Voluntary Action will support local community organisations to develop their community benefit need bids before they are uploaded to the national community benefit gateway. Working in this way we believe will improve the quality of bids and support organisations to access alternative funding if their needs do not fit with the community benefit gateway criteria. The local interface was launched in March 2023. FVA have been raising awareness of the portal with local organisations at locality funding events and are currently working with a number of community organisations with a target of reaching approximately a dozen bids uploaded to the national portal by the end of June 2023.

We have established an Anchor's Operational Group which will develop priority areas for inclusion in the Anchors Strategic plan by October 2023. The Operational group will agree milestones, and progress will be tracked through monthly meetings to measure against outcomes using self-assessment against the local progression framework.

The Anchor's Strategic Plan will align with NHS Population Health & Wellbeing Strategy, NHS Fife Medium Term Plan and Public Health Midterm Delivery Plan recovery drivers. The baseline focus will include:

- Utilisation of land and assets to support communities
- Purchase locally to support social benefit
- Prioritise environmental sustainability
- Widen access to work

6.6 Transport needs

Plans are in place to

- Revise the Patient Information leaflet on claiming travel costs and will include:
  - Promotional Plan – via Primary Care, Localities, and NHS Acute
  - Monitoring and evaluation
- Deliver Poverty Awareness Training Post incorporating travel claims as part of health inequalities workforce training.

There is work ongoing with the 7 Localities groups to gather data and information on barriers to accessing service and health inequalities. For example, patients travel to other health board areas for treatment.

7. Innovation Adoption

NHS Fife Corporate Objectives 2023/24 mapped to this Recovery Driver are:

To improve staff health and wellbeing

- *Collaborate with University of St Andrews to develop the ScotCOM medical school*

7.1 Working with (ANIA)2 partners

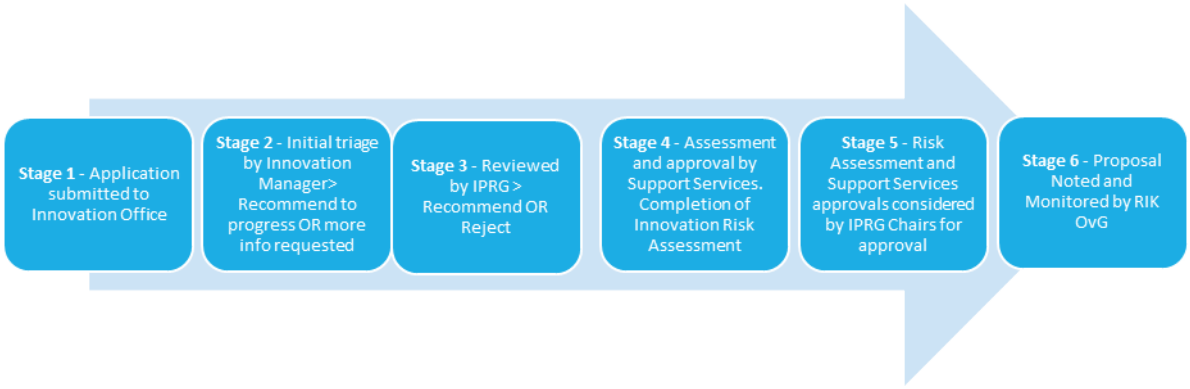
NHS Fife has invested in supporting innovation at a local level, with an Innovation Manager and Clinical Innovation Champion within Research, Innovation and Knowledge (RIK), and a Programme Manager, PMO, Innovation and Technical Design in Digital and Information (D&I). This resource also supports deeper engagement with the South East Innovation Test Bed (HISES), as one of the three member Boards (Fife, Lothian and Borders), providing stakeholder input, leadership and strategic input.

To facilitate fast tracking high impact innovations and to develop a sustainable and data driven approach to implementation locally, an Innovation Governance Framework has been developed and implemented. Within this framework an Innovation Project Review Group (IPRG) has been established. The IPRG will provide the forum and approval pathway for innovation projects and new developments that might merit advice and recommendations for development, investment, D&I support and/or surfacing to HISES. The IPRG will review Innovation submissions from multiple routes including, but not limited to, HISES, other NHS Boards, Scottish Health and Industry Partnership (SHIP), Scottish Government, Centre for Sustainable Delivery (CfSD) Accelerated National Innovation Adoption (ANIA) pathway or direct from Industry and Academic Partners.

Innovation challenges supported by SHIP as part of the Demand Signalling programme are generally aimed at Industry, encouraging partnership with the NHS and academia; widely called the ‘Triple Helix’ approach to innovation. In support of this approach NHS Fife is engaged locally with Fife Council, the business community, and the University of St Andrews in the promotion of SHIP activity and engagement with the South East Innovation Test Bed.

The IPRG will play a role in supporting a mechanism for the implementation of any potential approved solution, from whatever source, that requires a robust digital IT infrastructure and/or has clinical service delivery or resources impact. The IPRG will operate within a framework considering local, regional and national strategic priorities supporting transformation of health service delivery through innovation. The Innovation Manager will provide an update to the IPRG and NHS Fife Research, Innovation and Knowledge Oversight Group (RIK OvG) on high impact innovations progressing through the ANIA pathway.

Figure 1: Flow chart of projects through Innovation Governance Framework



7.2 Reducing the barriers to national innovation adoption

NHS Fife is a member Board of HISES and our processes have been designed to align with processes already established within the HISES governance framework. Innovation Projects supported by HISES, looking to test an innovation, will follow a robust governance process to manage innovation across the test bed, which is consistent with the governance structures across each of the partner Boards with from NHS Fife in the senior HISES team and governance structures and pathway. The HISES governance pathway does not include projects for adoption.

Innovation team within NHS Fife, works with and attends regular meetings with groups involved in the Scottish Innovation landscape including regional monthly meetings with CfSD, InnoScot Health, DataLoch and locally with Fife HSCP. NHS Fife is a contributing member of the HISES Network group and quarterly Oversight Group, SHIP and Scotland Innovates bi-monthly pipeline meeting, National Innovation Project Managers monthly meeting, and has engagement with the Scottish Health Technology Group (SHTG).

The ANIA Pathway is the mechanism for adoption of innovation for a small number of high impact innovations. The process for consideration and adoption of new innovations in NHS Fife from the ANIA pathway is under development. NHS Fife interacts with the ANIA team at regular meetings with the South East Test Bed and at the SHIP pipeline bi-monthly meeting.

It is planned that the NHS Fife Innovation team will communicate and update the RIK OvG on the current ANIA Pathway pipeline following feedback from the HISES representative on the Innovation Design Authority board. Awareness of the ANIA Pathway pipeline will allow for discussions and consideration of proposed national adoption innovations within NHS Fife in advance of the Stage Gate points when CEOs are informed or consulted.

7.3 Development of ScotCOM medical degree at University of St Andrews

University of St Andrews is developing a new five-year MBChB programme for medical students (ScotCOM), with NHS Fife as its partner Board. NHS Fife will develop suitable clinical placements to align with the St Andrews curriculum.

8. Workforce

NHS Fife Corporate Objectives 2023/24 mapped to this Recovery Driver are:

To improve staff health and wellbeing

- *Develop and deliver an action plan to support the Implementation of the Health & Care (Staffing) (Scotland) Act 2019 (Safe Staffing Legislation)*
- *Develop and deliver a sustainability plan for the nursing and midwifery workforce*
- *Deliver specific actions from the workforce strategy to support both patient care and staff wellbeing*

8.1 Develop a sustainable nursing and midwifery workforce

The nursing and midwifery workforce plays a vital role in the delivery of healthcare services and ensuring an adequate and well-supported nursing and midwifery workforce is essential for maintaining safe and high quality care.

This section explores the challenges faced by NHS Fife in terms of supply, retention, and vacancies, and provide trajectories for 2023, 2024 and 2025.

Supply Challenges

One of the key challenges is the supply of registered nurses (RNs). There is a growing demand for nursing professionals due to an aging population, increased prevalence of chronic diseases, and advancements in healthcare technology.

However, the supply of nurses has not kept pace with this demand. Factors contributing to this challenge include the aging nursing workforce, limited enrolment in nursing programmes, and competition from other sectors.

a) Age profile

The median age for nurses and midwives in NHS Fife is 44 years, however 20.2% of the nursing workforce is aged over 55 (NES Turas Data March 2023). This percentage is higher in specific services with district nursing, learning disability and mental health nursing demonstrating that over 25% of nurses are aged 55 or over.

b) Student Intake

The shortfall of new nursing students starting their degrees in 2022 means that there will be fewer newly qualified practitioners (NQPs) in 2025. This means that the gap between the number of registered nurses needed and those entering the workforce is set to widen. The significant reduction of 20% in student places that took place between 2010 and 2013 continues to impact workforce numbers. The increase in adult and mental health student places from 2013 – 2019 has returned to pre-2010 levels.

Student attrition rates continue to cause concern. The number of applicants for nursing courses in Scotland in 2023 is 24% down compared to the same point last year.

c) Newly Qualified Practitioners

We begin recruiting students, who are due to graduate from September, in February and March each year. In March 2022, we recruited 180 WTE students across Fife; this dropped to 155 in June, but with less than 145 WTE eventually joining us.

This year, we again recruited 180 WTE (this includes a rise of 10 WTE in midwifery). Of this 129 WTE were adult nurses, but this has already dropped to 112 WTE. There is concern that only 130 WTE will join us this year.

d) Vacancies

There are significant vacancy challenges. These vacancies arise due to retirements, resignations, and difficulties in attracting new nurses. Staff shortages can strain the remaining workforce, increase workload, and potentially compromise patient care.

The vacancy rate is part of the NES published data. The vacancy gap reported for Fife is 12.9% for March 2023 (data is embargoed until June 2023). The anticipated published figure assumes that the establishment equates to staff in post plus all advertised vacancies. This methodology loses its accuracy due to how we advertise posts (bulk recruitment, targeted recruitment, student recruitment etc).

We can calculate an approximation of vacancies using the WTEs from the financial system, noting these do not provide an actual representation of vacancies due to staff who do not generate a WTE, and other caveats related to translating financial information into workforce numbers. Nursing & Midwifery funded establishment in the ledger at March totals 4267, estimated vacancies based on difference between WTEs worked in March compared to the funded establishment is 424 WTE, approximately 10% of our nursing workforce.

There has been an agreement with Directors of Finance, Workforce and Nursing to use 10% as a realistic vacancy rate. NES data suggests 587 WTE vacancies. Work between Workforce and Finance describes 329 WTE RN vacancies of less than 3 months, 55.6 WTE between 3 and 6 months and 18.5 WTE over 6 months – a total of 403 WTE RN vacancies.

e) Turnover

Turnover rate has increased from December 2022 (10.8%) to 13.5% in March 2023 (based on NES data).

Supply Opportunities

a) International Recruitment

International recruitment is recognised as a contribution to the medium-long term solution with this being a positive experience to date for both the Board and the International Recruits, working in collaboration with Yeovil Hospitals Foundation Trust. The cost is £12k per nurse with funding from SG in Acute to date for 23 in 2021/22, 50 in 2022/23 and for 7 in HSCP making a total so far of 80 RNs.

There is no confirmation of continued funding by SG, but organisational agreement is required to maintain the potential pipeline. There is however a stop/start arrangement with Yeovil Trust disrupting a consistent flow. Currently, there are 28 RNs in post with 15 completing OSCEs (Objective Structured Clinical Examinations) for registration, however, this can take 4–6 months from arrival to registration.

There is now an International Recruitment Coordinator in post within the Workforce Directorate and a PPD Facilitator in post in order for OSCE prep to be all in-house.

NHS Fife can support 8 IRs per month with limiting factors being accommodation and OSCE support. To do this we require confirmation of the additional funding required from SG.

b) Return to Practice

We have 5 applicants for programme to commence this year.

c) Open University

5 places have been made available to Fife - in discussion with Open University for additional places.

d) HNC Route

There have been 16 applicants for HNC with interviews planned in May 2023. This 2-year course allows entry to 2nd year of pre-reg nursing course.

e) Assistant Practitioners

The development of bands 2 to 4, particularly the role of the Assistant Practitioner, is being implemented to support a sustainable workforce.

- Cohort 1 (n=21) started PDA in April- should qualify January 2024
- Cohort 2 (n= 44) start PDA in August- should qualify May 2024
- Cohort 3 (n tbc) start PDA in January 2025

8.2 eRostering

Work is progressing on the implementation of eRostering, with plans for roll out to the next phase of services being agreed. Business as usual resource requirements are currently work in progress, with initial agreement for the Workforce Directorate to host eRostering in future once full implementation has been realised.

Implementing eRostering can bring numerous benefits to NHS Fife. Key advantages include:

1. Efficient workforce management: eRostering streamlines the process of creating, managing, and updating staff rotas. It allows for automated rostering, reducing the administrative burden on managers and ensuring optimal allocation of staff resources.
2. Time and cost savings: The automation of rostering processes saves time for both managers and staff. Manual rostering can be time-consuming and prone to errors, whereas the eRostering system can quickly generate rosters, taking into account various factors such as staff availability, skill mix, and workload requirements. By reducing the time spent on rostering, managers can focus on other critical tasks. Moreover, efficient rostering leads to better staff utilisation, minimising overtime costs and reducing the need for supplementary staff.
3. Enhanced staff satisfaction: the eRostering systems has an online app feature which allows staff members to indicate their availability, preferences, and requests for time off. Time spent requesting leave on paper forms and delays in manager's response is replaced with a simple, online solution.
4. Improved patient safety: Effective rostering plays a vital role in ensuring patient safety. With eRostering, managers can ensure appropriate staffing levels, skill mix, and continuity of care. By accurately matching staff to patient needs, the risk of errors and adverse events can be reduced. Additionally, as the system is implemented, including the Safecare model, the system can

provide real-time visibility into staffing gaps or potential issues, enabling proactive adjustments to maintain patient safety standards.

5. Compliance with regulations: NHS Fife must comply with working time directives and contractual obligations. eRostering systems can help automate compliance monitoring by tracking staff working hours, rest breaks, and leave entitlements. This ensures that rostering practices align with legal and regulatory requirements, reducing the risk of non-compliance.
6. Data-driven decision making: eRostering can generate a wealth of data related to staffing patterns, workload distribution, and resource allocation. Analysing this data can provide valuable insights for workforce planning. Managers can identify trends, predict staffing needs, and make data-driven decisions to improve efficiency and resource allocation in the long term.

In summary, implementing eRostering will lead to efficient workforce management, time and cost savings, improved staff satisfaction, enhanced patient safety, compliance with regulations, and data-driven decision making. It will significantly transform the rostering process and contribute to the overall effectiveness and performance of NHS Fife.

8.3 Health & Care Staffing Act 2019 – Safe Staffing legislation

Work is progressing across professions in preparation for full implementation of the Health and Care (Staffing) (Scotland) Act 2019 on 1 April 2024. Teams are currently in testing Guidance chapters. Learning from the plans for implementation of the legislation across nursing, midwifery and other clinical professions, is being shared across the organisation.

8.4 Staff Health & Wellbeing

Supporting wellbeing and maximising attendance is a key focus of our recovery work. In addition, we continue to work on creating a culture of kindness, where employees look after each other. This is a shared commitment led by our Board and our Executive team working in partnership with our staff. “Well@Work” is the branding of NHS Fife’s employee Health and Wellbeing programme.

NHS Fife has a range of core staff wellbeing services in place as part of the tiered approach to wellbeing, starting at local level within teams / wards. This includes:

- Occupational Health Service
- Spiritual Care
- Peer Support
- Staff Listening Service and
- Psychology Staff Support

Our approach is focused on the Four Pillars of Wellbeing, as detailed in the diagram below, with each area of wellbeing being supported by:

- Workplace policies, processes, and guidance
- Internal wellbeing initiatives
- Resources available to those employees who need them
- Communications for all employees on wellbeing and how to access support

8.5 Recruitment & Retention of Staff

In addition to the work described above and in Section C below in relation to our Bank & Agency Programme, a number of other initiatives are ongoing within NHS Fife to support recruitment and retention of staff, including within our Medical & Dental and Pharmacy functions and through development of extended roles in terms of advanced practitioners, consideration of areas where Physicians Associates and other MAPs could be employed, skill mix and improved use of technology.

9. Digital

NHS Fife Corporate Objectives 2023/24 mapped to this Recovery Driver are:

To deliver value and sustainability

- *Develop the digital medicines programme*

9.1 Optimising M365

We will establish a secure baseline in the M365 products and national tenancy by October 2023 and implement federation with Local Authority by October 2023.

We will assess future options for maximisation of M365 products in line with current licence/capacity restrictions and the work of National Groups by December 2023.

9.2 National digital programmes

We are committed to strengthening the use of national and regional systems for delivery of key programmes in which economies of scale can be realised. We have committed to a number of programmes which will continue to be delivered over the medium term. These include:

- e-Rostering – NHS Fife have begun the rollout of the National rostering system which supports staff to deliver services. This will conclude during the medium-term plan period
- Community Health Index (CHI) – We are collaborating with the national team to deliver this programme.
- Child Health – This programme had a reset in 2022, therefore we continue to support whilst a new programme timeline is delivered.
- M365 – Maximising Benefits and federation – M365 was rolled out during the pandemic, there are a number of areas which still require to be maximised whilst also supporting more joined up utilisation across Health and Social Care.
- GP IT – To deliver a new GP IT system is currently being taken through governance within Fife and will be implemented within the medium term.
- HEPMA – NHS Fife has finalised a contract to deliver Hospital Electronic Prescribing and Medicines Administration across both acute and community areas.
- Laboratory Information Management System (LIMS) – NHS Fife are one of three early implementation boards and are working closely with other boards to deliver this programme locally, regionally and nationally.
- PACS – Fast Access to images, NHS Fife have undertaken several upgrades of the current PACS system implemented in Fife, following contract award, NHS Fife will consider the best approach to implementation and work with colleagues within Radiology to implement the new PACS system into NHS Fife.

- Vaccination and Immunisation – continue to support this work ongoing within this area.
- Radiology Information System (RIS) – Consideration to a new national approach to RIS is being undertaken if this is brought forward, NHS Fife will support the inclusion of this work within their plan.
- Digital Pathology – Has been implemented within NHS Fife we will continue to collaborate closely with teams to ensure safety standards continue to be met.

9.3 Organisational Digital Maturity Exercise

NHS Fife completed a digital maturity exercise in 2019 this will be repeated in 2023. The results of the previous Digital Maturity exercise helped to shape the priorities for NHS Fife. The 2023 study will be undertaken to ensure consistency with the delivery plan we are undertaking and ensuring that any emerging themes that have not already been considered are part of the key ambitions for our next digital strategy scheduled for delivery in 2024.

9.4 Leadership in digital

We will plan our delivery for both our service users and those who utilise digital but we will also focus internally to ensure that we continue to upskill in order to meet the demands of the workforce and ensure that leaders across health and care are equipped with the necessary skills, we are therefore committed to undertaking training locally and also highlighting to leaders across the board when digital programmes are offered, in the medium term example of the areas are:-

- Information Technology Infrastructure Library (ITIL) – Digital have committed to the continued support of ITIL for those working within the digital environment.
- Digital Leadership – An MSc Course is available and will be cascaded to relevant teams, with leaders within the organisation supported to undertake this qualification.
- Digital Mindset Masterclasses – We will support the cascading of these sessions to our senior leadership team in order to create a shared understanding of the challenges of digital delivery.
- KIND – Senior Leaders within digital are signed up to the KIND network and are committed to supporting and rolling out training which is identified within this programme to teams both internal to digital and externally where appropriate.

Roles and Pathways – Digital are in the process of creating a skills matrix which will support those interested in a career in digital in achieving their ambitions. In addition, NHS Fife digital are supporting modern and graduate apprenticeships to support the ongoing delivery of digital and show the benefits of a career in digital to young people within the local community.

9.5 Scottish Health Competent Authority

NHS Fife will undergo the NIS (Network and Information Systems) audit in July 2023. Following the completion of the report the NIS Action Plan will be created and presented to the Information Governance and Security Steering Group and the Digital and Information Board for awareness and assurance. Both groups will then

track the progress of the Action Plan in the normal manner. Items of note will also be escalated through the standing governance arrangements as required.

NHS Fife continues to seek confirmation of the strategy for the Cloud Centre of Excellence (CCoE) and its associated services. On identification of these then direct engagement, in relation to support of compliance with NIS will form part of the Action Plan. At present engagement with CCoE is based on their national role in informing threat intelligence and identification.

9.6 Paperlite project

The Paperlite project as it was known has been reshaped into an Electronic Patient Record programme, with key benefits beginning to be derived, which will be around 70% complete within the medium-term delivery timescale. The programme will focus on maximum utilisation of our key cornerstone systems, providing value to the NHS whilst also reducing the need for paper in delivery of clinical care. This focus will also be directly related to those system suppliers who have proven their ability to keep pace with the requirement for well design and rapid pace developments. This will support our clinical teams to deliver care, with information which is up to date at point of care, therefore improving clinical decision making and the patient experience.

This programme will also focus on how we interact with patients to improve their experience through the continued use and introduction of digital technology.

Examples of Key deliverables are:

- Our strategic programmes will ensure we maximise the use of existing systems through the extension of Electronic Patient Record programme, as the most appropriate way to support the design and deliver our services.
- The inclusion of innovation in our strategic framework will bridge the gap and support implementation of a true EPR for NHS Fife that is available to patient through a digital “doorway”, while recognising the need for alternatives in supporting those that find themselves excluded from the digital world.
- Near Me – The pandemic saw the introduction of Near Me within Fife for all Acute, Community and Mental Health services, this was further supported by the introduction of Near Me, Near You with specialised Near Me rooms in the community for those who do not have connectivity at home. In the medium-term NHS Fife will continue to support the use of Near Me for group consultation. NHS Fife are also aware of further work being undertaken within the HSCP to support the rollout of Near Me within Social Work services and will support this process by sharing lessons learned with teams.
- Digital Front Door – NHS Fife will extend its digital front door through the continued introduction a digital hub for patients, which supports patients to have key clinical information in relation to their care their engagement with services, and their ability to have access to staff and services through the use of digital exchange including modern telephony solutions. NHS Fife have also recently introduced ‘Elsie’ to support digital preassessment within orthopaedics, in the medium term there is an ambition to further expand the use of this technology. We will continue to commit to this both at a local level and with supporting the introduction of any recommendations which we receive from Scottish Government which will support this key area.

- Digital Pathways – Through introduction of digital pathways for COPD, Heart Failure, Asthma, Monitoring at Home for Blood Pressure and platforms which support this care such as Inhealthcare, Lenus and the Right Decision Service. NHS Fife are concerned with the number of platforms which are in use across Scotland, but we will work to ensure that our community understands access points for delivery of their care.
- Digital Mental Health Support – Digital will work with Mental Health teams to ensure we support the ongoing work which is being undertaken as part of Care in the Digital Age.
- Digital Inclusion – Ensuring that access to services is equal for all, that no one is left behind in the move to a digital future, we will work closely with services to ensure that we meet their needs whilst also ensuring that we develop pathways and services which meet the needs of all service users especially those who are most vulnerable in our society.

9.7 Digital Scotland Service Standard

Previously known as Digital First, NHS Fife are committed to aligning our digital deliveries with this methodology to ensure services are based on the needs of users, are sustainable and continuously improving, secure and resilient, and that good technology choices made.

10. Climate

NHS Fife Corporate Objectives 2023/24 mapped to this Recovery Driver are:

To deliver value and sustainability

- *Implement actions to support climate emergency*

10.1 Decarbonise fleet

NHS Fife are to remove all fossil – fuelled small and light commercial vehicles in the NHS Fleet. We will also ensure all small and light commercial vehicles are powered by renewable alternatives by 2025 and no longer buy or lease large fossil fuelled vehicles by 2030. We are however reliant on larger vehicles, especially tail lift vehicles, becoming more financially viable. To support the transformation of our fleet, we will continue to install electric vehicle charging points throughout the NHS estate and collaborate across the public sector on charging infrastructure.

We are heavily reliant on the Transport Scotland grant funding and have submitted a 2023/24 bid to the 'Switched-on fleet' grant for 8 light commercial vehicles, increasing the percentage of light commercial EVs to approximately 60%. If our 2023/24 bid to the Switched-on Fleet Grant is successful, we will increase the charge point network by 8 double charge points increasing the total number of charge points across NHS Fife to 77.

10.2 Achieve waste targets

The new tenders for waste have within them a mandated data return for all 15 categories of waste. These new contracts will improve our data collection. We also use the data from invoices to augment the information on the current national data system (RIO), which is of limited use currently. We are investigating the installation of bulk scales to confirm some of the data produced by contractors.

An annual audit of the very basic "what is going in which bin" ensures that we are gradually improving the segregation of waste. This ensures that more is presented for recycling and less is seen as Domestic waste, which has reduced by 15%.

Our contractor for domestic waste collection is Fife Council. Fife Council continues to invest in processing which ensures the minimum of waste goes to landfill. We will be working with Fife Council to ensure that we can extract data from their system which evidence progress to the target, ensuring no more than 5% of domestic waste goes to landfill. We will also ensure that we can demonstrate our waste is treated to meet the target of 70% of domestic waste is composted or recycled in conjunction with Fife Council.

There will be continued investment in and increase the use of dewatering equipment to reduce the overall weight/volume of food waste disposed of. We will invest in the National Catering Information System to better control production waste and improve the timeliness of ordering. We will continue to follow/improve on SG direction in the withdrawal of some disposables and introduce Reverse vending.

We will also take part in trials of re-usable PPE, ensure laundering improvements to reduce the use of disposable curtains and mopheads and will pursue the installation

of a heat recovery system within laundry. The latter utilising hot water to be re-circulated and reduce gas consumption.

10.3 Reducing medical gas emissions

There is a commitment to ending the use of desflurane and will therefore promote Sevoflurane as the first-choice option within Anaesthetics. The use of Tiva will also be promoted and encouraging the use of regional or local anaesthetics to reduce the need for volatile gases.

Work is ongoing to decommission nitrous oxide manifolds across the estate. A nitrous oxide mitigation team will be formed then discuss and document our approach to eliminating piped nitrous oxide. By the end of 2023, these reductions will be incorporated as part of our annual reporting process.

10.4 Learning from the National Green Theatre Programme

Having already made great progress in implementing the National Green Theatres programme, our next steps will involve further development of the theatre action plan to align with the national green theatre programme. NHS Fife has learned through our Regional Group of the steps taken in the implementation of Green Theatres by NHS Lothian and are looking to incorporate these into our Action Plan which is being developed for 2023/24.

This year we will create a green theatres project group which will involve recording the progress that has already been made and then identifying areas that still need focused on to fully implement the national green theatre programme across NHS Fife. We have actioned 7 areas of the green theatre programme with all other areas being in progress. Using a tracking document to monitor our progress across the areas outlined in the ‘bundles’, we will create a timeline and plans for achieving the remaining targets.

10.5 Implementing of a building energy transition programme

To begin the implementation of a building energy transition programme, we have started the process of creating net zero road maps for all NHS Fife sites. Within these, they have provided an analysis of current energy consumption and created action plans on how to reduce emissions and meet targets.

To become a net-zero health service by 2040 we will have all 12 net-zero road maps completed by the end of year 1. Then, using the completed road maps we will identify the measures to take that will allow us to deliver a 75% reduction by 2030, compared to 1990. We will then outline the funding we are going to apply for in order to carry out these projects and curate a plan as to how they can be implemented as soon as possible. We will put in funding applications for some of the projects that need to take place and aim to deliver those over the next 7 years between now and 2030.

10.6 Implementing the Scottish Quality Respiratory Prescribing guide

Our quality improvement approach for implementation of the Scottish Quality Prescribing Guide includes:

- Implement recommendations from Respiratory Quality Prescribing Guide
- Review of local prescribing guidance following publication of the Respiratory Prescribing Guide and reflecting formulary choices, which have considered environmental factors

- Further local communication and education
- Person-centred reviews (as above)
- Utilise ScriptSwitch® and other electronic prescribing systems to promote formulary choices and to highlight overuse of SABAs
- Respiratory prescribing will be reviewed through the Fife Prescribing Forum, utilising primary and secondary care prescribing data, benchmarking, and National Therapeutic Prescribing indicators

NHS Fife is one of three NHS Boards participating in redesign to transition from three separate formularies to a single East Regional Formulary (ERF). As part of this process, the Respiratory prescribing section was reviewed in October 2021 and released in December 2021.

The ERF group was tasked with reviewing inhaler choices based on the following criteria: Efficacy, Safety, Cost Effectiveness and Environmental impact. This represented the first time that Formulary Committee made a conscious effort to include environmental considerations in Formulary choices. To guide prescriber selection, a clear sign has been added to the inhaler poster to enable environmentally friendly choices of inhalers.

NHS Fife is currently awaiting publication of the Scottish Quality Respiratory Prescribing Guide (SQRPG), due April 2023. To pre-empt the SQRPG, ERF Committee is establishing an Expert Working Group of Clinicians and Respiratory Pharmacists to review how we utilise the current choices of formulary inhalers in order to assess how current choices affect the environment. A plan will then be developed to improve inhaler choices to reduce greenhouse gas emissions and limit detrimental effects on the climate. The ERF group will align discussions with the SQRPG.

10.7 Implementing an Environmental Management System

We have engaged with HDR to implement an Environmental Management System (EMS) across NHS Fife. They attended site in May to carry out an initial assessment of Victoria Hospital, with the intention of populating an EMS at this site first. We are aiming to populate an EMS at our largest site, Victoria first, with the intention of rolling out our EMS across all NHS Fife sites moving forward. Phase 1 of EMS implementation will involve Victoria Hospital, and this will be done in quarter 3 giving us 6+ months. Phase 2 will involve EMS implementation at all major sites and phase 3 will be EMS implementation at all sites. We also aim to have full implementation of an EMS at 2 sites by the end of quarter 4. By the end of quarter 1 we want to have a full plan written as to how we are going to progress with our EMS over the next year.

Section B: Finance and Sustainability

NHS Fife Corporate Objectives 2023/24 mapped to this Recovery Driver are:

To deliver value and sustainability

- *Deliver year one actions of the financial improvement and sustainability programme*

Medium-term Financial Plan

We have recently submitted our medium-term financial plan to Scottish Government which sets out the key risks to delivery of financial balance in-year and over the medium-term. Discussion is ongoing with Health Finance Directorate colleagues in relation to our key planning assumptions including:

- Ongoing distance from our NRAC share and the cumulative impact of this on the financial position
- Unsustainable levels of reliance on bank and agency staffing to support significant workforce availability challenges
- Requirement to maintain all surge capacity throughout the full year
- Significant cost pressure within our SLAs with other NHS and Independent Sector Providers
- Increasing cost pressure within SLAs for Mental Health and Learning Disability Services
- Inflationary pressures impacted by record global energy costs, across a number of areas, particularly PFI contracts which are directly linked to RPI
- Reduced levels of funding for planned care services
- Significant increasing costs across acute prescribing budgets

NHS Fife continues to operate outwith the agreed Board risk appetite in relation to delivering value and sustainability. The financial plan does however set out a realistic and credible plan to respond effectively to this over the medium-term. During 2023/24, we will continue to utilise the infrastructure we put in place previous year to help support delivery and identification financial and productive opportunities.

Establishment of Financial Improvement and Sustainability Programme

We are committed to supporting the Scottish Government's Sustainability and Value programme and have plans in place to deliver the 3% recurring savings target required by the programme.

We have established an executive led Financial Improvement and Sustainability (FIS) Programme which contains a range of activities to deliver increased capacity and productivity and to release cash efficiencies and cost reduction. During 2023/24 we have established 3 key cost improvement initiatives to reduce; bank and agency spend, surge capacity and corporate overheads. We also have a significant medicines optimisation plan and a range of initiatives to reduce property and asset management costs.

Section C: Workforce Planning and Sustainability

NHS Fife Corporate Objectives 2023/24 mapped to this Recovery Driver are:

To improve staff health and wellbeing

- *Develop and deliver an action plan to support the Implementation of the Health & Care (Staffing) (Scotland) Act 2019 (Safe Staffing Legislation)*
- *Develop and deliver a sustainability plan for the nursing and midwifery workforce*
- *Deliver specific actions from the workforce strategy to support both patient care and staff wellbeing*

Workforce Plan

The Board's three-year Workforce Plan for 2022 to 2025 was published in November 2022 and gave a commitment to the development of Directorate/Service based Workforce Plans, which in turn would form the supporting action plan to achieve the commitments set out in the Workforce Plan.

As part of the Board's Strategic Planning & Resource Allocation process, all services were provided with and submitted documentation in support of meeting this commitment, which enabled workforce projections aligned to the Workforce Plan to be captured, alongside workforce commitments, priorities and risks aligned to service deliverables. This demonstrated our triangulated approach to Service, Finance and Workforce Planning.

The details submitted have been harvested and are in the process of being analysed, so that Directorate and Service based workforce plans can be completed by the end of quarter 2 of 2023/2024. This will allow us to map corporate priorities across to the SPRA submissions, identifying those submissions that may impact the future shape of the staffing complement, and highlight any sustainability pressures, included within the Workforce Plan for 2022 to 2025.

Through our joint work with Fife HSCP workforce colleagues, we have contributed to their Workforce Action Plan, reinforcing the linkages necessary in workforce terms with our partners, including Fife Council and the voluntary and third sectors.

Key Priorities

The key priorities in the Workforce Plan for 2023/24 are:

a) General Practice Sustainability

NHS Fife and Fife HSCP continue to experience significant clinical and managerial workforce challenges within Primary Care Services, which impact directly on safe and effective service delivery within 2C Board managed General Practices. NHS Fife initiated a tender process for external bids in early 2023, for three General Practices in this category, working towards an outcome of stability and resilience. The initial tender process has been agreed and will be implemented over 2023/24. This is part of a longer-term plan to ensure safe and effective service delivery and ongoing management of 2c General Practices. The aim being to develop resilience and enhance sustainability across Primary Care Services and anticipating future pressures on General Practice.

b) International Recruitment

This has been a positive experience for both NHS Fife and the candidates, and it is hoped that international recruitment will increase and expand to other professions over 2023/24. Unfortunately, it will not be possible to recruit Midwives or Mental Health Nurses internationally due to incompatibilities with NMC requirements for training, for around another 6 months.

c) Development of Assistant Practitioner and Healthcare Support Worker Roles

Our Band 2 to 4 workforce progression will focus on establishing a recruitment programme, career development from Band 2 through to post registration and support for managers and educators.

d) Youth Employment, Employability

Last year dedicated leadership on the Employability agenda supported NHS Fife is progressing our aims in this area which sit at the heart of the Employer commitments in our Anchor Organisation delivery plan. Lessons learned from our first-year delivery are now informing our intended planning for an increased capacity for our Modern Apprenticeship (MA) programme expansion. This work will also be informed by the Director of Workforce's role in the newly established NHS Scotland Anchors Workforce Strategic Group.

In 2023/24 we will grow our MA numbers in partnership with Fife College with initial focus on our Healthcare Support Worker workforce, aligning with the work being led by our Nursing & Midwifery Workforce Group to support Band 2-4 progression to address establishment gaps within this job family. As well as building numbers in Nursing & Midwifery we will develop plans to increase our MA provision across other professions and to integrate this work with Foundation Apprenticeship activity as we build our connections with local schools to open access to increased numbers of school leavers accessing health & social care career pathways.

As part of this initiative, links are being established with NHs Fife's Executive Directors with Head Teachers across the eighteen secondary schools in Fife.

e) Health & Wellbeing Framework

The NHS Staff Health & Wellbeing Framework was published in December 2022 and is aligned to the Population Health & Wellbeing Strategy. Given the importance of and continued focus on Staff Health and Wellbeing generally and in the context of the legacy of the pandemic, confirming our intentions was key. The Framework clearly sets out the ambitions, focus, structure and reporting arrangements for staff health and wellbeing activity within the Board and takes account of current and evolving work in this area.

In addition, the Framework aligns to the commitments set out in the three-year Workforce Plan, Annual Delivery Plan and National Workforce Strategy, with the emphasis on the "Nurture" pillar of the five pillars of the workforce journey.

The infrastructure to support this has been enhanced this year by the opening of new Staff Hubs on several of NHS Fife sites, providing staff with bright, modern spaces to relax, refresh and recharge.

f) Implementation of Safe Staffing - The Health and Care (Staffing) (Scotland) Act 2019.

NHS Fife is working towards implementation of the Act in 2024 and will undertake Chapter Guidance testing, as part of the work commissioned by HIS and SG. This includes the establishment of a local reference group covering all clinical disciplines,

actively using the current real-time staffing tools to identify risks to care arising due to staffing issues, ensuring staff are aware of these, and that relevant staff have appropriate training and time and resources to implement them. This is in advance of the implementation of eRostering, which will facilitate escalation and reporting once the “Safe Care” module is live.

g) Bank & Agency Programme

Work on delivering a more sustainable and cost-effective approach to the use of Bank and Agency staff is a high priority area for NHS Fife.

An existing commitment made by the Executive to create a consolidated single Staff Bank for the management of all supplementary staffing needs has now been expanded under a new Bank & Agency Programme led by the Director of Workforce which will aim to deliver a revised model to contribute to financial and workforce sustainability to meet current and future service needs.

The Programme will be to deliver the aims set out by the national Supplementary Staffing Task & Finish Group including the adoption of the National Principles for the Management of Agency Workforce Supply to NHS Scotland Health Boards. As the model is developed it will align with our broader work on staff recruitment and retention noted above and will reflect and work compatibly with the introduction of the new national e-Rostering solution and implementation of the Health and Care (Staffing) (Scotland) Act 2019.

Section D: Value Based Health and Care

The Realistic Medicine (RM) Plan is being rolled out to embed Realistic Medicine across Fife. Engagement meetings with stakeholders suggest that communication is the most important factor in embedding Realistic Medicine in Fife. A risk workshop was organised with the RM and NHS Fife Clinical Governance Teams to identify RM risks. A stakeholder analysis workshop was also undertaken, and Communications and Engagement Plan developed. A Benefits Workshop has been undertaken to identify benefits and enable benefits realisation. A workshop is being planned to support governance arrangements. Engagement meetings were held with the Realistic Prescribing steering group to identify areas of collaboration.

Process mapping exercises were undertaken with a Sexual Health Consultant and a Consultant Surgeon on their process of engaging with patients and sending letters to them. This was undertaken for the Organisational Learning Group (OLG). It helped to identify areas of efficiency and improvements in patient satisfaction.

The 'Questions that matter' (QTM) RM tool has been developed for use in Fife and has been rolled out to patients. The tool ensures that patients are able to reflect on questions to ask ahead of consultations. A one-page digital version and QR code have been developed with excellent feedback. The RM message has been embedded on Desktops in NHS Fife with fantastic feedback and request for more information from staff.

Engagement meetings have been undertaken with the NHS Fife Communication team to identify areas of collaboration, such as developing Communications Matrix (workshop). Information on Realistic Medicine are to be rolled out to staff on desktops, hospital screens and pop-up banners. Information Realistic Medicine is now on the NHS Fife Staff intranet (Blink). There has been engagement with RM network meetings and other NHS Boards (such as NHS Ayrshire and Arran) to share learning and practice. We plan to work with Realistic Prescribing and other teams to reduce waste and enable strategies for a greener, sustainable health care system.

We plan to align our work with the 5 strategic priorities of the Scottish Government. With regards to encouraging staff to access the RM Module on TURAS, we will engage with Directors and workforce committees and ensure that staff have easy access to the RM module on TURAS via the staff intranet (Blink). We will also engage with NHS Education for Scotland (NES) to ensure the TURAS module contents flow better.

There are plans to engage with the General Medical Council (GMC), GP clusters and staff and disseminate information about RM through grand rounds. With regards to encouraging patients and families to as the BRAN (Benefits, Risks, Alternatives, Nothing) Questions, we plan to engage with the Patient Experience Team to embed RM principles, engage with patients and continue to roll out the QTM that contains BRAN questions. We plan to mainstream person centred stories and collaborate with communications and Information technology to ensure that information on BRAN questions is placed on patient and staff facing sides of NearMe (video conferencing) with prompts on IT systems on the BRAN questions.

With regards to evaluation of shared decision making from patients, we plan to undertake a variety of strategies including surveys, analysing data from care opinion and staff engaging with patients to fill feedback forms. With regards to supporting

local teams work with the Centre for Sustainable Delivery (CfSD) to roll out the Active Clinical Referral Triage (ACRT), Patient Initiated Review (PIR) and Effective and Quality Intervention (EQUIP) Pathways, we plan to engage with local teams to facilitate RM sensitive pathways. Taking cognisance of encouraging local teams to engage with the CfSD to consider current and future Atlas of Variation, we plan to collaborate with colleagues at Public Health Scotland to facilitate better understanding and consideration of this with local teams in Fife.

Section E: Integration

In Fife we have embraced the legislation associated with the Public Bodies (Joint Working) (Scotland) Act 2014, which requires NHS Boards and local authorities to collaborate to integrate the provision of health and social care services known as 'health and social care integration'.

This focuses not only what we do, but, also how we do it, developing our culture of Integration based on interagency parity and respect. We describe our collaborative approach to Integration as "Team Fife", recognising integration across health services, joint working with the Health and Social Care Partnership (HSCP) and multi-agency working across local authority and third and independent sectors in line with our community planning aspirations described within the Plan for Fife. It is by working collegiately together towards a common purpose to improve outcomes for the people of Fife that we will make greatest impact in people's lives and support our workforce.

Fife HSCP provides a wide range of delegated health and care services for NHS Fife and Fife Council. We have worked together to ensure close alignment between the Population Health and Wellbeing Strategy and Fife HSCP Strategic Plan, and we will work together to deliver and develop services for people in Fife.

Fife Health and Social Care Partnership has a three-year 'Strategic Plan 2023 to 2026' that sets out the future direction of all health and social care services across Fife. This includes how the nine National Health and Wellbeing Outcomes for Health and Social Care will be delivered locally, along with the six Public Health Priorities for Scotland.

The Partnership's Strategic Plan is supported by transformational and business enabling strategies and delivery plans. The opportunity provided by being co-terminus is that we can evidence clear alignment to both the Integration Joint Board and NHS Fife statutory responsibilities.

Some key examples of joint working that can evidence "integration in action" in Fife are:

- Collegiate work to support capacity and flow supporting the use of the whole system OPEL tool enabling whole system response using common language and agreed action in response to service pressures and risk.
- The Primary Care Strategy is jointly commissioned through professional leads in NHS Fife and Fife IJB Chief Officer to enable the recovery, quality and sustainability of Primary Care
- The Prevention and Early Integration strategy and delivery plan is another example of strong joint working aligned to Public Health Priorities and galvanising a whole system response to promoting population health and wellbeing across the life span.
- The collective efforts to support prevention are also evidenced through joint working in relation to unscheduled care to support joint improvement actions to enable the right care, right place, first time.
- We are also joining up an enhancing our collective approach to communications, participation and engagement evidenced through strategy

development and supporting us to engage meaningful with the people of Fife to inform our priorities.

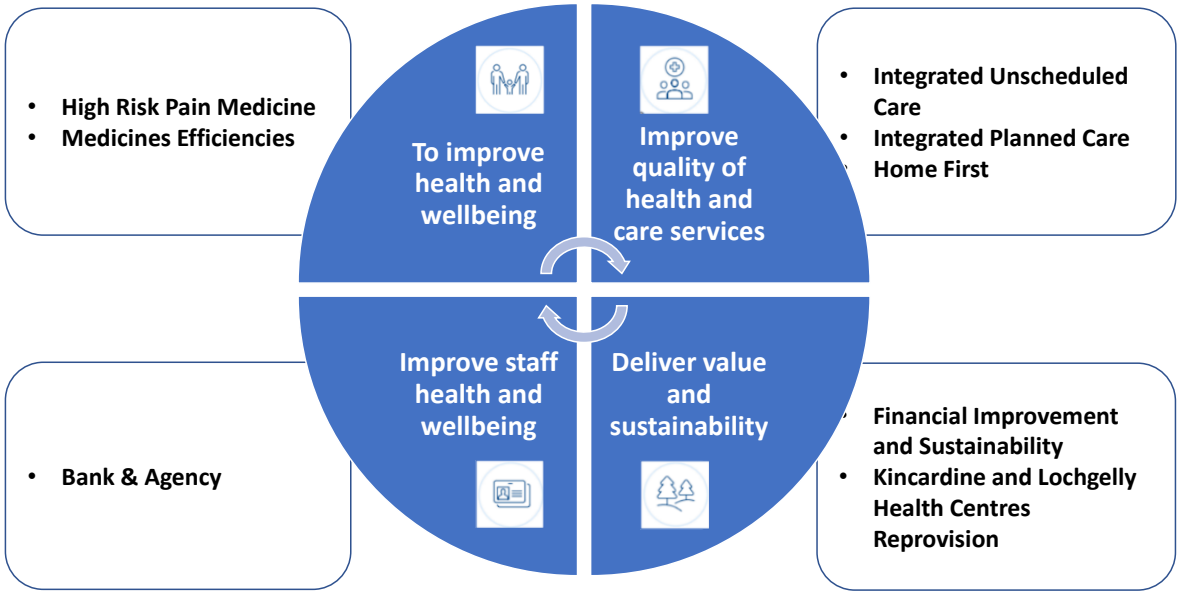
- Through our Community Planning Partnerships, we are supporting delivery against the Plan 4 Fife with the focus on place, people and community wealth building.

Section F: Improvement Programmes

NHS Fife and Fife Health and Social Care Partnership have established Programme Management Offices to manage and deliver the key strategic improvement programmes for the respective organisations.

We have high aspiration to support improvement and transformation of services in Fife. This is supported by a Programme Management Approach in both NHS Fife and the Health and Social Care Partnership which recognises the multi-agency integration of many programmes of work within the community. The examples below relate to the programmes aligned to NHS Fife services recognising there are a range of wider improvement programmes also aligned to Fife Council delegated services not listed within this plan.

The diagram below illustrates the programmes currently underway. A more detailed table with objectives and outcomes for each programme can be found in Appendix D.



Appendices

Appendix A: New Outpatient Capacity Projections by Specialty

Specialty	Urgency	April 2023 Planned	May 2023 Planned	June 2023 Planned	July 2023 Planned	August 2023 Planned	September 2023 Planned	October 2023 Planned	November 2023 Planned	December 2023 Planned	January 2024 Planned	February 2024 Planned	March 2024 Planned
All Specialties	All Urgencies	7573	7372	7364	7565	7340	7432	7421	7432	7421	7436	7436	7436
All Specialties	Routine												
All Specialties	Urgent												
Anaesthetics	All Urgencies	0	0	0	0	0	0	0	0	0	0	0	0
Anaesthetics	Routine												
Anaesthetics	Urgent												
Cardiology	All Urgencies	130	130	130	130	130	130	130	130	130	130	130	130
Cardiology	Routine												
Cardiology	Urgent												
Dermatology	All Urgencies	843	642	642	843	642	642	642	642	642	642	642	642
Dermatology	Routine												
Dermatology	Urgent												
Diabetes/Endocrinology	All Urgencies	48	48	48	48	48	48	48	48	48	48	48	48
Diabetes/Endocrinology	Routine												
Diabetes/Endocrinology	Urgent												
ENT	All Urgencies	871	871	871	871	871	871	871	871	871	871	871	871
ENT	Routine												
ENT	Urgent												
Gastroenterology	All Urgencies	125	125	125	125	125	125	125	125	125	125	125	125
Gastroenterology	Routine												
Gastroenterology	Urgent												
General Medicine	All Urgencies	0	0	0	0	0	0	0	0	0	0	0	0
General Medicine	Routine												
General Medicine	Urgent												
General Surgery (inc Vascular)	All Urgencies	715	715	707	707	707	723	712	723	712	727	727	727
General Surgery (inc Vascular)	Routine												
General Surgery (inc Vascular)	Urgent												
Gynaecology	All Urgencies	750	750	750	750	750	750	750	750	750	750	750	750
Gynaecology	Routine												
Gynaecology	Urgent												
Neurology	All Urgencies	233	233	233	233	233	233	233	233	233	233	233	233
Neurology	Routine												
Neurology	Urgent												
Neurosurgery	All Urgencies	0	0	0	0	0	0	0	0	0	0	0	0
Neurosurgery	Routine												
Neurosurgery	Urgent												
Ophthalmology	All Urgencies	518	518	518	518	518	553	553	553	553	553	553	553
Ophthalmology	Routine												
Ophthalmology	Urgent												
Oral & Maxillofacial Surgery	All Urgencies	169	169	169	169	169	210	210	210	210	210	210	210
Oral & Maxillofacial Surgery	Routine												
Oral & Maxillofacial Surgery	Urgent												
Oral Surgery	All Urgencies	0	0	0	0	0	0	0	0	0	0	0	0
Oral Surgery	Routine												
Oral Surgery	Urgent												
Orthodontics	All Urgencies	74	74	74	74	74	74	74	74	74	74	74	74
Orthodontics	Routine												
Orthodontics	Urgent												
Other	All Urgencies	770	770	770	770	770	770	770	770	770	770	770	770
Other	Routine												
Other	Urgent												
Pain Management	All Urgencies	88	88	88	88	88	88	88	88	88	88	88	88
Pain Management	Routine												
Pain Management	Urgent												
Plastic Surgery	All Urgencies	49	49	49	49	49	49	49	49	49	49	49	49
Plastic Surgery	Routine												
Plastic Surgery	Urgent												
Respiratory Medicine	All Urgencies	192	192	192	192	192	192	192	192	192	192	192	192
Respiratory Medicine	Routine												
Respiratory Medicine	Urgent												
Restorative Dentistry	All Urgencies	0	0	0	0	0	0	0	0	0	0	0	0
Restorative Dentistry	Routine												
Restorative Dentistry	Urgent												
Rheumatology	All Urgencies	186	186	186	186	162	162	162	162	162	162	162	162
Rheumatology	Routine												
Rheumatology	Urgent												
Trauma & Orthopaedics	All Urgencies	1316	1316	1316	1316	1316	1316	1316	1316	1316	1316	1316	1316
Trauma & Orthopaedics	Routine												
Trauma & Orthopaedics	Urgent												
Urology	All Urgencies	496	496	496	496	496	496	496	496	496	496	496	496
Urology	Routine												
Urology	Urgent												

Appendix B: TTG Capacity Projections by Specialty

Specialty	Urgency	April 2023 Planned	May 2023 Planned	June 2023 Planned	July 2023 Planned	August 2023 Planned	September 2023 Planned	October 2023 Planned	November 2023 Planned	December 2023 Planned	January 2024 Planned	February 2024 Planned	March 2024 Planned
All Specialties	All Urgencies	1138	1139	1139	1144	1144	1145	1162	1162	1163	1164	1164	1164
All Specialties	Routine												
All Specialties	Urgent												
ENT	All Urgencies	90	90	90	90	90	90	90	90	90	90	90	90
ENT	Routine												
ENT	Urgent												
Gastroenterology	All Urgencies												
Gastroenterology	Routine												
Gastroenterology	Urgent												
General Surgery (inc Vascular)	All Urgencies	190	190	190	190	190	190	190	190	190	190	190	190
General Surgery (inc Vascular)	Routine												
General Surgery (inc Vascular)	Urgent												
Gynaecology	All Urgencies	101	101	101	101	101	101	101	101	101	101	101	101
Gynaecology	Routine												
Gynaecology	Urgent												
Neurology	All Urgencies												
Neurology	Routine												
Neurology	Urgent												
Ophthalmology	All Urgencies	222	222	222	222	222	222	226	226	226	226	226	226
Ophthalmology	Routine												
Ophthalmology	Urgent												
Oral & Maxillofacial Surgery	All Urgencies	52	52	52	52	52	52	52	52	52	52	52	52
Oral & Maxillofacial Surgery	Routine												
Oral & Maxillofacial Surgery	Urgent												
Oral Surgery	All Urgencies												
Oral Surgery	Routine												
Oral Surgery	Urgent												
Orthodontics	All Urgencies												
Orthodontics	Routine												
Orthodontics	Urgent												
Other	All Urgencies	51	51	51	51	51	51	51	51	51	51	51	51
Other	Routine												
Other	Urgent												
Plastic Surgery	All Urgencies	30	30	30	30	30	30	30	30	30	30	30	30
Plastic Surgery	Routine												
Plastic Surgery	Urgent												
Rheumatology	All Urgencies												
Rheumatology	Routine												
Rheumatology	Urgent												
Trauma & Orthopaedics	All Urgencies	267	268	268	273	273	274	287	287	288	289	289	289
Trauma & Orthopaedics	Routine												
Trauma & Orthopaedics	Urgent												
Urology	All Urgencies	135	135	135	135	135	135	135	135	135	135	135	135
Urology	Routine												
Urology	Urgent												

Appendix C: Diagnostic Capacity Projections by Key Test

New Elective Diagnostic Test - Activity Projections	Urgency	April 2023 Planned	May 2023 Planned	June 2023 Planned	July 2023 Planned	August 2023 Planned	September 2023 Planned	October 2023 Planned	November 2023 Planned	December 2023 Planned	January 2024 Planned	February 2024 Planned	March 2024 Planned
All Endoscopy	All Urgencies	899	899	899	899	899	899	899	899	899	899	899	899
All Endoscopy	Routine												
All Endoscopy	Urgent												
All Endoscopy	Urgent Suspicion Cancer												
All Endoscopy	Bowel Screening												
Upper Endoscopy	All Urgencies	291	291	291	291	291	291	291	291	291	291	291	291
Upper Endoscopy	Routine												
Upper Endoscopy	Urgent												
Upper Endoscopy	Urgent Suspicion Cancer												
Lower Endoscopy (other than colonoscopy)	All Urgencies	131	131	131	131	131	131	131	131	131	131	131	131
Lower Endoscopy (other than colonoscopy)	Routine												
Lower Endoscopy (other than colonoscopy)	Urgent												
Lower Endoscopy (other than colonoscopy)	Urgent Suspicion Cancer												
Colonoscopy	All Urgencies	450	450	450	450	450	450	450	450	450	450	450	450
Colonoscopy	Routine												
Colonoscopy	Urgent												
Colonoscopy	Urgent Suspicion Cancer												
Colonoscopy	Bowel Screening												
Cystoscopy	All Urgencies	27	27	27	27	27	27	27	27	27	27	27	27
Cystoscopy	Routine												
Cystoscopy	Urgent												
Cystoscopy	Urgent Suspicion Cancer												
All Radiology	All Urgencies	4222	4222	4222	4222	4222	4222	4222	4222	4222	4222	4222	4222
All Radiology	Routine												
All Radiology	Urgent												
All Radiology	Urgent Suspicion Cancer												
Magnetic Resonance Imaging	All Urgencies	944	944	944	944	944	944	944	944	944	944	944	944
Magnetic Resonance Imaging	Routine												
Magnetic Resonance Imaging	Urgent												
Magnetic Resonance Imaging	Urgent Suspicion Cancer												
Computer Tomography	All Urgencies	1285	1285	1285	1285	1285	1285	1285	1285	1285	1285	1285	1285
Computer Tomography	Routine												
Computer Tomography	Urgent												
Computer Tomography	Urgent Suspicion Cancer												
Non-obstetric ultrasound	All Urgencies	1993	1993	1993	1993	1993	1993	1993	1993	1993	1993	1993	1993
Non-obstetric ultrasound	Routine												
Non-obstetric ultrasound	Urgent												
Non-obstetric ultrasound	Urgent Suspicion Cancer												
Barium Studies	All Urgencies												
Barium Studies	Routine												
Barium Studies	Urgent												
Barium Studies	Urgent Suspicion Cancer												

Appendix D: Improvement Programmes

Strategic Priorities	Programme	Objectives	Benefits / Outcomes
 **To improve health and wellbeing**	High Risk Pain Medicine	Develop a High Risk Pain Medicines Patient Safety Programme to: 1. Understand how pain is currently managed across Fife including examples of good practice, in order to increase: • learning, educational opportunities and understanding with the people of Fife regarding the use of High Risk Pain Medicines; to enable more effective and safer pain management solutions • options and the use of supported self-management solutions for pain management. 2. Reduce the prescribing culture and use of High Risk Pain Medicines across all NHS Fife settings.	• Improved Quality of Life for Service Users / Patients • Safe and effective use of HRPM medicines no mater what setting in NHS Fife • Appropriate initiation, review and stopping of HRPM. • Improved financial efficiency for NHS Fife in relation to HRPM.
	Medicines Efficiencies	1. Formulary Compliance – patients to be changed to formulary alternative medicines, where appropriate. 2. Reducing Medicine Waste – reduce waste in patients own homes, hospitals and care homes 3. Realistic Prescribing – ensure effective prescribing of medicines and to reduce polypharmacy	• Cost-effective, quality and appropriate prescribing for the population of Fife in line with change in demographics
 **Improve quality of**	Unscheduled Care Programme, specifically supporting: 1. Care Closer to Home 2. Redesign of Urgent	The guiding principles for all the work underway for Unscheduled Care to ensure the safety and wellbeing of patients and staff, and support the public to access the right care, at the right time, first time for urgent care.	• Improved and increased number of pathways that ensure that patients are directed to the right place across the whole system

Strategic Priorities	Programme	Objectives	Benefits / Outcomes
health and care services	3. Discharge without Delay		• Increase in people directed to alternative pathways • Increase in scheduled appointments
	Planned Care Programme, specifically Remobilisation of Elective Programme	Implement CfSD tools and development of speciality specific improvement plans to improve service efficiency	**Timely:** manage the reduction of flow of referrals coming through to secondary specialties and reducing waiting lists and waiting times. **Person-Centred:** Providing the right care by the right person at the right time, involved from the outset and to have information/guidance to make choices for next steps in the management of their symptoms/condition. **Effective & Efficient: C**linicians can offer improved methods of access to service when systems are robust. **Equitable: I**mplement pathways and sharing best practice across the nation that will promote less unwarranted variation.
	Home First	1. There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission. 2. Services will be redesigned/developed in an integrated manner, with a focus on prevention, anticipation and supported self-management. 3. Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions. 4. Services will be redesigned/developed so they are flexible to growing and changing demands, as well as being sustainable.	• Reduction in admissions through interventions of a team (Data will demonstrate number of bed days avoided through community intervention) • Reduction of admissions from Care Homes • Number of 'At Risk' individuals avoidably Admitted (or re-admitted) to hospital • Reduction in Digital Summoning of Support (Telecare, Rapid Response, etc.) that rapidly meets / de-escalates need • Reduced number of "delayed days" (Total Number of Days in Delay)

Strategic Priorities	Programme	Objectives	Benefits / Outcomes
		5. Assessment and planning of treatment/care will be co-ordinated. 6. Data will lead the planning and commissioning of services.	
 **Improve staff health and wellbeing**	Bank / Agency Project	• Finance – to deliver a £10 million pounds reduction in bank and agency spend in 2023/24. • Workforce – To create a consolidated single Staff Bank for the management of all supplementary staffing needs. • To communicate the benefits of joining Staff Bank, the new rules around 'On Framework Agencies only' and offer consistent messaging around polices and processes to managers and staff	• Delivery against the savings target • Improvements in Bank / Agency processes
 **Deliver value and sustainability**	FIS Programme	Overseeing the following work: • Bank/Agency Spend • Reduce Surge Capacity • Corporate Spend	• Financial Control
	Kincardine and Lochgelly Health and Wellbeing Centres Provision	Progress the Full Business Case process in line with Scottish Government timelines and funding availability.	

NHSScotland Chief Operating Officer

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11 August 2023

Dear Carol

NHS FIFE : ANNUAL DELIVERY PLAN 2023/24

Thank you for submitting your Annual Delivery Plan (ADP), setting out your operational priorities and key actions for 2023/24. May I take this opportunity to thank you and your team for all the hard work that has gone into the preparation, and subsequent review, of the ADP over the last few months.

As set out in the Delivery Plan Guidance issued in February, this year's ADP process is intended to move us forward from the volatility of the last three years and make further progress along the path towards recovery and renewal as set out in *Re-mobilise, Recover, Re-design: the framework for NHS Scotland*. As such, the guidance was framed around 10 'drivers of recovery' and we welcome the considered way in which you have responded to these when developing your 2023/24 Plan.

Following discussions between our teams, I am now satisfied that your 23/24 Annual Delivery Plan broadly meets our requirements and provides a shared understanding between the Scottish Government and NHS Fife regarding what is to be delivered in 2023/24.

There are a small number of areas where some further detailed work is required and these have already been discussed with your team. Annex 1 sets out a summary of our agreed joint position on key milestones and deliverables for 2023/24.

In moving to focus on delivery of the Plan, we do this through strenghtened engagement around the quarterly updates and the six-monthly joint Executive meetings – the next round of which is currently being scheduled for September/October.

My team will be in touch shortly to discuss your recently submitted Medium Term Plans (MTP), which provide the opportunity to set annual plans within a medium-term context. We wish to use these MTPs as the basis on which we can work in a collaborative way with Boards to ensure that they provide a robust foundation on which we can build stronger medium and long term planning capacity and capability both within Scottish Government and Boards.

Looking ahead, we will continue to build on the foundations of the annual planning process that have been laid here. In particular, we will work to ensure the ADP planning and reporting cycle is better integrated with financial and workforce planning, as well as enhanced regional and national planning. Our intention is also to bring forward the planning timetable for 2024/25, with the aim of finalising ADPs earlier in the year, and we look forward to working

with your Planning team on this to ensure we can meet this aim without placing undue pressure on Boards during busy periods.

One again, many thanks to you and all your colleagues, and we look forward to continuing to work with you as we plan and deliver the highest possible quality of care for patients, improve the experience of our staff and ensure the best possible value for citizens
If you have any questions about this letter, please contact Paula Speirs, Deputy Chief Operating Officer, in the first instance (paula.speirs@gov.scot).

Yours sincerely

JOHN BURNS
NHS Scotland Chief Operating Officer

Annex 1 : Fife 2023/24 ADP Review Feedback and Responses

Primary & Community Care

No	Key Result Areas	SG Review Feedback	Board Comments	SG Final Sign Off Comments
1.1	Within your response, set out what you will deliver in terms of the scaling of the MDT approach by quarter and set out expected impact in terms of increased activity, extended hours.	ADP sets out a plan, through the Primary Care Strategy and Delivery Plan, to review the integration of Primary Care nursing teams and all primary care workforce, to aid more sustainable workforces but also equitable provision of Immunisation, CTAC and Chronic Disease Management. Detail is missing for FIF-PPCS-02 on specific milestones, targets and actions that will be progressed during 23/24 or narrative to explain challenges in providing this detail. This will help monitoring of actions against this deliverable. There is scope to mention the preventative role of public health nursing services e.g. Health Visitors, Family Nurses and School Nurses and how they might work across multidisciplinary teams in the community.	Additional milestones have been added to FIF-PPCS-02. As the prevention and early intervention strategy is implemented from Q3, scoping will identify opportunities to enhance integration of services including community children's services to maximise health and wellbeing for people in Fife applying a life course approach.	Content
1.2	Plans to deliver a sustainable Out of Hours service, utilising multi-disciplinary teams.	It is noted that the overall ambition is to develop plans for 24/7 'Urgent Care Hubs', interfacing between Primary and Secondary care, creating sustainable workforces across Urgent Care Services and create consistent Urgent Care support to Primary Care. It is encouraging to hear the Board's plans to expand their Urgent Care infrastructure and the continued development of urgent care pathways. We would ask that ADP2 (FIF-UUC-005 and FIF-PPCS-01) sets out further detail on key actions, milestones and associated risks in relation to this, reflecting the criticality of a	Within Fife, Urgent Care Services (USCF) – Fife's OOH Service – has a sustainable workforce model, with well-established MDT, supporting GPs as Senior Clinical Decisions Makers. Along with a well-developed MDT, UCSF host Fife's Flow Navigation Centre (FNC) and leadership team is integrated within our In-Hours Urgent Care team. The aims for 2023-2024 are to expand on this replicate and test our OOHs Urgent Care model in-hours, however this is reliant on additional funding given ongoing constraints with PCIP funding and the priorities directed by MOU2.	Content We are grateful for the Board's update, and note the milestones and dependency on factors mentioned.

		more resilient service for this winter.	Additional milestones have been added to FIF-PPCS-01 within ADP2 but are dependent on funding and workforce availability. FIF-UUC-05 is now FIF-PPCS-23.	
1.3	Build and optimise existing primary care capacity to align with existing and emerging mental health and wellbeing resources with primary care resource – with the aim of providing early access to community-based services.	It is noted that there are plans to establish MHWPCS within GP clusters or localities, with three initial test sites have been identified and then roll out across the 7 localities of Fife. More detail around optimising primary care capacity could be included. Further detail is however requested in FIF-CCCS-13 on key actions, milestones and associated risks of delivery. Without the detail on quarterly milestones, it will be challenging to monitor progress against this plan. As requested in 1.3, we would also ask that you provide detail on plans to optimise primary care capacity within the project to establish MHWPCS.	Additional milestones have been added to FIF-CCCS-13.	Content
1.4	In 2023/24, set out plans and approaches for the early detection and improved management of the key cardiovascular risk factor conditions: diabetes, high blood pressure and high cholesterol.	RE T2DPF: no specific actions around type 2 diabetes prevention/ weight management services in relation to this action (1.4)	Section added to ADP1 and deliverable added to ADP2.	Content
1.5	In parallel with development of the national frailty programme, outline the approach of primary care to frailty and particularly managing those at most risk of admission. This should include the approach to progressing plans for Care Homes to have regular MDTs with appropriate professionals.	Mental Health Performance Build capacity of the existing MCN service to include an MCN for Frailty to ensure that people with frailty in the community can be cared for utilising recognised national approaches placed into a local framework. All Fife Care Home residents will have an anticipatory care plan in place. The ACP will be shared with MDT including GPs to anticipate any decompensation in long term condition and pro-	Noted	Content

		actively manage symptoms and offer support to avoid admission to hospital.		
1.6	Increase capacity for providing in-hours routine and urgent dental care for unregistered and deregistered dental patients.	The Scottish Government recently advised NHS Boards of a further revision of the Scottish Dental Access Initiative (SDAI) capital scheme to include four areas in Fife which took effect from 26 April 2023. It is hoped that this initiative will attract interest from dental practices. The Board's accompanying narrative provides a good indication of the actions which it will undertake to support access, however these are not well defined in ADP2 milestones and mitigating controls. Workforce concerns are particularly highlighted as a key risk but mitigations are not articulated. There is no consideration of baseline metrics and stretch targets to improve. It would be helpful to understand how some actions will be taken forward, including further detail on the tests of change proposed from Q2.	Additional content added to ADP1 and deliverable FIF-PPCS-05 has been updated. National indicators include calls to dental advice line, number of patients seen in OOH dental services which are currently recorded by PDS to give baseline metrics.	Content
1.7	As part of the objective of delivering more services within the community, transition delivery of appropriate hospital-based eyecare into a primary care setting, starting with the phased introduction of a national Community Glaucoma Scheme Service. Within your response, please include forecast 2023/24 eyecare activity that will transition from hospital to primary care settings.	The Scottish Government is of the understanding that NHS Fife had the capacity to potentially go live with the Community Glaucoma Service in 2023/24. Please can the Board explain why their aim is to go live in April 2024.	Noted	Content, noting that it has been agreed to follow up on go live timeline for Community Glaucoma service as part of ADP progress update
1.8	Review the provision of IPC support available to Primary Care, including general practice and dental practice	The Board has described its first steps to implementing the IPC workforce strategy in both the acute and primary care. An Oversight Board	Deliverable FIF-NURS-08 on ADP2 has been updated. Initially mapped to wrong deliverable.	Content

		has been convened to develop a local integrated service delivery plan with the HAI exec lead and DoN working immediately on strengthening the HP, AMR and IPC workforce. More clarity is requested on timescales and addition of detail relating to IPC to GP, dental and primary care.		
N/A	General Comment	It is encouraging to see such a comprehensive set of deliverables relating to primary and community care. Although many of these are in addition to the set of areas requested in the Delivery Plan Guidance, it would be helpful to understand the scale of resource available to deliver on this wide set of actions.	Resource is either via current base lined budgets and/or non-recurring monies for specific programmes of work. Our workforce as our most valuable asset and resource are critical to success of the deliverables and any plans are anchored against our HSCP and NHS Fife workforce strategies. There is however known high level risks associated with workforce which is not specific to individual services but across all disciplines and finance and we have mitigating actions in place which are formally recorded and managed with robust oversight and governance of change activities. Digital capacity as a resource is also critical to achieving many of the deliverables within the plan and again, we are aligned with the digital strategy to seek opportunities for progression and completion	Content

Unscheduled Care

No	Key Result Areas	Initial SG Feedback	Board Comments	SG Final Sign Off Comments
2.1	Boards are asked to set out plans to progress from the De Minimis Flow Navigation Centre (FNC) model to further optimise.	Although there are actions set out in relation to elements of the FNC, we would ask for confirmation of your commitment to meet the De Minimis Specification	**Planned work/actions to progress development of FNC** Ability to carry out video consultations is in place but not currently being used, within the scope of the improvement plan for 2023/24 (NearMe).	Content

			Able to transfer patient record to receiving department / clinic but currently manual process. This is to be reviewed as part of Data & Digital workstream. Ability to capture process measures data within unscheduled care linked data is not in place. Adastra use needs to be reviewed and the outcomes / data being recorded. Work to be actioned by the operational team and then to be reviewed as part of Data & Digital workstream. Confirmation is required on what the standardised national referral process is. Referrals do come from other areas and accepted. Scoping work to be undertaken to identify what further work is required in relation to a Directory of Services that includes availability. Fife Referral Organisational Guidance (FROG) provides information on services and referral processes but not availability of appointment slots. Open access for all GP referrals 24/7 (SDEC) but scheduling processes still being built to allow visibility of appointment times / slots for Emergency and Ambulatory Care. To be reviewed as part of Data & Digital Workstream. Technically able to pass requests for transport to the appropriate provider (HB provider/SAS), where patient's need non-public transport, is not in place. This has not been identified as a requirement through FNC as a process is in place.	
2.2	Extend the ability to 'schedule' unscheduled care by booking patients into slots which reduce	Although FIF-UUC-04 references scheduling of unscheduled care, further detail is required on	All people including children accessing and assessed as requiring clinical consultation via FNC are able to be booked into slots available	Content

	self-presentation and prevent over-crowding.	specific milestones, targets and delivery risks. There is potential to include School Nurses and Health Visitors in this work to improve outcomes for mothers, babies and young people.	dependant on their care need. Improvement work continues to seek opportunities for scheduling people for care across the wider system including ambulatory care pathways. Booking systems already are in place across other services including primary care and opportunities to enhance or develop scheduling across the health and social system are being explored as part of a programme of transformational change.	
2.3	Boards to outline plans for an integrated approach to all urgent care services including Primary Care OOH and community services to optimise their assets.	There are no clear plans on integrated approach to urgent care services involving OOHs and Community services.	OOH within Fife delivered by urgent care services (USCF) are well established with pathways available to support care navigation to the right place and right time across the system. A host of professional-to-professional lines and channels for communication are established. This includes but not withstanding community nursing, community pharmacy, mental health services, social work and social care, care homes and Scottish ambulance service. At present to support safety and as a contingency primary care services including primary medical services can access UCSF if necessary.	Content
2.4	Set out plans to implement and further develop OPAT, Respiratory and Hospital at Home pathways.	Although there is reference in FIF-COMC-07 to alternatives to inpatient care, further detail is required on specific actions and trajectories.	Also see FIF-EMER-03 in ADP2 Deliverable FIF-COMC-07 within ADP2 has been updated. The below KPIs will be monitored as part of Home First Programme. • Reduce the number of times that H@H Service reaches maximum capacity from 10 (baseline) to 5 by Oct-23 • Increase in the numbers of patients of	Content

			complex community care prevented from re-admission to hospital with exacerbations of chronic respiratory disease from 50 (baseline) to 60 by Oct-23 • Increase in the numbers of patients with respiratory disease who are prevented from re-admission to hospital with exacerbations of their chronic condition from 15 (baseline) to 25 by Oct-23	
2.5	Set out plans to introduce new pathways, including paediatrics and heart failure.	No detail provided in respect of this ask.	Detail was provided in ADP1 section 2.2.2. Deliverables will be added to ADP2 when applicable. We will explore development of the Paediatric Rapid Review clinic, including options around Near-Me, for 'urgent' referrals and potentially to review children sent home from ED. Achievement of this deliverable will be dependent on stabilisation of Paediatric Middle-grade rota. Acute Cardiology Service scoping options to appoint Heart Failure nurse for front door in reach admission prevention. The below KPIs will be monitored as part of Home First Programme. • Increase in the numbers of patients with heart failure who are prevented from re-admission to hospital with exacerbations of their chronic condition from 56	Content

			(baseline) to 68 by Oct-23	
2.6	Boards are asked to set out plan to increase assessment capacity (and/or footprint) to support early decision making and streaming to short stay pathways.	Although the ADP makes reference to various actions to reduce length of stay, further detail is required, as set out in 2.6, including milestones and targets on forecast length of stay reduction into short-stay wards and reduction in boarding.	A short stay enhanced triage model (RTU) has been implemented. Target 60 patients per week with LoS for area less than 6 hrs with average <4 hrs, meeting target projection of 4hrs by Nov23. Medical Admissions Unit LoS to reduce from 24hrs to 18hrs by Nov23. Currently 19 hrs. Target of no boarding to Surgical Admissions Unit. But in the event, it occurs, numbers should not exceed 4 patients. Average boarding to Planned Care wards should not exceed average monthly figure of 25.	Content
2.7	Set out plans to deliver effective discharge planning seven days a week, through adopting the 'Discharge without Delay' approach.	Although FIF-COMC-02 does include response to 2.7, further detail on specific actions and trajectories, by quarter, is required.	Please also refer to ADP2 deliverable FIF-EMER-04 Weekend planning will include Friday verification of ECD patients to ensure Criteria Led Discharge can be maintained over Saturday & Sunday. Increase flow through reduced opening occupancy on Saturday morning. The aim to increase Weekend discharges by 10% by August 2023 and 15% by December 2023 and maintain through to March 2023. ADP1 section 2.3.1 denotes goal to have no more than 44 standard delays across Acute and Community settings. The below KPIs will also be monitored as part of Home First Programme. • Deliver a sustained reduction in delayed discharges in the acute setting so no patient is	Content

			waiting in delay by Dec-23 • Increase the number of Planned Discharge Date (PDD) being met from 60% (baseline) to 90% by Dec-23	
2.8	Outline your approach to move towards full delivery of the Best Start Programme, as outlined in your Plan submitted to the Best Start Programme Board in Autumn 2022. This should include summary of the delivery and assurance structures in place including oversight at Board level.	Good description of governance. Although there is much description of risks and challenges, this needs to be balanced out with more detail on proposed actions and milestones for 2023/24.	Please refer to ADP2 deliverable FIF-WCCS-04	Content
	General comment	It is encouraging to see such a comprehensive set of deliverables, however, many of them are missing specifics on plans and trajectories beyond Q1. Reflecting the criticality of these actions on a more resilient service for this winter, we would ask that further detail on milestones and quarterly trajectories is provided for FIF-UUC-04, FIF-EMER-01, FIF-EMER-02, FIF-EMER-03, FIF-EMER-04, FIF-UUC-02, FIF-COMC-02, FIF-COMC-04, FIF-COMC07, FIF-COMC-08.	Deliverables have been reviewed and updated appropriately. Further milestones will be incorporated in due course as planning for winter progresses.	Content

Mental Health

No	Key Result Areas	SG Review Feedback	Board Comments	SG Final Sign Off Review
3.1	Build capacity in services to eliminate very long waits (over 52 weeks) for CAMHS and PT	Mental Health Performance CAMHS Trajectories provided, in the required template, but as a pdf. Could we have the excel file please? Continue focus on initiatives to deliver, achieve and maintain the 18-week referral to treatment standard and increase capacity. The ADP lacks clarity on which initiatives, specifically Fife will focus on, and the impact these will have on overall performance. Project that the CAMHS standard will be achieved by March 2024. CAMHS will build capacity to deliver improved services underpinned by agreed standards and specifications for service delivery. Fife CAMHS will achieve the standards set within the National CAMHS Service Specification. CAMHS Early Intervention Service is in place to ensure the right support is delivered at the right time by the right services. <u>Psychological Therapies</u> Trajectories provided, in the required template, but as a pdf. Could we have the excel file please? NHS Fife project that they will meet the PT standard by December 2024. On-going recruitment activity is a key component of building capacity. Demand-capacity data is collated and interrogated routinely and is used to inform improvement actions. The service has a	Noted	Content

		detailed plan of improvement actions which relate to both the waiting times target and improving access to PTs. Fife Psychology Service will increase capacity to improve access to PTs, eliminate very long waits (over 52 weeks) and meet & maintain the 18-week referral to treatment waiting times standard. Fife Psychology Service will have capacity to meet demand, achieve & sustain the LDP access and waiting times standard for PTs.		
3.2	Outline your plans to build capacity in services to deliver improved services underpinned by these agreed standards and specifications for service delivery.	ADP sets out pathways to clinical services provided by CAMHS, informed by the CAMHS National Service Specification are in place or in development to ensure Mental Health support is accessible for those with the greatest need and are most vulnerable. Partners within Fife HSCP will continue to build capacity across services to achieve the standards set within the National Neurodevelopmental Specification for children and young people. Fife HSCP will achieve the standards set within the National Neurodevelopmental Specification.	Noted	Content
3.3	Boards should report on the timetable to achieve full compliance with CAPTND data set and/or plans to improve quality as above which may include work to replace or enhance their systems to achieve compliance.	Mental Health Performance Fife CAMHS have robust data collection processes in place that supports the delivery of local priorities and aligns to national standards. Engagement with CAPTND Clinical Reference Group and NHS Fife Information Services will ensure that Fife CAMHS systems for data collection have the capability to support and	Noted	Content

		adapt to future data collection requirements. The Psychology Service is currently working with NHS Fife Digital & Information team to introduce a new patient appointment system and also an electronic patient record system. Mental Health Services will have a robust data gathering and analysis system to allow for service planning and development. Improve compliance with CAPTND dataset. Fife Psychology Service will have improved systems to support compliance with the CAPTND data set Timelines dictate that the service will be better placed to achieve full compliance with CAPTND data set during 2023/24.		
3.4	Boards are asked to set out their plans to 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%.	Although recognising the challenges in the Medium-Term Financial Plan and noting current discussions with Health Finance colleagues, we still require further detail on how NHS Fife plan to increase their MH services spend to the PfG commitment of 10% by 2026 and to increase the spend on the MH of C&YP to 1%.	Early discussions are being established with Chief Finance Officer and DoF to explore this situation. The Fife Mental Health Strategic Implementation Group has commissioned a needs assessment which will be available to inform local strategic improvements within 2023 calendar year. The outcomes from the Needs Assessment will inform the financial discussions. Mental Health spend will be reviewed to take into account the significant level of spend via SLAs elsewhere in Scotland and indeed cross border activity.	Content SG Lead will pick up with Board during routine engagement

Planned Care

No	Key Result Areas	SG Review Feedback	Board Comments	SG Final Sign Off Review
4.1	Identifying a dedicated planned care bed footprint and associated resource by Board/hospital to enable a "hospital within a hospital" approach in order to protect the delivery of planned care.	Although it is noted that protected planned care beds has been established for orthopaedics, via NTC-Fife and also that Ward 24 has been reconfigured to provide an increased bed base for elective activity. We would ask however for clarity if this is protected.	Ward 24 has 9 inpatient beds for elective and emergency activity for Gynaecology. In extremis there may be occasions where a female patient may be boarded into ward 24, but to date elective activity has been sustained and none cancelled as a result of bed capacity.	Content
4.2	Extending the scope of day surgery and 23-hour surgery to increase activity and maximise single procedure lists.	NHS Fife are creating a procedure room in day surgery facility at QMH to release theatre capacity to increase procedures which can be conducted under LA, noting it is due for completion June 2023. This will generate ten additional sessions per week and will allow transfer of lists from VHK to QMH, freeing up theatre capacity at VHK. We would ask for confirmation on plans to further extend day surgery and for 23-hour surgery.	Completion of Procedure room now delayed for early September due to issues with static flooring in procedure room. 5-6/10 sessions occupied within procedure room. Exploring demand for local cases with specialities. In terms of transfer of lists from VHK – General Surgery, ENT and OMFS will all transfer suitable lists to QMH.	Content
4.3	Set out plan for 2023/24 to reduce unwarranted variation, utilising the Atlas Maps of variation and working with CfSD and respective Specialty Delivery Groups (SDGs) and Clinical Networks.	Comprehensive set of actions on work with CfSD to reduce unwarranted variation aligning to ATLAS of variation. It is also noted that NHS Fife are participating and engaging with the national drive toward standard high volume same procedure lists such as Cataracts. Clinical engagement with CfSD SDGs is encouraged in support of the implementation of national pathways, including Endometriosis for Gynaecology and development of an NHS Fife sustainable model including training for local consultants. TTG and NOP Capacity Projections by Specialty provided and Same Day Knee and Hip Replacement Projections	We are currently focusing on the roll out of ACRT and PIR within national and local priority specialties but plan to develop our plans for the Atlas of Variation later in 2023/24. This will be reported through the Integrated PC Board, including any proposed trajectories. Ongoing work with ophthalmology to increase throughput. Meeting with IPCT 13/7 who support test of change. Plans to introduce/trial HIIT lists for hernias at QMH. Date TBC. Same day hip and knee projections will be unchanged, clinically seeing an increase in patients with multiple pathology and frailty. Increasing number of arthroplasty patients	Content

		provided, in line with BADS guidance. Further detail is requested in relation to forecast reductions as set out in 4.3.	deemed not fit for surgery at pre-assessment stage. Staffing gaps in pre-assessment resulting in reduced number of available patients assessed fit for surgery and impacting on theatre utilisation.	
4.4	Approach to validation of waiting lists for patients waiting over 52 weeks, including potential alternatives for treatment. Board responses should also outline level of engagement with the National Elective Co-ordination Unit (NECU) to support validation.	Engagement with NECU commenced early 2023 Adopt NECU process locally to improve current processes and moving from paper-based systems which have been in place for the past 2 years to implement NETCALL	None required	Content

Cancer Care

No	Key Result Areas	SG Review Feedback	Board Comments	SG Final Sign Off Review
5.1	Set out actions to expand diagnostic capacity and workforce, including endoscopy and its new alternatives	Reviewing efficiencies in service, with designated project manager(s), exploring tests of change, regular audits undertaken. For radiology - introduction of text reminder service, improve processes for utilisation of patient cancellations, monitor performance in utilisation of unused slots, weekend CT lists etc. Commitment to continue to prioritise USCs. Diagnostic capacity projections included (for endoscopy and radiology) from April 23 – March 24, forecasting a static position. Further detail is required, as requested, in the diagnostic plans as part of your 62 day improvement plan, by cancer type.	Please refer to deliverables on ADP2 relating to Endoscopy (FIF-PLAN-06) and Radiology (FIF-WCCS-03) Additional funding was unsuccessfully requested for Cancer WT therefore we have no additional capacity to offer. NHS Fife prioritise USC when vetting referrals to Radiology and will continue to do so.	Content Fife has developed a 62 day improvement plan which will be supported by expected levels of cancer waiting times funding (to be released Aug 23).
5.2	Plan for continued roll out of RCDS's – both Board level and regional approaches will be required.	One of first RCDSs in Scotland and already expanded into UGI with consideration underway to open access to pathway up to pharmacy.	Noted	Content
5.3	Set out plans to achieve full adoption of Framework for Effective Cancer Management	Little detail on actions is provided to deliver the Framework, or immediate priorities, however performance trajectories have been provided - 85.4% at March 24 for 62 day and 94.5% by March 24 on 31	Please refer to ADP2 deliverable FIF-QGC-07, this has been updated since submission.	Content Quarterly FECM returns will continue to be closely monitored by officials.

		day. We would ask that you reflect the actions that will be included within the quarterly returns summarising progress in delivering FECM. Officials will review these alongside the Board's 62 day improvements plan, mentioned above.		
5.4	Outline plans to improve the quality of cancer staging data	NHS Fife have already identified areas for improvement locally which is to be welcomed, with staging data collection for Prostate to be further improved by ensuring that this information is provided for or at multidisciplinary team (MDT) meetings. For renal, consideration is given to include the staging field in the outcomes of the MDT. For bladder, record pathological T staging prior to each TURBT (Trans Urethral Resection of Bladder Tumour) procedure and pathological TNM staging prior to cystectomy.	Noted	Content
5.5	Confirm you have: • Implemented or have plans to implement provision of single point of contact services for cancer patients • Embed referral, where clinically appropriate, to Maggie's prehab service and use of national prehab website in cancer pathways • Assurance of routine adherence to optimal diagnostic pathways and Scottish Cancer Network clinical management pathways • Embed the Psychological Therapies and Support Framework	ADP covers all areas requested and confirmation of future engagement responded to. Good evidence of activities and target milestones. Single point of contact – established for USC, colorectal or urological and to be expanded to lung cancer also this year. Many services (4 mentioned) have a dedicated pathway navigator. Looking to expand this to include breast. Maggie's Prehabilitation – comprehensive with universal sessions for anyone with a cancer diagnosis. Adherence to Pathways - A project group has been set up to implement the Optimal Lung Cancer Pathway. Psychological framework – psychological support is already embedded. Looking to use the framework to ensure equitable access to psychological support across Fife and tumour groups, and identify areas for further development. Signposting and referrals – all patients diagnosed with cancer are referred to Macmillan Improved Cancer Journey (ICJ). Potential to reference CHAS and existing relationships for children	Noted	Content

	• Signposting and referral to third sector cancer services embedded in all cancer pathways In addition, Boards are asked to confirm that they will engage and support with future data requests and advice to deliver the upcoming National Oncology Transformation Programme.	who need to access palliative care Risk noted in relation to workforce and non-recurrent funding not secured.		

Health Inequalities

No	Key Result Areas	SG Review Feedback	Board Comments	SG Final Sign Off Review
6.1	Summarise local priorities for reducing health inequalities taking into account national strategies around Race, Women's Health Plan and any related actions within most recent Equality Mainstreaming Report	Specific action in FIF-WCCS-05 to target vaccination uptake amongst vulnerable populations (including minority ethnic people), and to capture uptake data Potential to provide further detail on how health services are identifying and supporting patients in poverty e.g. requirement for Health Visitors to support income maximisation and build links with LA Money Advice Services. No explicit reference to WHP in 6.1 but is well accounted for in 1.4 and 6.4.	In partnership with Fife Child poverty group and the tackling poverty, preventing crisis group, there will continue to be a focus in maximising household income through work with CARF in relation to Money talks and the embedding of the financial inclusion referral pathway which all midwives, health visitors and FNP have been trained in. The uptake and use will be monitored, and any improvements identified and implemented.	Content
6.2	Set out actions to strengthen the delivery of healthcare in police custody and prison; ensuring improvement in continuity of care when people are transferred into prison and from prison into the community. Boards are also asked to set out any associated challenges in delivering on the actions. This should include actions to allow primary care staff to have access to prisoner healthcare records and delivery against MAT Standards.	The Exec Level lead has been named although it seems the role is shared – more context on this approach would be welcomed. There is, however, no reference in ADP2 on plans, actions or milestones to deliver 6.2 in relation to strengthening delivery of healthcare in police custody and prison, including continuity of care or implementation of MAT Standards by 2025 in custody settings.	NHS Fife confirm that the executive lead for prison healthcare is the Director of Health and Social Care and those in custody is the Director of Acute Services. Detail added to ADP2 (FIF-CCCS-14) on how the organisation will ensure that the mental health needs of individuals in custody or leaving prison is effective and provided with equitable interventions aligned to rest of the Fife population.	Content

	Boards are also asked to state their Executive Lead for prisons healthcare and those in custody, reflecting that the prisoner population is spread across all Board areas.	We welcome the commissioning of hospital liaison although it is not clear what this will do and how those in or leaving custody will benefit – we would ask for clearer outcome measurement of this in ADP2.		
6.3	Set out plan to deliver the National Mission on Drugs specifically the implementation of MAT Standards, delivery of the treatment target and increasing access to residential rehabilitation.	ADP includes examples of work being progressed to support delivery of MAT standards. Although ADP1 sets out specific timelines, this needs to be reflected in ADP2 FIF-CCCS-09.	FIF-CCCS-09 has been removed, please see FIF-BUSE-01, FIF-BUSE-02 and FIF-BUSE-03 in relation to MAT Standards.	Content
6.4	Establish a Women's Health Lead in every Board to drive change, share best practice and innovation, and delivery of the actions in the Women's Health Plan.	ADP reflects action to deliver on the WHP Plan, including appointment of lead and local priorities.	Noted	Content
6.5	Set out approach to developing an Anchors strategic plan by October 2023 which sets out governance and partnership arrangements to progress anchor activity; current and planned anchor activity and a clear baseline in relation to workforce; local procurement; and use or disposal of land and assets for the benefit of the community.	Comprehensive response.	Noted	Content
6.6	Outline how the Board will ensure Patients have access to all information on any relevant patient transport (including community transport) and travel reimbursement entitlement.	No reference to the Young Patients Family Fund either in ADP or embedded weblink.	Parents and families of infants and children cared for within the in-patient Paediatric and Neonatal services are signposted to the Young Patients family fund for assistance with travel and subsistence costs, with written information available in both areas.	Content

Innovation Adoption

No	Key Result Areas	SG Review Feedback	Board Comments	SG Final Sign Off Review
7.1	Set out the approach and plans to work with ANIA partners (coordinated by CfSD) to adopt and scale all approved innovations coming through the ANIA pipeline. This should include an outline of Board resource to support the associated business change to realise the	Strong response noting that NHS Fife has invested in supporting innovation at a local level. This resource also supports deeper engagement with the South East Innovation Test Bed (HISES), as one	Noted	Content

	benefits, which could include collaborative approaches to adoption.	of the three member Boards (Fife, Lothian and Borders), providing stakeholder input, leadership and strategic input. A realistic approach is set out in local adoption of ANIA, noting that the process for consideration and adoption of new innovations in NHS Fife from the ANIA pathway is under development.		

Workforce

No	Key Result Areas	SG Review Feedback	Board Comments	SG Final Sign Off Review
8.1	*Support all patient-facing Boards to implement the delivery of eRostering across all workforce groups* Resources to be identified locally to support business change and roll out of e-Rostering/safer staffing too including optimal integration between substantive and flexible staff resource.	ADP1 provides a strong response to benefits of erostering and noted that plans for roll out to the next phase of services has been agreed. ADP2 however doesn't include any corresponding actions or milestones to progress implementation of the benefits set out in ADP1. This detail is requested to support monitoring of proposed milestones.	New deliverable added to ADP2 around BAU following implementation.	Content

Digital

No	Key Result Areas	SG Review Feedback	Board Comments	SG Final Sign Off Review
9.1	**Optimising M365** Boards to set out plans to maximise use and increase benefits of the Microsoft 365 product. Plans should consider collaborative (local/regional/national) to offer alternative options for the delivery of programme benefits. This should include: Outlining how you will develop and improve digital skills of the workforce to realise the full operational benefits of M365	NHS Fife will establish a secure baseline in the M365 products and national tenancy by October 2023 and implement federation with Local Authority by October 2023. NHS Fife will assess future options for maximisation of M365 products in line with current licence/capacity restrictions and the work of National Groups by December 2023.	NHS Fife has an existing M365 Programme Team that is able to support the approach to roll out of M365. These resources are currently working directly with the national team on the implementation of Infrastructure Readiness and Security and Compliance baselines in line with the Operational Delivery Group. These controls also support the safe and secure use of Teams, Sharepoint, OneDrive and	Content

		Lack of detail around what resources are being used to roll out M365, along with detailing the approach being used to deliver the business change.	Local Authority Federation. An assessment on future stages will be considered once the renegotiation with Microsoft is complete.	
9.2	Boards to provide high level plans for the adoption/implementation of the national digital programmes	NHS Fife are committed to strengthening the use of national and regional systems for delivery of key programmes in which economies of scale can be realised. We have committed to a number of programmes which will continue to be delivered over the medium term, which have been included in the ADP. The ADP lacks clarity around the high-level milestones for 23/24, issues/challenges around the implementation and any identified resource pressures.	The milestones are set by the NSS Programme teams leading CHI, GP IT etc. We await the SG delivery plan finalisation to be able to make the detail assessment requested. The local ADP can be made available to provide further detail on current status.	Content
9.3	Boards to complete the Organisational Digital Maturity Exercise to be issued in April 2023, as fully as possible and in collaboration with their respective Integrated Authorit(y)ies.	Not applicable	Noted	Content
9.4	Boards should outline: • Executive support and commitment to how you are optimising use of digital & data technologies in the delivery of health services and ongoing commitment to developing and maintaining digital skills across the whole workforce • How candidates accepted on to the Digital Health and Care Transformational Leaders master's Programme are being supported and how learning is being shared across the organisation	The Psychology Service is currently working with NHS Fife Digital & Information team to introduce a new patient appointment system and also an electronic patient record system. In order to support the full adoption of National Elective Co-ordination Unit (NECU) within NHS Fife, Digital & Information are procuring a digital solution (NETCALL) within patient hub. This will digitise the current paper process with benefits identified in service efficiencies within Health Records and improved patient experience through better communications with those experiencing long waiting times. Digital & Information will look to implement by the end of	Noted	Content

		2023 and will be engaging with NECU shortly.		
9.5	Boards to demonstrate progress against the level of compliance with the Refreshed Public Sector Cyber Resilience Framework via the independent audit process. Health Boards should outline processes in place for engaging with the Cyber Centre of Excellence (CCoE) as part of compliance with the NIS regulations.	Slight lack of detail on the training being offered	Noted	Content

Climate

No	Key Result Areas	SG Review Feedback	Board Comments	SG Final Sign Off Review
10.1	Set out proposed action to decarbonise fleet in line with targets (2025 for cars / light commercial vehicles & 2032 for heavy vehicles at latest).	Gives a high level overview of progress to date and future ambitions in-line with objectives. It would be useful to have further information on the type and size of current charging infrastructure, perhaps referencing the Board's Switched on Fleets funding bid. Reliance on the Switched on Fleets funding stream is noted and is consistent across NHSScotland Boards. However, it would be useful to know what work, if any, is being done outwith this funding stream.	We believe our 2023/24 bid for infrastructure funding will be successful and the additional work will mean that we have a total of 77 charging points across NHS Fife. This will mean that (subject to a little change in behaviours/routines) we will have sufficient charge points in place to service all of our small vehicle fleet as they are changed to EVs (excluding the Enterprise Pool Cars). Out with this funding stream, wherever funds allow we are routinely switching to EV leased vehicles. We are reviewing the overall number of vehicles required with a view to reducing numbers. This will have the effect of increasing our % of vehicles which are EV.	Content NHS Fife demonstrates a positive commitment and trajectory to 2025 targets and beyond.
10.2	Set out plan to achieve waste targets set out in DL (2021) 38.	The performance data provided does not align with data provided by the Board in the past 6 months as part of a national Roue Map project and we would ask this to be reviewed and clarified so both data sets align. Whilst we commend the commitment to the existing targets the route	NHS Fife have asked for clarification on what performance data is being referred to and are unable to provide a complete response at this time. **Food waste** We are about to start a pilot in North East Fife to strengthen what we do. Due to our style of food	Content

		map data shows that the health board has considerable work to do to achieve these targets ongoing. Continued investment in food waste equipment and in national catering system is noted and welcomed. No specific reference is made to supporting the circular economy, also referenced in DL (2021)38. Circular Economy activities. The significant work done by the WMO in NHS Fife to reduce waste is noted. Regular auditing, communication about good segregation and the involvement of the WMO in the green theatre programme locally has greatly helped to engage clinical staff. The comments around the national tool on reporting is concerning but consistent across NHS Scotland currently. The WMO has been very proactive in ensuring that waste data is still reported and has developed an individual reporting system to ensure consistency. There is no reference to a waste management group which would be useful to identify the objectives and forward plan for the Board. Given that there is still work to be done by the Board it would be useful to have a plan on how the Board intends to meet the targets in the 18 months until the deadline of 2025.	service at Victoria Hospital (VHK), Queen Margaret Hospital (QMH) and Cameron Hospital, we have no production waste. Traditionally this has only been directed at patient food waste - not the food that NHS Staff bring in for consumption - this has increased dramatically with COVID and closures of staff facilities. The figures I am using are only benchmarked from 2017 - using OLLECO collections, this captures all food that comes directly out of the kitchens. We introduced food waste processing prior to 2015. **Circular economy: practical examples** We have our own in-house version of Warp-it as we have recycled furniture for years. We are in the process of getting Warp-it set up for NHS Fife. We routinely recover/refurbish chairs to avoid buying them. We are currently re-using masses of Fife Council desks from buildings they are closing. We are currently re-using vaccine centre equipment. In addition, we are currently measuring the wood and metal at VHK. **Waste Management Group** There is a quarterly waste management group for NHS Fife that is chaired by the waste management officer. **Targets** Our Domestic waste contractor uses energy from waste technology. We are already in	

			discussion with CIRECO however waste segregation is still measured in what we present rather than what they are working on which includes further segregation of waste. Re-launch of dry mixed recycling (DMR) following COVID (most wards or areas removed all of their bins and these have not been replaced). NHS assure are also getting up to 40% of all clinical orange bag waste recycled but this is reflected in NHS Scotland total clinical waste - not detailed down to health boards. PC waste is recycled through our eHealth colleagues and these figures are not recorded in the recycling process. We are counting DMR, cardboard and confidential waste as this is recycled following shredding. **Next 18 months** We will review our figures and the gathering there-of. We will roll out success of food waste pilot from North East Fife.	
10.3	Set out plan to reduce medical gas emissions – N20, Entonox and volatile gases – through implementation of national guidance.	Medical gases is a high priority area, please be clear about timelines for each gas mitigation project. Would be helpful if the clinical leads are identified for each gas mitigation project.	ADP2 updated accordingly. A nitrous oxide mitigation group has been established. This group also includes the remit for Entonox. Our clinical lead for both Nitrous Oxide and Entonox is Katie Hunter, Consultant Anaesthetist. Phase one of Victoria hospital Kirkcaldy has decommissioned its Nitrous oxide Manifold. We hope to have Phase 3 at VHK Nitrous Oxide manifold decommissioned by the end of August.	Content

			QMH and phase 2- VHK have already been decommissioned. Leaving us with no Nitrous oxide manifolds hopefully by end of August. In relation to Entonox we are awaiting a SG document detailing ask of boards and then will be able to provide timelines.	
10.4	Set out actions to adopt the learning from the National Green Theatre Programme; provide outline for greater adoption level.	HB has established group and has been tracking progress and will continue to do so. Appears limited to initial actions only and not on going work.	The board are fully committed to delivering the green theatre agenda. We have developed a local agenda which outlines that there are 17 ongoing sustainability projects in theatres which are included as part of our local action plan. The green theatres action plan will be further developed in line with the bundles provided by the centre for sustainable delivery. The sustainability tracker document previously referenced has 2 sections: open and closed actions. Open actions refer to those that are ongoing and closed refers to actions that have been completed.	Content
10.5	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.	Good high-level overview and clear reference to Energy Transition programme. Clear focus of year 1 to complete net zero roadmaps. Would clearly define whether Year 1 is 2023/24 or not. Where possible, add more clearer objectives on which (if any) decarbonisation measures that will be undertaken during 2023/24.	ADP2 updated accordingly. We confirm that year one is 2023/24. We will have completed all 12 roadmaps by December 2023 and by March 2024 will have identified the measures we need to take to reach targets. We have already started the process of decarbonisation on many of our sites. Measures taking place during 2023/24, fund dependant include: • Cameron Hospital steam decentralisation project which involves decentralising	Content Clear objectives highlighted for 2023/24.

			steam to ground source heat, design complete to RIBA 3 and now into next design stage with DNO. • Laundry Heat Recovery Project • The installation of double-glazed windows at Whyteman's Brae is underway. • Decarbonising Dalgety Bay Health Centre - Route to net-zero through installing air source heat pumps, LED Lighting & solar PV • Decarbonisation of Fife College of Nursing - Route to net-zero through installing LED Lighting, new windows and building insulation	
10.6	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.	ADP includes NHS Fife's quality improvement approach for implementation of the Scottish Quality Prescribing Guide Good to see clear plan and incorporation of environmental issues within respiratory prescribing involving the multidisciplinary team in anticipation of the quality prescribing guide release.	Noted	Content
10.7	Outline plans to implement an approved Environmental Management System.	The Board worked with HDR, a consultancy, to implement an EMS across NHS Fife. A very high-level outline plan has been provided with soft timescales, phase 1 has commenced and while they have included that it would take 6 months to roll out, timescales for phases 2 and 3 are needed. Further clarity around the phases and implementation plan with timescales is needed.	We have created an 'NHS Fife EMS implementation Roadmap' which outlines exactly how we will implement an EMS across our estate. Focusing on Victoria Hospital as our Pilot site, we will use this document as a way of steering our EMS activities and ensuring we have an effective system in place. The roadmap outlines the steps we will take across the next 2 years. The first 3 phases	Content

			are expected to take circa 18 months. Phase 1 which will occur over the next 6 months will involve developing our EMS team before carrying out a legal review. This will involve focusing on legislation and identifying the aspects that need to be addressed immediately as a starting point as well as defining legislative responsibilities. Upon completion of phase 1, Phase 2 will take around 8 months and involve creating a full Environmental Policy defining NHS Fifes' Environmental commitments and developing full impacts and aspects register as well as defining NHS Fifes environmental objectives and targets and defining key roles and responsibilities in relation to EMS. Phase 4 will involve developing the correct EMS documentation, defining operational control over aspects of our operations that impact the environment and ensuring staff with EMS responsibilities have the correct training. At the end of this phase, we will have an effective EMS in place.	

Finance & Sustainability

No	Key Result Areas	SG Review Feedback	Board Comments	SG Final Sign Off Review
1.1	Delivery of ADP / Financial Plan	The financial information within the submitted ADP aligns to that presented in the Boards 2023-24 financial plan. We recognise the financial challenges presented by the Board and we will monitor its progress against the 2023-24 financial plan through the in-year financial performance return process, beginning with the Quarter One review. In addition, a revised financial plan is due to be submitted at the end of June 2023 that will provide an updated forecast for 2023-24 and further detail on expected delivery of savings.	Deliver year one actions of the financial improvement and sustainability programme. We are committed to supporting the Scottish Government's Sustainability and Value programme and have plans in place to deliver the 3% recurring savings target required by the programme. We have established an executive led Financial Improvement and Sustainability (FIS) Programme which contains a range of activities to deliver increased capacity and productivity and to release cash efficiencies and cost reduction. During 2023/24 we have established 3 key cost improvement initiatives to reduce; bank and agency spend, surge capacity and corporate overheads. We also have a significant medicines optimisation plan and a range of initiatives to reduce property and asset management costs.	Content

Value Based Health Care

No	Key Result Areas	SG Review Feedback	Board Comments	SG Final Sign Off Review
1.1	Outline the executive sponsorship arrangements of the local Realistic Medicine Clinical Lead and Team.	No mention of the exec sponsorship In line with the condition of funding set out would expect to see a clear link to the named exec sponsor of RM locally.	The Executive Sponsor is the Medical Director the NHS Fife (Dr Chris McKenna)	Content
1.2	Indicate the connection to and overall approach of the local RM Action Plan, including the 5 key areas stipulated as conditions of funding.	RM action plan to align our work with the 5 strategic priorities of the Scottish Government Links to local action plan highlighting the alignment of the 5 key areas to RM funding.	Our RM plan, submitted to the RM team at SG in May 2023 has been explicitly aligned with the 5 strategic priorities which are implicit in ADP 1 and have been highlighted in bold in the RM plan (encouraging staff to access RM module on Turas, parents and	Content

			families encouraged to ask BRAN questions, evaluation of shared decision making from patients' perspectives, supporting local teams work with centre for sustainable development roll out ACRT, PIR and EQUIP and encouraging local teams consider current and future atlas of variation). Notwithstanding, there were other related actions in the preceding action plan (2022/23) that have been rolled over into the new RM plan (2023/24) as are still relevant in embedding RM in NHS Fife. The 5 priorities are now embedded in updated version of ADP2.	
1.3	Outline the governance arrangements for monitoring the delivery of the local RM Action Plan.	A risk workshop was organised with the RM and NHS Fife Clinical Governance Teams to identify RM risks. More detail needed on how the local governance structure and how that is connected to the local RM team and how it will monitor delivery and impact.	The current RM programme team includes the Executive Sponsor, Associate director clinical governance, the RM leads and senior project manager. The Realistic Medicine Clinical Leads directly report to MD and the RM Senior Project Manager is line managed by the Associate Director of Quality & Clinical Governance who reports to the Medical Director. RM in NHS Fife sits within the wider Clinical Governance departmental team where team members provide support that enable mainstreaming RM to the different departments in Fife. RM is now embedded in the ADP, SPRA and different departments (such as cancer). Regular meetings with Associate Director of Quality & CG to ensure we are delivering against our action plan. There are regular monthly RM team meetings. RM is on agendas as standing item and instrumental in a number of strategies in Fife. There are also regular update meetings	Content

			with the clinical governance senior managers team. Links have been made within NHS Fife to CfSD champions and planning an Atlas of Variation presentation as a topic for discussion in global cafe at Governance Workshop billed for September 2023. Following the risk workshop, we are planning a Governance Workshop to discuss with other departments on the best governance arrangements for embedding RM in Fife and if there are better ways that can be implemented. From the Governance Workshop, the governance structures and reporting processes to NHS Board will be agreed and implemented. Delivery and impact are monitored through surveys, interviews, workshops and focus group discussions. Progress reports are currently shared through the ADP, MTP, SPRA and Snapshot reports (to Scottish Government, through the RM National Team).	

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**8 September 2023**
Title:	**Scottish Healthcare Associated Infection (HCAI) Strategy 2023 – 2025**
Responsible Executive:	**Janette Keenan, Executive Director of Nursing**
Report Author:	**Janette Keenan, Executive Director of Nursing** **Julia Cook, Infection Control Manager**

1 Purpose

This report is presented for:

- Assurance

This report relates to:

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

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

- Safe
- Effective
- Person Centred

This report aligns to the following Staff Governance Standard(s):

- Well informed
- Appropriately trained & developed
- Provided with a continuously improving & safe working environment, promoting the health& wellbeing of staff, patients and the wider community

2 Report summary

2.1 Situation

The Scottish Healthcare Associated Infection (HCAI) Strategy 2023 – 2025 was published in June and sets out the Scottish Government's approach to supporting NHS Scotland to reduce HCAIs as we recover from the COVID-19 pandemic. This paper has been prepared to provide information on the Strategy to the Clinical Governance Committee.

2.2 Background

The COVID-19 pandemic has had an unprecedented impact across health and social care and, as we emerge from the most significant public health crisis of our time, it is important to build upon the appetite for effective IPC measures to ultimately reduce HCAIs.

Prior to the pandemic, Scotland was continuing to make strides in reducing the incidence of HCAIs across healthcare and the community. This strategy is intended to support the recovery from the pandemic response and reduce HCAI rates.

The strategy highlights the importance of ongoing education and training, surveillance, and monitoring. By adopting this strategy, we can regain progress interrupted by COVID-19 and continue to improve patient outcomes.

Some of the challenges associated with IPC and HCAI reduction, however, are not solely restricted to infection prevention. NHS capacity, built environment, and staffing levels are some areas that require wider whole system leadership and change. It has been emphasised that this strategy is not intended to be viewed in isolation and should be used in conjunction with other frameworks and strategies to help achieve our vision.

2.3 Assessment

As Scotland's response towards COVID-19 changes, the intention of this two-year HCAI Strategy is to establish a new baseline position which will provide the foundations for a five-year IPC strategy which will follow (2025- 2030).

The HCAI Strategy (2023-2025) was developed over a condensed period of time in order to provide NHS Scotland with a supportive national direction. Previous HCAI strategies followed a five-year running period to allow for adequate transformation to take place. This current strategy will only cover the interim period of 2023-2025. The overall aim of the HCAI strategy (2023- 2025) is to reduce the incidence of HCAIs and aid Health Boards in their recovery from COVID-19.

The intention of this strategy across its two-year lifespan is Recovery. The year one (2023-2024) deliverables are included in the strategy. The Scottish Government will engage with stakeholders on the details of year two and conduct an annual review which will inform an updated delivery plan. The Scottish Government will communicate this as appropriate.

Year 1

Year one of this strategy will be dedicated to the ongoing review of existing guidance, processes, and educational materials. The responsible stakeholders for these deliverables will primarily be the Scottish Government and the National Health Boards.

Year 2

The review of guidance, process and educational materials will continue into year 2, and will focus on planning, implementing, and embedding the outputs of year one. The Scottish Government expect that year two may include specific deliverables for Territorial Health Boards. By focusing on recovery, it is anticipated that NHS Scotland will be in a strong position to support the development and delivery of the subsequent 5-year IPC strategy.

2.3.1 Quality / Patient Care

The overarching aim of the strategy is to reduce the overall incidence of HCAI, supporting the quality and safety of patient care.

2.3.2 Workforce

The strategy is not intended to be viewed in isolation and should be used in conjunction with other frameworks and strategies to help achieve the vision. One such strategy is The Infection Prevention Workforce: Strategic Plan 2022 – 2024. This plan provides a framework to meet our goal of having an appropriately skilled, resilient, sustainable, and confident IPC workforce across all health and care settings.

2.3.3 Financial

The financial impact of the Strategy is unknown.

2.3.4 Risk Assessment / Management

The strategy specifically highlights risk assessment and management in 2 of its 7 strategic goals:

- Incident reporting processes will support the timely identification, investigation, and management of incidents, as well as providing opportunities for preventative measures to be implemented
- Staff in the health and social care sector will be supported to enhance their capability and improve their confidence in identifying and managing risks within the built environment

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

Following an Equality Impact Assessments (EQIAs) screening exercise, it was found that people of protected characteristics as outlined in the Equality Act (2010) are not impacted either positively or negatively by this strategy. Therefore, an EQIA was not required in this instance.

An Impact Assessment will be undertaken in Year 2 when specific deliverables are published for territorial boards.

2.3.6 Climate Emergency & Sustainability Impact

N/A

2.3.7 Communication, involvement, engagement and consultation

The HCAI Strategy 2023 – 2025 was launched at the Golden Jubilee Hospital in June and was attended by the Infection Control Manager, Lead Infection Control Doctor and HCAI Executive Lead. Further meetings are planned.

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.

- Infection Control Committee 09/08/2023
- EDG 10/08/2023

2.4 Recommendation

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

3 List of appendices

The following appendices are included with this report:

- Appendix No. 1, Scottish Healthcare Associated Infection (HCAI) Strategy 2023 – 2025

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Scottish Government
Riaghaltas na h-Alba

Scottish Healthcare Associated Infection (HCAI) Strategy 2023 - 2025

Contents

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

I am pleased to introduce the Scottish Healthcare Associated Infection (HCAI) Strategy 2023 – 2025, which sets out our approach to supporting NHS Scotland to reduce HCAIs as we recover from the COVID-19 pandemic.

HCAIs[1] remain a concern for all of us, and their implications are clear. In addition to the impact infection has on the lives of the Scottish people who use our health service and their families, the recent ECONI[2] study found that HCAIs result in longer hospital stays, increased healthcare costs, and additional overall pressures on health and social care resources.

This is why the Scottish Government takes the task of reducing HCAIs seriously. Since 2007, Scotland has seen significant and sustained progress in reducing HCAIs such as Staphylococcus aureus bacteraemia and Clostridioides difficile infection, to very low levels. Although it will never be possible for any hospital to eradicate and avoid all cases of infection, the Scottish Government will continue to work towards reducing the rates of HCAIs to as low a level as possible.

We continue to emphasise the importance of evidence-based Infection Prevention and Control (IPC) programmes and practice, as well as the need for robust systems and surveillance to understand and reduce the incidence of HCAI, and to effectively manage incidents as they occur to stop onward transmission.

I am confident this strategy will play an essential role in improving the quality of care we provide, enhancing the overall health of our communities.

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

1 Healthcare Associated Infections (HCAI) are infections resulting from medical care or treatments in a hospital setting, primary care setting, nursing home, or the patient's own home.

2 https://www.gcu.ac.uk/aboutgcu/academicschools/hls/research/researchgroups/safeguardinghealththroughinfectionprevention/econi

Foreword by Chief Nursing Officer (CNO)

The COVID-19 pandemic has had an unprecedented impact across health and social care and, as we emerge from the most significant public health crisis of our time, it is important to build upon the appetite for effective IPC measures to ultimately reduce HCAIs.

Prior to the pandemic, Scotland was continuing to make great strides in reducing the incidence of HCAIs across healthcare and the community. As the pandemic unfolded, resources were rightly diverted to support our response. The time is now right to revisit and refocus on reducing HCAIs.

This strategy is intended to support the recovery from the pandemic response and reduce HCAI rates. The strategy highlights the importance of ongoing education and training, surveillance, and monitoring. By adopting this strategy, we can regain progress interrupted by COVID-19 and continue to improve patient outcomes.

Some of the challenges associated with IPC and HCAI reduction, however, are not solely restricted to infection prevention. NHS capacity, built environment, and staffing levels are some areas that require wider whole system leadership and change. For that reason, I would like to emphasise that this strategy is not intended to be viewed in isolation and should be used in conjunction with other frameworks and strategies to help achieve our vision.

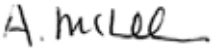
One such strategy is **The Infection Prevention Workforce: Strategic Plan 2022 – 2024**. Published in December 2022, this plan provides a framework through which we can work together to meet our goal of having an appropriately skilled, resilient, sustainable, and confident IPC workforce across all health and care settings.

The UK Antimicrobial Resistance[3] (AMR) National Action Plan (NAP) should also be considered alongside this strategy. The World Health Organisation (WHO) has identified AMR as one of the top ten global health threats.

As Scotland's Senior Responsible Officer for the delivery of policy outputs of the UK AMR NAP, I am committed to prioritising the reduction of infections in our health service. Effective IPC and antimicrobial stewardship (AMS) will reduce the occurrence and control the spread of HCAI, which will in turn reduce the need for the use of antimicrobials. It should be noted that AMS plays a crucial role in mitigating against AMR and is not explicitly referenced within this document.

It would also be remiss of me not to mention the key role that social care settings have in infection prevention. Indeed, if we are to continue in our progress of improving patient and service user care, as well as preventing AMR, then reducing infections in social care settings is vital. Although this strategy and the included deliverables focuses on healthcare settings, I would invite social care colleagues to consider the strategic goals within this document as these have been written to be inclusive of all health and care settings. This is the first step in what I hope will be a fully comprehensive IPC strategy in the future.

Lastly, I would like to extend a personal thanks to our workforce across Scotland's health and social care service for their tireless efforts and vital work during the pandemic response, and their continued commitment in reducing incidence of HCAIs.



Sincerely,
Professor Alex McMahon
Chief Nursing officer

3 Antimicrobial Resistance occurs when microorganisms which cause disease (including bacteria, viruses, fungi and parasites) are no longer affected by antimicrobial medicines.

Introduction

In 2016, the Scottish Government published the Scottish Antimicrobial Resistance and Healthcare Associated Infection – 5 Year Strategic Framework (2016-2021). This Strategic Framework aimed to support the creation of a 'zero tolerance approach' to avoidable infections, controlling healthcare associated infections (HCAIs) and containing antimicrobial resistance (AMR). The Strategic Framework was designed to support NHS Boards in taking forward key delivery areas such as AMR, cleaning and decontamination, IPC, quality improvement, and surveillance.

The Strategic Framework built upon the existing achievements of the NHS in Scotland at the time and acknowledged that the prevention and control of HCAI was an important issue for all settings where healthcare is delivered. The Scottish Antimicrobial Resistance and Healthcare Associated Infection – 5 Year Strategic Framework (2016-2021) was intended to be in place until 2021.

The onset of the SARS CoV-2 (COVID-19) pandemic posed a significant challenge in delivering the 2016 Strategic Framework. Some NHS Board and public body activities aligning with the Strategic Framework were paused, and resources were reallocated in order to respond effectively to the threats presented by the pandemic. As a result of the disruption caused, and the additional pressures which NHS Boards had to manage, some of the later strategic goals from The Scottish Antimicrobial Resistance and Healthcare Associated Infection – 5 Year Strategic Framework were not able to be fully achieved and implemented as presented in the original timeline.

In spite of the challenges posed by the pandemic, several of the actions included in the previous framework were delivered, including the development of a Care Home IPC Manual (CH IPCM), the development of new IPC standards, and the launch of the Infection Prevention Workforce: Strategic Plan 2022 – 2024.

Additionally, the many lessons learned during the COVID-19 response have reinforced the essential role of IPC in reducing the risk of, and responding to, HCAI clusters and incidents. This includes a broader understanding of the barriers to effective IPC. For example, education, guidance implementation, and the challenges posed by the built environment.

The Scottish Government remains engaged with these ongoing pandemic-focused workstreams, which includes the sharing of lessons learned during COVID-19 and feeding in recommendations from independent expert groups into wider pandemic preparedness workstreams. Outputs from these COVID-19-focused workstreams will be taken forward separately.

As Scotland's response towards COVID-19 changes, the intention of this two-year HCAI Strategy is to establish a new baseline position which will provide the foundations for a five-year IPC strategy which will follow (2025-2030).

The HCAI Strategy (2023-2025) was developed over a condensed period of time in order to provide NHS Scotland with a supportive national direction. Previous HCAI strategies followed a five-year running period to allow for adequate transformation to take place. This current strategy will only cover the interim period of 2023-2025. The overall aim of the HCAI strategy (2023-2025) is to reduce the incidence of HCAIs and aid Health Boards in their recovery from COVID-19.

Development of this Strategy

This strategy was developed by the HCAI Strategy (2023-2025) Oversight Board which was chaired by the Chief Nursing Officer and comprised of Officials of the Scottish Government, expert stakeholders, and relevant National Health Boards. **(Full membership details can be found in Annex A**).

The Oversight Board was established to ensure the strategy was founded on Health Board experience, up to date evidence, and professional expertise. The strategic goals, objectives, and deliverables have been developed and agreed with Oversight Board members to align with business plans and key workstreams already underway or planned for the period 2023-2025.

A key consideration of the Oversight Board was the wellbeing of staff in Health Services and the question as to how to ensure that the deliverables and outcomes from the strategy not only aid in the reduction of HCAI incidences, but also aid in the improvement of staff wellbeing.

The organisations responsible for completion and implementation of the deliverables will be mindful of the challenges and pressures faced by frontline services at the time of publication and throughout the term of the strategy.

Links to wider healthcare and social care sector

Given this strategy's relatively short lifespan, and the focus on Health Board recovery from the pandemic, the objectives and deliverables are primarily applicable within the acute hospital environment and therefore do not specifically reference social care.

That being said, Scottish Government recognises that infection risk is not solely restricted to the healthcare environment, and that social care settings play a key role in infection prevention.

This strategy's Oversight Board included officials from Scottish Government's Directorate of Social Care and National Care Service Development on the basis that this strategy lays the foundational work for a whole system transformational 2025-2030 IPC Strategy by making cross-organisation links as early as possible. This is being developed in the light of the WHO draft global strategy for IPC being published.

The strategic goals in this current HCAI strategy 2023-2025 were developed to be inclusive of all health and care settings. It should also be noted that some of the deliverables due to be completed in year one will also be relevant to social care staff and settings. For example, the review of IPC learning materials included on TURAS and LearnPRO.[4]

4 TURAS and LearnPro are the online platforms where learning and training material can be accessed by staff within health and social care.

Implementation

By liaising with stakeholders in National Health Boards and encouraging a collaborative interagency approach, the Scottish Government aims to use its national position to ensure programmes of work are aligned, coordinated, and ultimately support Territorial and National Health Boards who deliver direct patient care in the reduction of HCAIs and recovery from the COVID-19 pandemic.

National Health Boards will also take this approach and facilitate, where possible, that appropriate engagement with Territorial Health Boards and other National Health Boards, and NHS Scotland staff to support the overarching aims of this strategy.

The intention of this strategy across its two-year lifespan is Recovery. The year one (2023-2024) deliverables are included in this strategy. We will engage with our stakeholders on the details of year two and conduct an annual review which will inform an updated delivery plan. The Scottish Government will communicate this as appropriate.

Year 1

Year one of this strategy will be dedicated to the ongoing review of existing guidance, processes, and educational materials. The responsible stakeholders for these deliverables will primarily be the Scottish Government and the National Health Boards.

Year 2

Whilst the review of guidance, process and educational materials will continue, year two will focus on planning, implementing, and embedding the outputs of year one. The Scottish Government expect that year two may include specific deliverables for Territorial Health Boards.

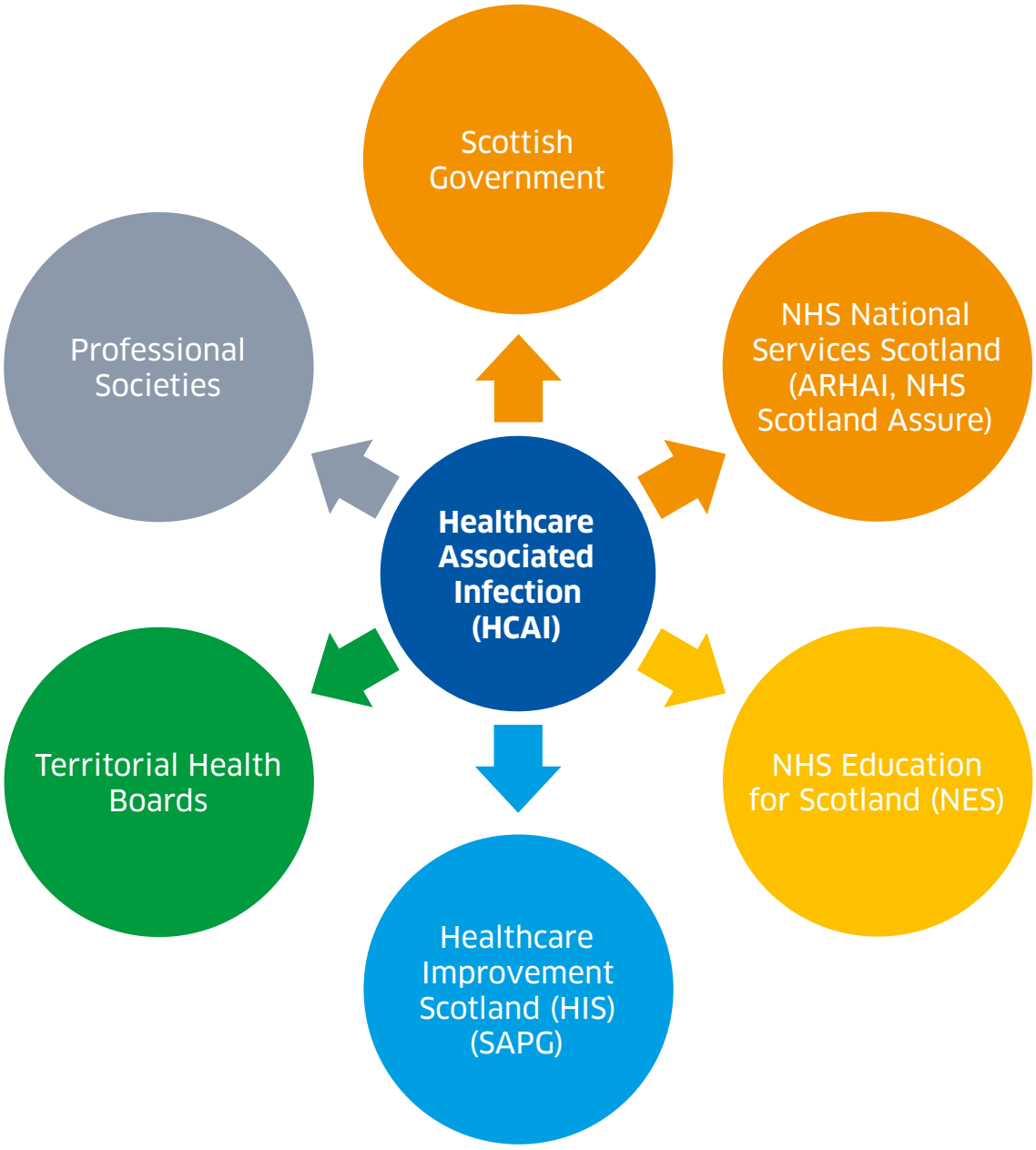
By focusing on recovery, it is anticipated that NHS Scotland will be in a strong position to support the development and delivery of the subsequent 5-year IPC strategy.

Monitoring implementation

Following publication of this strategy, the Scottish Government will liaise with stakeholders utilising existing mechanisms and structures to monitor stakeholder progress, implementation, and delivery. In addition, existing data reporting resources will be used to measure this strategy's impact on post pandemic recovery and overall incidence of HCAI.

The Healthcare Associated Infection (HCAI) Landscape

The graphic below is an illustration of the organisations who work towards reducing HCAIs. Each organisation has a different but important role.



Full role and remit descriptors of this strategy's key stakeholders can be found in Annex B.

Impact Assessment

Following an Equality Impact Assessments (EQIAs) screening exercise, it was found that people of protected characteristics as outlined in the Equality Act (2010) are not impacted either positively or negatively by this strategy. Therefore, an EQIA was not required in this instance.

World Health Organisation (WHO) Core components

The World Health Organisation Guidelines on Core Components of Infection Prevention and Control (IPC): Programmes at the National and Acute Health Care Facility Level were published in 2016. The WHO Core Components were designed to be applicable for any country and suitable to local adaptation. The WHO Core Components underpin this strategy and were used as a guide when developing the strategic goals and the associated objectives and deliverables.

Scotland can demonstrate adherence to the principles included within the core components through its well-established programmes and initiatives, such as hand hygiene monitoring. Scotland, along with the wider United Kingdom, through its government and stakeholders, are a contributor to the WHO, and regularly report to the WHO on their IPC and HCAI monitoring. It is important to acknowledge these core components and embed their core themes throughout the HCAI strategy.

The eight core components noted below take into account the strength of available scientific evidence, the cost and resource implications, as well as patient values and preferences.

Supporting Documents

This strategy acknowledges the multi-faceted elements required to deliver its aims and recognises that certain elements will link with other published healthcare strategies and policies. This document should therefore be read alongside the healthcare polices and strategies below. Together, these will support the aim of NHS Scotland recovery as well as a reduction in HCAI incidence.

- The World Health Organisation (WHO) Core Components of Infection Prevention and Control
- Excellence in Care Framework
- Healthcare Improvement Scotland IPC standards
- Health and Social Care: National Workforce Strategy
- The Infection Prevention Workforce: Strategic Plan 2022 – 2024
- UK 5-year action plan for antimicrobial resistance 2019 to 2024
- NHS Education for Scotland: Our Strategy 2023 – 2026
- WHO: Draft global strategy on infection prevention and control
- Minimum Requirements for Infection Prevention and Control Programmes
- Care Home Review: A Rapid Review of Factors Relevant to The Management of COVID-19 in The Care Home Environment in Scotland
- Genomics in Scotland: Building our Future

Roles and responsibilities in relation to the delivery of the Scottish HCAI Strategy (2023-2025)

Role of the Scottish Government

The Scottish Government is responsible for overseeing and monitoring the deliverables in this strategy. The Scottish Government will work with stakeholders in the process of delivery and will actively promote collaboration between stakeholders to ensure cross cutting information/learning is shared where relevant.

Role of National Health Boards

As stated previously, this strategy primarily contains objectives and deliverables during year one for the National Boards.

With a view of establishing a new baseline, National Health Boards will conduct evaluations/reviews of the current IPC guidance and processes to assess their relevance, usefulness, and effectiveness. Stakeholders, such as Territorial Health Boards, may be asked to engage in and provide feedback on these reviews, where appropriate.

Role of Territorial Health Boards

While this strategy does not have any initial deliverables for the Territorial Health Boards, the recommendations from year one outputs may lead to operational changes within Territorial Health Boards. The Scottish Government will communicate any relevant recommendations, including appropriate timescales for implementation, and will provide support and direction as appropriate.

Strategic Goals

Using the WHO IPC Core Components as a guide, seven strategic goals were developed in collaboration with members of the Oversight Board. Clear objectives with realistic deliverables for stakeholders are set out in the following section.

Overarching Aim	
To reduce the overall incidence of HCAI and support the recovery of NHS Scotland from the impact of the COVID-19 pandemic.	
Strategic Goal 1	Infection prevention programmes will be progressed with engagement and agreement from key stakeholders to ensure maximum impact for patients, staff, services, and the wider population.
Strategic goal 1 seeks to ensure all relevant stakeholders are involved in the development and implementation of IPC programmes. Programmes should take into account past learning and incorporate multiple facets when seeking to achieve its goal, including staff wellbeing and the impact on patients.	
Strategic Goal 2	IPC guidance and policy, relevant to various health and care settings/staff, will be developed from reviews and evaluation of international evidence of best practice and using a robust engagement process.
Strategic goal 2 seeks to ensure future IPC guidelines and policy will include learning from previous infection incidents (such as COVID-19), be applicable to all health and social care settings where appropriate and align itself with international evidence and best practice.	
Strategic Goal 3	A range of educational and practice development resources and formats are available and reviewed at predetermined intervals to ensure they meet the needs of staff at all levels for a range of sectors and professional groups.
Strategic goal 3 seeks to ensure IPC and HCAI education is accessible to all staff in the health and social care sector. By ensuring educational resources are accessible to all staff levels (including non-clinical), this strategic goal seeks to equip staff to feel they have the skills and knowledge of IPC principles to achieve the over-arching aim of reducing the incidence of HCAI.	
Strategic Goal 4	HCAI surveillance is relevant, data capture is timely, and the output supports quality improvement initiatives both locally and nationally.
HCAI surveillance is a key tool in the monitoring of IPC guidance implementation and practice. This strategic goal seeks to build on the lessons learned in relation to data surveillance and data sharing during the pandemic, and further scope how best data can be shared at a local and national level to support best practice/quality improvement.	

Overarching Aim	
To reduce the overall incidence of HCAI and support the recovery of NHS Scotland from the impact of the COVID-19 pandemic.	
Strategic Goal 5	Tools to support the application of IPC measures will be relevant, fit for purpose, and appropriate guidance/training is provided for interpretation and use.
Strategic goal 5 seeks to support all staff across multiple sectors and roles to have at least a baseline knowledge of the application of IPC practices.	
Strategic Goal 6	Incident reporting processes will support the timely identification, investigation, and management of incidents, and will provide opportunities for preventative measures to be implemented.
Strategic goal 6 seeks to ensure reporting mechanisms are robust and provide a mechanism by which learning from incidents can be shared and be used as possible early indicators of HCAI incidents/threats.	
Strategic Goal 7	Staff in the health and social care sector will be supported to enhance their capability and improve their confidence in identifying and managing risks within the built environment.
Strategic goal 7 seeks to ensure that learning from previous incidents where the built environment has been a key driver of infection is fully embedded in IPC guidance and staff education resources. Additionally, strategic goal 7 also seeks to ensure that future guidance takes into account the various settings in which care is delivered i.e. not restricted to the clinical environment.	

Strategic Delivery Plan

The Strategic Delivery Plan expands on the strategic goals to include distinct objectives and deliverables, including responsible stakeholders for delivery.

It is expected that these deliverables will be commenced during year one of this strategy. Deliverables will be used as markers for progress during this strategy's lifespan.

The overarching aim of this two-year strategy is:

To reduce the overall incidence of HCAI and support the recovery of NHS Scotland from the impact of the COVID-19 pandemic.

Strategic Goal 1

Infection Prevention programmes will be progressed with engagement and agreement from key stakeholders to ensure maximum impact for patients, staff, services and the wider population.

Objectives	Responsible Stakeholder	Deliverables
1.1 The processes used to develop infection prevention programmes will be evaluated.	ARHAI Scotland	• Undertake an appraisal of the development of the guidance (focusing on communication, consultation and engagement) within the NIPCM and CH IPCM.
1.2 IPC programmes will have active engagement with all key stakeholders	All	• All National IPC programmes will have a term of reference (ToR) and membership will include all key stakeholders.

Strategic Goal 2		
IPC Guidance and policy, relevant to various health and care settings/staff, will be developed, maintained, and updated from reviews and evaluation of international evidence of best practice and using a robust engagement process.		
Objectives	**Responsible Stakeholder**	**Deliverables**
2.1 Staff will have easily accessible guidance and resources to enable safe practice and promote patient safety	ARHAI Scotland	• There will be continuous improvement and management of the NIPCM to ensure guidance and resources meet the needs of the service and reflect current available evidence.
	Scottish Government	• Liaise with ARHAI Scotland to commission the development of national guidance on the management of specific fungal species infection.[5]
2.2 Understanding of human behaviour during the COVID-19 pandemic on the application of IPC measures will be incorporated into IPC guidance and education for staff at all levels.	NES	• The training output from the CNOD-commissioned Behavioural Insights research by Edinburgh University[6] will be housed on TURAS Learn to support leaders to ensure the principles of good communication are adhered to when introducing new or updated guidance.
	ARHAI Scotland	• Will be able to demonstrate that they have used the behavioural insights principles when developing and/or updating IPC guidance and the NIPCM.

5 This deliverable has been developed as a result of a recommendation made by Healthcare Improvement Scotland

6 The Scottish Government funded a behavioural insights study in relation to Covid-19. Study findings can be found here: **A Social Identity Approach To COVID-19 Transmission in Hospital Settings.**

Strategic Goal 2		
IPC Guidance and policy, relevant to various health and care settings/staff, will be developed, maintained, and updated from reviews and evaluation of international evidence of best practice and using a robust engagement process.		
Objectives	**Responsible Stakeholder**	**Deliverables**
2.3 All remaining COVID-19 IPC guidance and policies across Health and Social Care will be reviewed regularly considering emerging evidence.	Scottish Government	• Review the remaining COVID-19 specific guidance with a view to determine whether these measures are still required. • Ensure guidance changes are communicated with appropriate notice for timely implementation by NHS Boards.
	ARHAI Scotland	• Continue to review remaining COVID-19 IPC guidance at regular intervals with a view to determine whether these measures are still required.

Strategic Goal 3		
A range of educational and practice development resources and formats are available and reviewed at predetermined intervals to ensure they meet the needs of staff at all levels for a range of sectors and professional groups.		
Objectives	**Responsible Stakeholder**	**Deliverables**
3.1 Support the development of a confident and skilled IPC and antimicrobial stewardship (AMS) workforce.	NES	• Using an agreed methodological approach, work collaboratively with stakeholders to develop frameworks for both specialist IPC practitioners, as well as a generalist framework for AMS. • Undertake a gap analysis of the current resources to assimilate current resources to the pathways and ascertain further educational resource requirement. • Scope the merits of centralisation of AMR/ AMS resources within TURAS Learn to ensure maximum usage.

Strategic Goal 3		
A range of educational and practice development resources and formats are available and reviewed at predetermined intervals to ensure they meet the needs of staff at all levels for a range of sectors and professional groups.		
Objectives	**Responsible Stakeholder**	**Deliverables**
3.2 Support the standardisation of IPC practice across Scotland.	NES	• Develop an IPC Education Strategy, which will begin the initial development of a general IPC curriculum in the planned 2025-2030 IPC strategy.
		• Continue developing bite-sized resources, incorporating stakeholder feedback, to provide a blended learning approach including short animations and podcasts which are aligned to the NIPCM and complement the Scottish IPC Pathway (SIPCEP).
3.3 Increase the awareness of and accessibility to IPC training resources at a local and national level.	NES	• Work collaboratively with health and social care colleagues to ensure that where education resources are developed/ maintained, this is done using the best available evidence and in a format that supports the needs of the learner. • Continue to collaborate with NES Digital, NHS Health Board Learning and Development teams to ensure any updates to SIPCEP on TURAS Learn are mirrored in LearnPro to ensure consistency and governance across platforms.

Strategic Goal 4		
HCAI surveillance is relevant, data capture is timely, and the output supports quality improvement initiatives both locally and nationally.		
Objectives	**Responsible Stakeholder**	**Deliverables**
4.1 Surveillance Systems and processes will be reviewed not only to consider existing programmes but identify any new priorities.	ARHAI Scotland	• Will undertake a review of current mandatory surveillance priorities and make recommendations for future priorities, including a review of current mandatory surveillance.
	Scottish Government	• Evaluate current mandatory surveillance policy in light of the completed review and will communicate any policy changes timeously.
4.2 The current National HCAI targets and indicators will be reviewed to ensure they are relevant and reflective of current context.	ARHAI Scotland	• Complete a review of the HCAI targets and indicators and provide the Scottish Government with the results of the review and any recommendations. • Continue analysis of NHS Board data and report progress towards delivery of HCAI targets and indicators for Scottish Government monitoring.
	Scottish Government	• Consider the recommendations made by ARHAI Scotland relating to the HCAI standards and indicators. • Communicate the outcome of the ARHAI Scotland review and any changes to the National HCAI targets and indicators to all relevant stakeholders. Ensure there is a lead-in time for implementation of any change.

Strategic Goal 5		
Tools to support the application of IPC measures will be relevant and fit for purpose, and that appropriate guidance/training is provided for interpretation and use.		
Objectives	**Responsible Stakeholder**	**Deliverables**
5.1 Assurance will be sought around local processes for Standard Infection Control Precautions (SICPs) and improvement work.	ARHAI Scotland	• Liaise with Territorial and other National Health Boards to conduct a gap analysis on SICPs monitoring.
5.2 Ensure strategic alignment with other relevant strategies pertaining to HCAI and the nosocomial agenda.	Scottish Government	• Engage in development of the Pathogen Genomic Strategy for Scotland 5 year strategic plan. • Consider relevant recommendations and outputs from the Public Health Scotland (PHS) needs and gap analysis of Scottish microbiology services in line with the Public Health Microbiology Strategy for Scotland.

Strategic Goal 6		
Incident reporting processes will support the timely identification, investigation, and management of incidents, as well as providing opportunities for preventative measures to be implemented.		
Objectives	**Responsible Stakeholder**	**Deliverables**
6.1 The methods of reporting incidents and outbreaks will be reviewed to ensure processes support the assessment and reporting of infection incidents and shared learning.	ARHAI Scotland	• Chapter 3 and Appendices 14 and 15 of the NIPCM will be reviewed to support the mapping of investigations, to explore hypotheses, and ultimately support the identification of preventative measures to reduce the likelihood of further infection incidents.
6.2 Data collection methods and processes will be improved to support early warning systems.	ARHAI Scotland	• Begin development of a local alert/early warning system for high-risk areas in collaboration with a pilot board.

Strategic Goal 7		
Staff in the health and social care sector will be supported to enhance their capability and improve their confidence in identifying and managing risks within the built environment.		
Objectives	**Responsible Stakeholder**	**Deliverables**
7.1 NES will deliver and evaluate flexible learning and development resources to support the specialist workforce members responsible for built environment.	NES/NHS Scotland Assure	• Continue with the delivery and implementation of the National Learning and Development Strategy for the Specialist Healthcare Built Environment Workforce (2021-2026) and provide delivery measures via their annual action plans.
7.2 The learning from built environment incidents and reviews will be reflected in future policy, guidance, and research.	NHS Scotland Assure	• Ensure learning from built environment incidents and reviews is reflected in updated guidance & policy documents. • Ensure that learning from built environment incidents and reviews is used to develop informed research topics.

Annex A: Oversight Board

The HCAI Strategy Oversight Board was established to ensure a comprehensive and collaborative approach to the development of this two-year strategy. Members consist of key stakeholders within NHS Scotland, Scottish Government, and relevant National Health Boards. Strategic goals, objectives, and deliverables have been developed and agreed with Oversight Board members to align with business plans and key workstreams that are already underway or planned for 2023-2025.

Membership:

Representative	Member (M) Deputy (D) Observer (O)	Job Title	Representing Body/ Professional Board
Alex McMahon	Chair	Chief Nursing Officer	Scottish Government
Irene Barkby	Deputy Chair	Associate Chief Nursing Officer	Scottish Government
Colin Urquhart	M	Head of HCAI/ AMR Policy Unit	Scottish Government
Emma Hamilton	M	HCAI/AMR Policy Team Leader	Scottish Government
Grant McPherson	M	HCAI/AMR Senior Policy Manager	Scottish Government
Rebekah Dunese	O	HCAI/AMR Policy Manager	Scottish Government
Emma Donnelly	O	HCAI/AMR Policy Admin Support	Scottish Government
Jamie Stewart	M	HCAI/AMR Policy Team Leader	Scottish Government
Elaine Ross	M	HCAI/AMR Policy – Professional Advisor	Scottish Government

Representative	Member (M) Deputy (D) Observer (O)	Job Title	Representing Body/ Professional Board
Michael Taylor	M	Primary Care Policy	Scottish Government: Primary Care
Fiona Hodgkiss	M	Social Care Policy	Scottish Government: Adult Social Care
Jennifer Gilmour	M	Social Care Policy	Scottish Government: Adult Social Care
Pamela Joannidis	M	HCAI/AMR Policy Unit Professional Nurse Advisor	Scottish Government:
Kathy Kenmuir	M	Primary Care Professional Advisor	Scottish Government: Primary Care
Ian Storrar	M	Assistant Director, Engineering & Assurance	NHS Scotland Assure
Thomas Rodger	D	Head of Engineering	NHS Scotland Assure
Laura Imrie	M	Consultant Lead ARHAI Scotland Interim Clinical Lead NHS Scotland Assure	ARHAI Scotland
Shona Cairns	M	Consultant Healthcare Scientist Clinical Scientist	ARHAI Scotland
Jacqui Reilly	M	HCAI Exec Lead	NHS National Services Scotland
Rona Broom	M	Infection Control Nurse	Infection Control Nurses

Representative	Member (M) Deputy (D) Observer (O)	Job Title	Representing Body/ Professional Board
Jonathan Horwood	M	Infection Control Manager	Infection Control Managers
Angela Wallace	M	HCAI Exec Lead	HCAI Exec Leads
Lesley Shepherd	M	Head of Programme	NHS Education for Scotland
William Malcolm	M	Pharmaceutical Adviser Clinical Lead for SONAAR programme ARHAI Scotland	SOHNAP
Alan Morrison	M	Deputy Director of Health Finance	Health Finance
Dr Andrew Seaton	M	Consultant in Infectious Diseases and General Medicine Chair of Scottish Antimicrobial Prescribing Group Committee (SAPG)	SAPG
Karen Wares	M	Scotland Branch Coordinator/ Country Lead	Infection Prevention Society
Michael Lockhart	M	Public Health Scotland Microbiologist	Public Health Scotland

Representative	Member (M) Deputy (D) Observer (O)	Job Title	Representing Body/ Professional Board
Dr Aleksandra Marek	M	Infection Control Doctor Chair of Infection Control Doctor Forum	Infection Prevention & Control Doctors (IPCD) SMVN subgroup
Dr Martin Connor	M	Clinical Lead Scottish Microbiology and Virology Network (SMVN)	Scottish Microbiology and Virology Network (SMVN)
Fiona Wardell	M	Health Improvement Scotland Standards Team	Health Improvement Scotland Standards
Dr Hazel Henderson	M	Health Protection Consultant	Health Protection Consultants Forum
Susan Laidlaw	M	Director of Public Health in NHS Shetland	Director of Public Health

Annex B: Role and Remits of National Health Boards

NHS Scotland Territorial Boards	NHS Scotland is made up of 14 regional Health Boards. Each one is responsible for protecting and improving the health of the population. Territorial Health Boards deliver frontline healthcare services, and therefore are key drivers of IPC, and in delivering reductions in HCAI and AMR.
NHS Scotland National Boards	There are 8 National Health Boards: • Healthcare Improvement Scotland • Scottish Ambulance Service • The Golden Jubilee University National Hospital • The State Hospital • NHS 24 • NHS Education • National Services Scotland • Public Health Scotland These boards support the Regional Boards by providing specialist and national services across the whole of Scotland.

National Services Scotland (NSS)	NSS is a Non-Departmental Public Body which provides advice and services to the rest of NHS Scotland. Accountable to the Scottish Government, NSS works within the health service, providing national strategic support services and expert advice to NHS Scotland. Within NSS sits Antimicrobial Resistance & Healthcare Associated Infection (ARHAI Scotland) Scotland, which is a key stakeholder in the healthcare associated landscape in Scotland. NHS Scotland Assure is also based in NSS. **ARHAI Scotland** ARHAI Scotland is a clinical service which coordinates the national programmes for IPC and AMR. ARHAI Scotland provides expert intelligence, support, advice, evidence-based guidance, and clinical assurance. ARHAI Scotland works closely to provide clinical leadership to local and national government, health and care professionals, the general public, and other national bodies. ARHAI Scotland also provides clinical assurance to NHS Scotland ASSURE. **NSS NHS Scotland Assure** NSS NHS Scotland Assure seeks to improve how NHS Scotland manages risk in the healthcare-built environment across Scotland. Managing risk in the right way gives those involved in maintaining NHS buildings, facilities, and equipment confidence and reassurance. This ensures safety, fitness for purpose, cost effectiveness, and capability to deliver sustainable services.
National Education Scotland (NES)	NHS Education for Scotland (NES) is an education and training body and a National Health Board within NHS Scotland. NES is responsible for developing and delivering healthcare education and training for the NHS, health and social care sector, and other public bodies. NES also has a Scotland-wide role in undergraduate, postgraduate, and continuing professional development education.

Healthcare Improvement Scotland (HIS)	The purpose of Healthcare Improvement Scotland is to enable the people of Scotland to experience the best quality of health and social care. Its broad work programme supports health and social care services to improve. Within Healthcare Improvement Scotland sits Scottish Antimicrobial Prescribing Group (SAPG), which is a key stakeholder in the HCAI landscape in Scotland. **Scottish Antimicrobial Prescribing Group (SAPG)** SAPG works with NHS boards across health and care settings in Scotland to improve antibiotic use, to optimise patient outcomes and to minimise harm to individuals and to wider society.
Public Health Scotland (PHS)	Public Health Scotland has been leading and supporting Scotland to respond to its health challenges, making a difference to the lives of people in our communities. As Scotland's national public health body, Public Health Scotland lead and support work across Scotland to prevent disease, prolong healthy life, and promote health and wellbeing.

Annex C: Glossary of Terms

AMR	Antimicrobial Resistance
AMS	Antimicrobial Stewardship
ARHAI	Antimicrobial Resistance and Healthcare Associated Infection
HCAI	Healthcare Associated Infection
HIIAT	Healthcare Infection Incident Assessment Tool
HIS	Healthcare Improvement Scotland
ICM	Infection Control Managers
IPC	Infection Prevention and Control
IPCT	Infection Prevention and Control Team
NAP	National Action Plan
NES	NHS Education for Scotland
NHS	National Health Service
NIPCM	National Infection Prevention and Control Manual
NSS	National Services Scotland
PHS	Public Health Scotland
PPE	Personal Protective Equipment
SICPs	Standard Infection Control Precautions
SIPCPs	Scottish IPC Pathway
WGS	Whole Genome Sequencing

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: 978-1-80525-697-7

Published by The Scottish Government, June 2023

Produced for The Scottish Government by APS Group Scotland, 21 Tennant Street, Edinburgh EH6 5NA
PPDAS1271982 (06/23)

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NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**8 September 2023**
Title:	**The Infection Prevention Workforce: Strategic Plan 2022-24**
Responsible Executive:	**Janette Keenan, Executive Director of Nursing**
Report Author:	**Janette Keenan, Executive Director of Nursing**
	Julia Cook, Infection Control Manager

1 Purpose

This report is presented for:

- Assurance

This report relates to:

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

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

- Safe
- Effective
- Person Centred

This report aligns to the following Staff Governance Standard(s):

- Well informed
- Appropriately trained & developed
- Provided with a continuously improving & safe working environment, promoting the health& wellbeing of staff, patients and the wider community

2 Report summary

2.1 Situation

The Infection Prevention Workforce: Strategic Plan 2022-2024 (appendix 1) was published by the Scottish Government in December 2022. Further information about the plan was provided in June 2023 when the Interim HCAI Strategy was launched. It is the intention that NHS Boards, Health and Social Care Partnerships, independent and third sector providers in Scotland, take the plan and work to operationalise it in the context of their own settings. To this end in Fife, a Local Integrated Service Delivery Plan (LISDP) Steering Group is being established (ToR Appendix 2).

2.2 Background

A review of the AMS and IPC Workforce was commissioned in 2020 by the Chief Nursing Officer. It fulfils a key commitment in the UK Government National Action Plan (NAP) for Antimicrobial Resistance (AMR) 2019-24: to assess current and future workforce needs to ensure capability and capacity for strong IPC and AMS across health and care settings; and develop future workforce targets based on the results of this assessment.

The projected demand for workforce over the next decade, make clear that we must not only recover from the pandemic and grow the workforce but also transform how we work.

We need to develop capacity and capability in our AMS, HP (limited to the IPC element of health protection) and IPC workforce using a range of approaches which include, but are not confined to, role clarification and career pathways, exploring opportunities to build on the relationships that currently exist, creation of a learning system to support this specialist workforce and ensuring there is capacity, which can be flexed to meet the needs of the ever-evolving service.

It is acknowledged that the COVID-19 pandemic placed additional pressure on both the HP and IPC teams locally and nationally due to there being a requirement to provide specialist HP and IPC advice to primary care areas such as dental and general practice, with HP teams providing support in the wider community, and IPC teams supporting Health Protection with outbreak management and providing general advice on IPC practice to care homes and care at home.

The pandemic has highlighted the need for this workforce to be broad based, flexible and adaptable and favours a future approach to training and recruitment, which recognises breadth of experience as being as important as an individual specialist contribution.

2.3 Assessment

The Strategic Plan contains 15 recommendations:

- Board: 7 Recommendations, although some dependent on SG action
- Board / CNOD: 1 joint Recommendation
- CNOD: 2 Recommendations
- SG: 2 recommendations
- NES: 2 Recommendations
- Regional Planning: 1 Recommendation

A LISDP (Appendix 3) has been drafted and describes NHS Fife's status in relation to the Infection Prevention Workforce Strategic Plan recommendations. This draft LISDP will inform and support the work of the LIDSP Steering Group.

2.3.1 Quality / Patient Care

The plan provides a framework through which we can work together to meet our goal of having: an appropriately skilled, resilient, sustainable and confident workforce working in an integrated way and with all appropriate disciplines, delivering evidence-based advice, guidance and interventions appropriate to localised need in both acute and community settings.

2.3.2 Workforce

The benefits of this Plan will be to provide the operational context for health and care AMS, HP and IPC workforce and workload planning at both local and national level, to determine the adequacy of current resourcing, ensure demand does not outstrip supply, and support succession and resilience planning for the future.

The Plan will also ensure accessibility and consistency of the standards of education and training for this workforce and meet expectations of these staff for professional growth and development from generalist to specialist, in addition to the continuing professional development needs of specialists.

2.3.3 Financial

The financial impact of the Plan is unknown but there is a real opportunity for the Board and Health and Social Care Partnership to explore how they might best further enhance the joint working of this resource, with sharing of knowledge, skills, and expertise building resilience into the system.

2.3.4 Risk Assessment / Management

There is some risk that recommendations cannot be actioned at Board level in a timely fashion as they are dependent on SG action. The Steering Group will monitor this closely.

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

An Impact Assessment will be undertaken and will help inform LISDP Steering Group as action plan is developed.

2.3.6 Climate Emergency & Sustainability Impact

N/A

2.3.7 Communication, involvement, engagement and consultation

Discussions have taken place, at national level, with SEND and ICM group. Furthe discussions at national event in June 2023, held at GJNH

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.

- Infection Control Committee 09/08/2023

- EDG 10/08/2023
- (Strategic Workforce Planning Group 29/08/2023)

2.4 Recommendation

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

3 List of appendices

The following appendices are included with this report:

- Appendix No. 1, The Infection Prevention Workforce: Strategic Plan 2022-2024
- Appendix No. 2, Local Integrated Service Delivery Plan (LISDP) Steering Group
- Appendix No. 3, Local Integrated Service Delivery Plan (LISDP)

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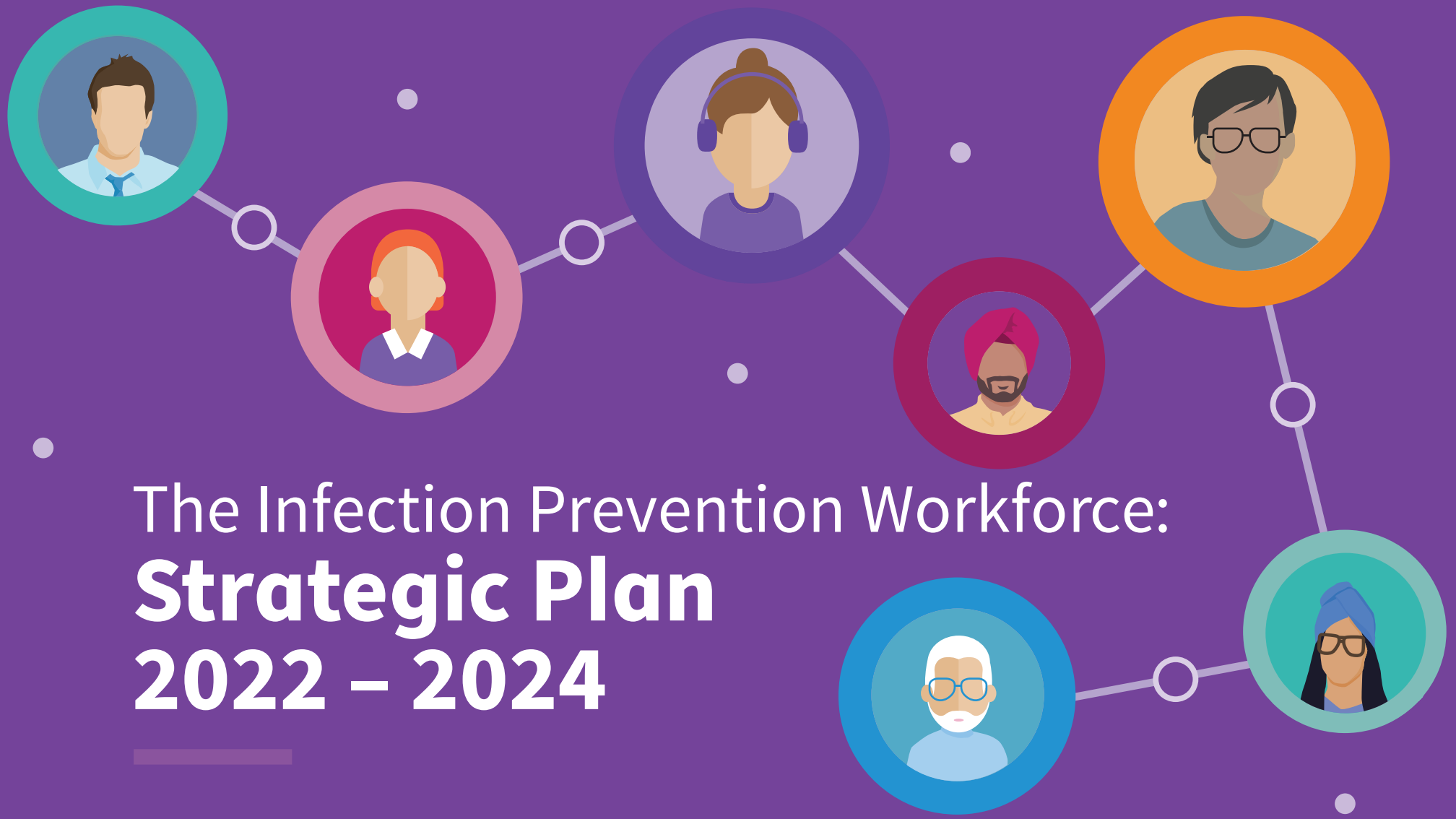

The Infection Prevention Workforce: **Strategic Plan 2022 – 2024**

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Foreword

I am sincerely thankful for the ongoing commitment, professionalism and dedication shown by our NHS Antimicrobial Stewardship (AMS), Health Protection (HP) and Infection Prevention and Control (IPC) Teams, who have played a crucial role in maintaining services and keeping people safe during the COVID-19 pandemic.

Decisive and visible political commitment, sustainable resources, leadership and engagement are required at the highest level to sustain and improve implementation of functional AMS, HP and IPC programmes. As the First Minister has said, 'no hospital anywhere in the world can eradicate completely the risk of infection in very sick patients'. We can, however, put in place the best possible systems to minimise that risk, and ensure that we respond to infection incidents with appropriately detailed action plans that are effectively implemented in all health and care settings. The Scottish Government is committed to preventing and reducing healthcare associated infections (HAI) and containing and controlling antimicrobial resistance (AMR), to promote individual safety in our healthcare settings and protect effective antimicrobial drugs for the future.

All health and social care staff have an important role to play in preventing the spread of infection by recognising that IPC is everybody's responsibility.

Finally, I would like to reiterate my thanks on behalf of the Scottish Government and myself, for all the tireless work you and your colleagues have undertaken across Health and Social Care before, during and since the pandemic and I look forward to continuing to work with you during this recovery phase and beyond.

Chief Nursing Officer
Professor Alex McMahon

Introduction

A review of the AMS and IPC Workforce was commissioned in 2020 by Professor Fiona McQueen, the then Chief Nursing Officer. It fulfils a key commitment in the UK Government National Action Plan (NAP) for Antimicrobial Resistance (AMR) 2019-24: to assess current and future workforce needs to ensure capability and capacity for strong IPC and AMS across health and care settings; and develop future workforce targets based on the results of this assessment.

Since this review was commissioned, the entire health and social care workforce has experienced rapid changes due to the COVID-19 pandemic, demographic shifts in care from acute to community settings, and opportunities brought by new data and analytical services, new technology and new ways of working. These are explored in the wider National Workforce Strategy for Health and Social Care 2022 (published on 11 March 2022), alongside which this more focused plan was developed.

This Workforce Plan is about building capacity and capability of AMS, HP (with relevance to IPC) and IPC workforce in all health and care settings, to enable recovery and development, reflecting on the need for planning post pandemic across all health and care and as part of the wider system infection management needs. This wider system includes the work of AMS and HP teams and so these are referenced throughout. It also considers the enablers, and thus IT and training are also addressed.

This Strategic Plan sits under the National Workforce Strategy, which will support and enable critical work through our tripartite ambition of Recovery, Growth and Transformation of the Health and Social Care workforce.

This plan is also set against the context of the NHS Recovery Plan, which the Scottish Government published in August 2021. The Recovery Plan sets out key ambitions and actions to be developed and delivered over the next five years to address the backlog in care and meet healthcare needs for people across Scotland.

The COVID Recovery Strategy published in October, emphasises tackling inequalities through national and local leadership. Both these documents inform our Workforce Plan.

The challenges identified in these documents, and the projected demand for workforce over the next decade, make clear that we must not only recover from the pandemic and grow the workforce but also transform how we work. We need to develop capacity and capability in our AMS, HP (limited to the IPC element of health protection) and IPC workforce using a range of approaches which include, but are not confined to, role clarification and career pathways, exploring opportunities to build on the relationships that currently exist, creation of a learning system to support this specialist workforce and ensuring there is capacity, which can be flexed to meet the needs of the ever-evolving service.

It is acknowledged that the COVID-19 pandemic placed additional pressure on both the HP and IPC teams locally and nationally due to there being a requirement to provide specialist HP and IPC advice to primary care areas such as dental and general practice, with HP teams providing support in the wider community, and IPC teams supporting Health Protection with outbreak management and providing general advice on IPC practice to care homes and care at home. Whilst specialist teams in these areas will be equipped to lead on this work, local implementation and delivery will involve the whole multi-disciplinary Team across all settings.

The pandemic has highlighted a gap in IPC knowledge and skills in staff working across the health and care system, including primary and community care settings, but has also pointed to the synergies which exist across the AMS, HP and IPC workforce with respect to IPC and outbreak management. This provides an opportunity to explore ways in which relationships and teams can be strengthened and roles developed going forward.

The pandemic has also highlighted the need for this workforce to be broad based, flexible and adaptable and favours a future approach to training and recruitment, which recognises breadth of experience as being as important as an individual specialist contribution. There is a leadership role for professionals who have training and experience across both the acute and community setting and with broad skills embracing AMS, HP and IPC.

This document provides a framework through which we can work together to meet our goal of having: **an appropriately skilled, resilient, sustainable and confident workforce working in an integrated way and with all appropriate disciplines, delivering evidence based advice, guidance and interventions appropriate to localised need in both acute and community settings.**

Part 1:

Acknowledgements

Preparation of this Workforce Plan required external and internal stakeholder dialogue and engagement, focusing on how the AMS, HP and IPC workforce could be strengthened in the short term whilst planning for a more sustainable long-term position.

The work of the sub-groups and Oversight Board has been instrumental in driving this Plan forwards. Thanks are due to all those who have given their time to this work, especially as this work was undertaken during the course of the pandemic.

Part 1:

Aims and scope of the Plan

The Plan sets out the evidence base and recommendations which will be taken over the short, medium and long term to achieve our ambition of Recovery and Development of our IPC services. These recommendations include:

- Identify the current AMS, HP (with regards to IPC) and IPC (including management) specialist workforce across health and care both locally and nationally, and assess and address current and future demands and potential service gaps, in order to succession plan and build sustainability.

- Review and address IPC capability within the AMS and HP workforce.

- To progress the work for a national eSurveillance system for Scotland, with the support of local and national stakeholders.

- Identify the requirements for new/emerging local/ national specialist roles, which will support phased implementation of a sustainable workforce.

- Consider services are led by a clinical leader with an appropriate level of seniority relative to the size and complexity of the Board, whose sole focus is on AMR, HAI and IPC, accountable to the Executive Team and partnership, ensuring safe and effective clinical service delivery.

Part 1:

Aims and scope of the Plan

This plan does not cover:

> Capacity building within the HP workforce, which will be addressed through the Workforce Plan for Renewal of the Local Public Health Workforce in Scotland.

It should be noted that this plan does not scope the needs of the wider HP service, but the IPC needs of the wider population in health and social care, and is for the Boards to determine how these needs are addressed.

To achieve our outcomes, underpinned by an ambition of Recovery we must do this through the 5 pillars of the workforce journey, as set out in the **Health and Social Care National Workforce Strategy.**

The Five Pillars of the Workforce

Aims and scope of the Plan

Benefits

The benefits of this Plan will be to provide the operational context for health and care AMS, HP and IPC workforce and workload planning at both local and national level, to determine the adequacy of current resourcing, ensure demand does not outstrip supply, and support succession and resilience planning for the future. **(Workforce management pillars: Plan, Attract).**

This Plan will also ensure accessibility and consistency of the standards of education and training for this workforce, and meet expectations of these staff for professional growth and development from generalist to specialist, in addition to the continuing professional development needs of specialists. **(Workforce management pillars: Train, Nurture).**

The Plan aims to ensure the resilience, governance and escalation within the system for assurance of services. **(Workforce management pillars: Plan, Employ).**

Consideration has been given to the need for integrated eSystems and to ensure that resources are in place for local and national IPC surveillance, reporting and patient management, with sufficient interconnectivity both locally (within Boards) and nationally (across Boards), which can be used for forward planning and which will help to maximise efficiency and productivity through more effective use of human resources. **(Workforce management pillars: Plan, Nurture).**

Strong and effective leadership is essential for the delivery of this plan, at all levels of the workforce, in tandem with the required recovery and transformation of processes, systems and structures.

Implementation

This plan is for all NHS Boards, Health and Social Care Partnerships and independent and third sector providers in Scotland who have an accountability to deliver AMS, HP and IPC services through deployment of suitably skilled workforce and associated support infrastructure (such as surveillance, reporting and patient management systems) at both local and national level.

It is the intention that NHS Boards, Health and Social Care Partnerships, independent and third sector providers in Scotland take this Plan and work to operationalise it in the context of their own settings.

The landscape in Scotland

Since the inception of the Healthcare Associated Infections (HAI) Taskforce in June 2002, Scotland has developed robust systems to prevent and control HAI and contain and control AMR. Key milestones have included the development of our National IPC Manual, published in January 2012, contribution towards the UK 5 year AMR strategy (2013) and publication and implementation of Scottish Management of Antimicrobial Resistance Action Plan ScotMARAP 2 in 2014. The development of the first HAI Standards in 2008 by the then Quality Improvement Scotland, reviewed in 2015, and updated in May 2022 (and renamed IPC Standards) by Healthcare Improvement Scotland, act as a key component in the drive to reduce the risk of infections in health and social care in Scotland. These standards underpin Healthcare Improvement Scotland's programme of inspection of the safety and cleanliness in acute and community hospitals. The Care Inspectorate inspects services using self-evaluation frameworks (which include IPC practice) that are informed by these standards and the National IPC Manual.

The report into the outbreak of Clostridium difficile at the Vale of Leven Hospital by The Rt Hon. Lord MacLean in November 2014[1] made a number of recommendations regarding responsibilities and educational requirements for Boards and roles of local IPC and AMS teams. In addition, the report called for clarity regarding the need for robust reporting and governance structures for IPC teams both locally and nationally. This includes ensuring that surveillance systems are fit for purpose and that users receive appropriate training. As a result, National Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) Scotland in NHS Services Scotland (NSS), has developed national guidance and national surveillance programmes which include timely data feedback (both nationally and locally) to support reductions in HAI and containment of AMR. NHS Education Scotland (NES) has led the development of training and education programmes based on the ARHAI guidance for the wider workforce in support of addressing IPC knowledge needs.

In 2016, the World Health Organisation (WHO) published their Guidelines on Core Components of IPC Programmes at the National and Acute Health Care Facility Level[2]. Recognising that effective IPC is the cornerstone of managing threats posed by epidemics, pandemics and AMR, these evidence-based recommendations on the core components of IPC programmes provide the framework for our national IPC programmes in Scotland.

The report from the Queen Elizabeth University Hospital's Oversight Board in March 2021[3] raised the need for national learning regarded the increasing need for robust IPC and the drive for improvement in terms of leadership, reporting and governance as well as the need for joint working across the whole system in order to reduce the risk of harm from infection to those who use our health and care services.

The recently published IPC report by the Director-General of the WHO[4] outlines the impact of HAIs and AMR globally and the gaps and challenges in implementing national and local IPC programmes. The burden of HAI and AMR within healthcare settings worldwide is approximately 7 out of every 100 patients and the COVID-19 pandemic has demonstrated how critical IPC is to maintaining health and care services and to ensure patient and health and care worker safety. In Scotland, we have seen improvement in our HAI data in recent years and the recent ECONI[5] study demonstrated real inroads had been made pre pandemic with an incidence of HAI in hospitals close to 1%. Our prevalence surveys in Scotland in recent years have pointed to the importance of HAI in all hospital types (acute and community) and care homes6. The pandemic has illustrated the importance of maintaining that focus on prevention and managing this with the balance of harms required in considering IPC in all health and care settings. Thus, our HP and IPC Programmes need to be supported by a dedicated and appropriately trained specialist HP and IPC workforce, both nationally and locally, and their activities need integrated and owned within the wider health and care system delivery.

The challenges

Despite the progress made over recent years, reducing health and care related infections and containing AMR remain significant challenges, and high demands are placed on the specialist AMS, HP and IPC workforce. These staff work in a wide range of settings, set against the threats of AMR and existing endemic and emerging HAI pathogens. Whilst real progress has been made in training and educational national programmes for the generalist workforce in IPC and AMS, the specialist workforce needs require further consideration to ensure all have access to specialist training, education and career development pathways. This is essential for succession planning and ensuring continuity of this specialist workforce.

Over time as services have evolved and are rightly based on local context and needs, some variation has developed, in terms of key roles and their functions, role titles, numbers of staff, workforce structures and development requirements. Significant Scottish Government funding has been provided to ensure Boards provide IPC leadership and management, antimicrobial pharmacists and additional cleaning staff every year since 2005.

Scotland's population needs a high-quality workforce in this key area. Since 2019, Scotland has contributed to the UK's 5-year National Action Plan (NAP) to tackle AMR and the UK's 20-year Vision to contain and control AMR by 2040. The NAP contains a commitment to assess current and future needs of this workforce (based in both health and care settings) and to develop future workforce targets. The aim of this exercise was to explore the three specialist teams who provide robust specialist infection prevention, control and management services namely AMS, HP and IPC.

	**Primary care** – General practice, General dental practice, Optometrists and community Allied Health professions (AHPs)
	**Prisons** – Health covered clinics in prisons and HPTs would cover outbreaks in prisons
	**Care at home**
	**Care homes**
	**Day centres**

If the gaps that have become apparent through the pandemic (including the built environment) are to be addressed then it is important to establish what the service will look like in the future. This is essential in order to scope the future needs of the workforce.

Part 4:

Local and National delivery and monitoring

There is a real opportunity for local Boards and Health and Social Care Partnerships to explore how they might best further enhance the joint working of this resource, with sharing of knowledge, skills, and expertise building resilience into the system.

Locally, Boards, Health and Social Care Partnerships and independent providers in Scotland with the accountability and responsibility to manage AMS, HP (as regards the IPC element) and IPC will be required to develop a local integrated service delivery plan (LISDP) so as to operationalise this Workforce Plan in the context of their own settings. These plans should be routinely monitored and reported via Board and Integration Joint Board local governance arrangements. A checklist for inclusion in LISDPs is at Annex 1.

Boards should ensure that education and mentorship is embedded in the development of LISDPs and should lead this planning work in partnership with Health and Social Care Partnerships.

NHS Education for Scotland (NES), ARHAI, Scottish Antimicrobial Prescribing Group (SAPG), PHS Scottish Health Protection Network (SHPN) and NHS Assure will be pivotal in the delivery of this Plan; specifically, but not confined to, the review of the current educational infrastructure for specialist AMR, HP and IPC and national IPC/AMR guidance, surveillance and policy respectively. SAPG will continue to lead on national AMS strategy and delivery in conjunction with local AMTs and in collaboration with other key stakeholders.

HIS IPC Standards 2022, set out the appropriate and responsive governance and accountability mechanisms which should be in place. This includes an expectation that Boards have an IPC assurance and accountability framework that specifies as a minimum, defined roles and responsibilities, quality monitoring and assurance arrangements, reporting and escalation structures, and an IPC risk management strategy with clear lines of responsibility.

Recommendation 1:

Each Board should consider having a Clinical Lead [1-3] for Infection Prevention and Control with overarching responsibility for IPC and AMR across the Health and Social Care Partnership and direct line of communication to the Executive Team. This Clinical Lead should be of an appropriate level of seniority relative to the size and complexity of the Board. A national core role descriptor will be made available by Scottish Government.

This would ensure all services are led by a clinical leader whose sole focus is on AMR, HAI and IPC, accountable to the Executive Team and partnership, ensuring safe and effective clinical service delivery.

This recommendation builds on evidence following:

[1] The Vale of Leven Hospital Inquiry Report (2014)

[2] The Queen Elizabeth University Hospital Review (2020)

[3] The Queen Elizabeth University Hospital/ NHS Greater Glasgow and Clyde Oversight Board: Final Report (2021)

Part 5:

Developing the Optimal Workforce

As already discussed, the AMS, HP and IPC workforce comprises a number of specialist roles; many of these are embedded in local Health Boards and others working nationally within special Health Boards e.g. PHS, ARHAI, NES and SAPG provide support and expertise across Scotland.

Currently, recruitment and retention of these specialist workforces presents a considerable challenge and risk to delivery of services, however, there is real opportunity to alleviate this.

Whilst traditionally, the geography of Scotland has provided a challenge in terms of recruitment and retention of AMS, HP and IPC specialist staff, with the concentration of the population and specialist health services being located within Central Scotland, it is becoming increasingly challenging for all Boards to recruit to this workforce.

Rural and smaller peripheral health boards are particularly challenged with recruitment of specialist HP (with relevance to the IPC element) and IPC staff particularly, given that staff taking up a specialist post in these areas are likely to have to relocate their families in order to do so, and the variability of Agenda for Change job banding for their posts in comparison with the larger Boards and national posts. However, this issue is not confined to territorial Boards. Recruitment of suitably qualified specialist IPC staff to national posts e.g. ARHAI has also been challenging in recent years. Previously, staff within national posts have moved from territorial Boards within the Central Belt of Scotland with few from the north or island Boards, however, as the pandemic has provided opportunity to work remotely, there are more opportunities for this specialist workforce.

Pressures on this workforce, coupled with contextual changes, e.g. ageing workforce, complexity of healthcare delivery and additional asks for expertise e.g. the built environment, have resulted in an inconsistent picture of the specialist IPC workforce both locally and nationally.

A SAPG review of the AMS workforce across Scotland has shown significant challenges with regards to expanding roles, changing patient populations and new ways of working, with wide variation in work force configuration and remuneration between Boards (see annex 2, SAPG review). Antimicrobial Teams are often seen as “external” by clinical teams, and one of the main hindrances for AMS is a lack of wider senior clinician involvement and engagement. Consideration of non-infection specialist clinicians as the AMT lead may improve how AMS is embedded in clinical practice.

The scale of the challenge to support Social Care and to address the unmet needs of citizens remains significant. The Campaign Advisory Group for the National Adult Social Care recruitment campaign is assessing a range of enablers to further support recruitment into the sector, including employability; positive messaging; flexibility in job roles; the role of registration; apprenticeships; and reaching out to groups currently less represented in the workforce.

We are clear that Health and Social Care are interdependent. In all our action to grow the workforce, we will carefully consider the implications of recruitment in one part of the Health and Social Care system on the remainder of that system, recognising finite people resources.

The Scottish Government and partners will continue to take a person-centred approach to transforming the Health and Social Care systems and workforce and enable a healthier population in line with the COVID Recovery Strategy's aims. This aligns with our National Performance Outcomes and the Scotland in which we wish to live. This Workforce Strategy provides the overarching framework for enabling a workforce to deliver these outcomes.

HPTs have been subjected to challenging pressures throughout the pandemic, providing IPC support in the community. This is an opportunity to explore traditional IPC roles and consider new ways of working, such as rotational posts, which allow for movement across AMS, HP and IPC.

Workload capacity issues are subject to Healthcare Staffing Legislation for all staff groups, (noting that at this time there is no validated workforce workload capacity demand tool for these teams) but within that framework and given the significant changes above, there is merit in reviewing workload capacity at local level in the context of AMS, HP and IPC.

Recommendation 2:

Identify and review the current specialist IPC roles – ICD, IPC specialists, surveillance, healthcare scientist (such as scientists working within the microbiology lab and registered with a professional body that supports the work of IPC through analysis of environmental samples such as water results), epidemiologist, as well as HAI Executive Lead and ICM needs, determining which of these roles can be filled by healthcare professionals from backgrounds that have not traditionally worked in these specialist roles and consider entry level and pathway for the posts.

Recommendation 3:

Review the provision of IPC support available to Primary Care, including general practice and dental practice, and consider how these settings can be supported in the future, e.g. the use of peripatetic IPC practitioners. We would expect Boards to link in with professional groups and the Primary Care workforce specialists in these areas when undertaking the review.

Recommendation 4:

Identify and review the current AMS service delivery roles – Antimicrobial Team (AMT) Lead, Antimicrobial Pharmacists and Pharmacy technicians, specialist antimicrobial nurses and dedicated data analysis resource for surveillance. AMS teams having access to laboratory testing results to inform and support timely stewardship interventions is also important. AMS work (including stewardship clinical activity, interventions and communication, diagnostic stewardship and guideline development/ assurance and surveillance) should be recognised and appropriately remunerated, with sessional/whole time equivalent time allocated.

Recommendation 5:

Identify and review what additional roles and resources are required within the AMS workforce to ensure peer/undergraduate/ care home staff education, supporting infection management and enabling clinical audit, quality improvement and data collection. Consider the wider IPC provision and development needs within AMS and HP staffing in terms of:

- Assessing current education/training needs of these existing roles as well as the needs of those in new/emergent roles to support progression from generalist to specialist.

- Considering the ongoing development needs of those in AMS, HP and IPC Specialist Roles.

Recommendation 6:

Review the current IPC functions currently met by HP Teams and consider if they meet population needs.

Recommendation 7:

Consideration of the built environment has been a big part of the workload during the pandemic, with healthcare scientists playing a significant role in this, with issues such as ventilation being at the fore. Review of this workforce should consider how this specialism could be further incorporated into teams to enable future proofing.

Boards should consider the impact on experienced resource to mentor/train any new cohort.

Recommendation 8:

Improvement is needed in the quality and coverage of national-level workforce data, the identification of Workforce Planning Tools/ Methodologies to capture workload and identify workforce requirements with consideration being given to revisiting the WHO Core Components in terms of minimum requirements for a functional IPC programme at the national and facility level[7]. (Scottish Government to lead on discussions).

Recommendation 9:

IPC education and workforce leads to collaborate on a video promoting IPC as a career option (with Scottish Government co-ordination).

Recommendation 10:

There is a need to establish IPC networks to support staff in these services to ensure shared learning and cross-organisational links to be able to effect change and retain staff as well as providing mentorship and clinical peer support. This has been a weekly way of working between NSS ARHAI and the Boards during the pandemic and requires to be formalised and built upon (Scottish Government to lead on co- ordination).

Recommendation 11:

Board Regional Planning Groups to consider the provision of a formal framework involving key stakeholders, which supports the resourcing, and resilience of some key IPC/service functions within remote and rural boards.

The local review of needs as set out in recommendations 2 - 7 will be critical to inform and influence the national programme of work, (set out in recommendations 8 - 11) in order to avoid inconsistencies.

Part 6:

eSystems Review

In 2009, the Scottish Government allocated funding to NHS Boards for investment in eSystems for IPC surveillance within secondary care. To date, 10 territorial Boards (NHS Borders, Dumfries & Galloway, Fife, Forth Valley. Grampian, Greater Glasgow & Clyde, Highland, Lothian, Orkney and Tayside) have procured the ICNET IPC Surveillance System to support alert organism surveillance. Additionally, Scottish Government also provided funding to develop functionality, interfacing and reporting from the system and to cover five years of support costs. Boards have since extended ICNET support arrangements, and the current contract runs until January 2024.

Those territorial Boards which decided not to invest in the above infection control system have implemented their own local systems for alert organism surveillance. These include NHS Lanarkshire, Shetland, Ayrshire & Arran, National Waiting Times Centre, Western Isles and Orkney.

Monitoring and surveillance of alert organisms is critical to IPC. Effective utilisation and timely sharing of data both locally and nationally not only helps inform the management of individual patients and incidents, but also enables accurate and timely assessments of wider current and emerging threats. High-quality electronic data management systems support this workforce by reducing the risk of human error and preventing the need for repeated capturing, recording and reporting of data in multiple formats to multiple forums. Consistent and interconnected eSystems such as patient management systems (PAS) also support the maintenance of high standards of data quality and comparability; and high-quality data on healthcare associated infections (HCAIs) and AMR trends supporting local and national intelligence; informing and prioritising future policy requirements.

Effective use of information and digital systems has already supported and improved management of IPC to varying degrees across NHS Scotland. However, the significant variation between Boards does not accommodate the whole system approach, where patients routinely cross health and care settings as well as Heath Board boundaries. A common approach to the utilisation of information and digital systems would lead to improvements in patient and public safety by enabling up-to-date information to be available at the point of care, irrespective of care provider or care setting.

The eResources Subgroup review found that NHS Scotland would benefit from a single IPC eSystem, both at local and national level. It would require to be linked to the national digital health and care architecture, to enable integration with local and national systems and services, including possibly HP Zone (with consideration being given to the Outbreak Management Tool- OBM) and GP platforms. There is an additional AMS function on ICNET which could be explored, as well as the accessibility of surveillance for AMS.

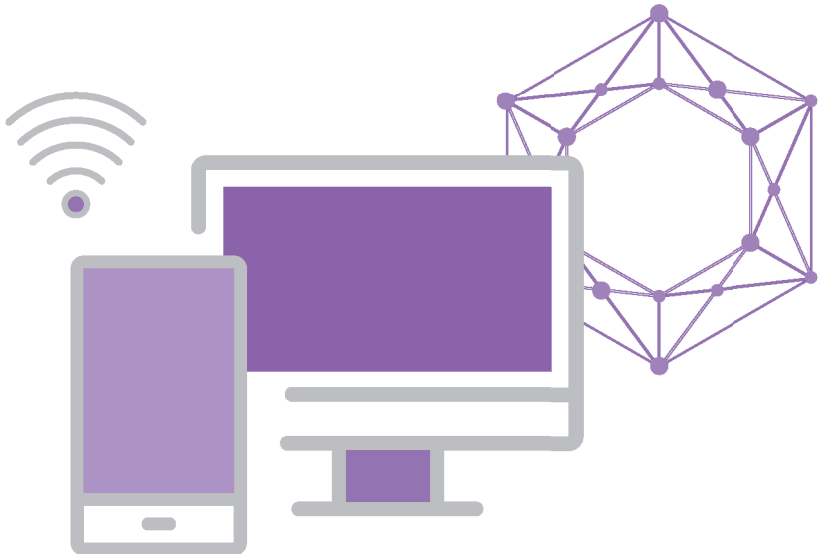
The current ICNET contract used by ten Health Boards is due to end in January 2024. The contract cannot be extended to include the remaining Health Boards, and it is unlikely that it can be extended in its current form beyond 2024. This situation provides an opportunity to develop a full business case (including options appraisal) for a national IPC surveillance eSystem. This exercise would enable Government, Boards, IT experts, data protection, HSE (in terms of General Practices) and other stakeholders, via a National Programme Board, to ascertain that proposals:

- are supported by a robust Case for Change – the Strategic Case;
- optimise Value for Money – the Economic Case;
- are commercially viable – the Commercial Case;
- are financially affordable – the Financial Case;
- can be delivered successfully – the Management Case.

A single system approach exists within NHS Wales, connecting local data to national and return, and the benefits are visible across the Welsh health and care system. The IPC surveillance system is managed and maintained by a single team and is flexible enough to allow local variance to meet local health and care requirements, whilst still forming part of a single system across the country. This system has supported robust and validated, real-time data and intelligence regarding nosocomial COVID-19.

Recommendation 12:

Scottish Government to commit to setting up of Programme Board to scope out and develop a business case for a national IPC surveillance eSystem for Scotland.



Part 7:

Opportunities for Education and Training

During the preparation of this Plan, stakeholders discussed induction, education, training, development and succession planning for the AMS, HP and IPC workforce.

Stakeholders highlighted that many existing development and educational materials are not clearly signposted, and that additional training in leadership behaviours, handling difficult situations and quality improvement are required.

To attract future workforce and retain existing staff:

Recommendation 13:

Boards should ensure staff are signposted and supported to higher educational materials and national resources via NES with regards to AMS, HP and IPC, to support their ongoing professional development needs.

In IPC, NES have delivered a suite of educational resources in recent years with a focus on building capacity and capability in the generalist workforce. Currently there are two specialist IPC MSc programmes offered in Scotland by Higher Education Institutions. A lack of a standardised training programme for ICDs has been highlighted, although Healthcare Infection Society run a Director of IPC development programme. Training and events programme - Healthcare Infection Society (his.org.uk).

Historically, colleagues within ARHAI have worked with NES to deliver epidemiology and outbreak training for specialist teams, which have involved local and national IPC, and HP teams working collaboratively using table top scenarios. These sessions have worked extremely well, not just in terms of knowledge and skills development but also in the provision of networking opportunities for IPC specialists across Scotland.

Further developments have been supported for building Quality Improvement capacity in IPC specialists in recent years with the Scottish Coaching in Leadership for Improvement Programme (SCLIP). This review provides an opportunity to develop a minimum set of knowledge and skills required for the role and a more attractive career progression based on educational knowledge and expertise. The Infection Prevention Society's 'Competencies Framework for IPC Practitioners'[7] will provide a very helpful reference point when reviewing IPC specialist development.

In HP, NES work in close partnership with PHS and stakeholders to progress a cohesive, integrated and progressive approach to workforce education development for the specialist HP workforce. This work has included the development of a national strategy, one part of which was the development and implementation of the 'Framework for Workforce Education Development for Health Protection in Scotland' (NES and HPS, 2006) which set the context for joint working. Staff working in wider Health Protection usually have a Masters in Public Health or are working towards the qualification. There are BSc/BSc (Hons) available in Public Health, while NES offer a variety of HP educational resources, including the HP nurse practitioner framework, and support the work of the SHPN.

In AMS, NES have worked collaboratively with ARHAI and SAPG, Scottish Antimicrobial Nursing Group (SANG) and Association of Scottish Antimicrobial Pharmacists (ASAP) to develop and test locally a wide range of educational modules to support prudent antimicrobial prescribing which are aimed at various staff groups and disciplines and hosted by the NES/ ARHAI team on the TURAS platform. Additionally, for those who wish to progress onto a career within AMS, there are online training courses available to support knowledge and skills e.g. University of Dundee. Through their AMS role, SAPG have also developed a wide range of antimicrobial prescribing and infection management guidance for practitioners and prescribers.

There is a need for creation of a learning-system aimed at building specialist AMS, HP and IPC workforce capability which is based on the current and future needs of the service and which is supported nationally by NES and ARHAI to meet the post graduate needs of the workforce, in addition to ensuring that foundation level IPC modules are available to all health and social care staff.

Learning should be role and context specific and recognise the required skillsets and interdependencies of each speciality.

Recommendation 14:

NES to undertake a gap analysis to review the current educational pathway and identify key priorities for development to meet future and evolving needs.

Recommendation 15:

NES to undertake a review of the existing IPC frameworks for the IPC workforce, as well as creation of an AMS framework (HP nurses have an existing framework).

We envisage that there will be some educational modules which will transcend across all frameworks, while some will need to be tailored to the specific specialist workforce. The frameworks will lead the learner from generalist to specialist.

It is anticipated that NES will continue to engage with Higher Educational Institutions, during the development of the IPC Compendium and frameworks.

Part 8:

Summary of Recommendations Mapped to National Workforce Plan

Local and National delivery and monitoring (Plan, Employ)

Recommendations	Owner	Timescale
Recommendation 1 - Local Each Board should consider having a Clinical Lead for Infection Prevention and Control with overarching responsibility for IPC and AMR across the Health and Social Care Partnership and direct line of communication to the Executive Team.	NHS Boards	March 2024
Recommendation 1 - National Core Role Descriptor developed for Clinical Lead role.	CNOD	March 2023

Developing the Optimal Workforce (Plan, Attract)

Recommendations	Owner	Timescale
Recommendation 2 – Local Identify and review the current specialist IPC roles – ICD, IPC specialists, surveillance, healthcare scientist (such as scientists working within the microbiology lab and registered with a professional body that supports the work of IPC through analysis of environmental samples such as water results), epidemiologist, as well as HAI Executive Lead and IPC specialist needs, determining which of these roles can be filled by healthcare professionals from backgrounds that have not traditionally worked in these specialist roles and considering entry level posts.	NHS Boards	March 2024
Recommendation 3 – Local Review the provision of IPC support available to Primary Care, including general practice and dental practice, and consider how these settings can be supported in the future, e.g. the use of peripatetic IPC practitioners. We would expect Boards to link in with professional groups and the Primary Care workforce specialists in these area when undertaking the review.	NHS Boards	March 2024

Developing the Optimal Workforce (Plan, Attract)

Recommendations	Owner	Timescale
Recommendation 4 – Local Identify and review the current AMS service delivery roles – Antimicrobial Team (AMT) Leader, Antimicrobial Pharmacists and Pharmacy technicians, specialist antimicrobial nurses and dedicated data analysis resource for surveillance. AMS work (including stewardship clinical activity, interventions and communication, diagnostic stewardship and guideline development/ assurance and surveillance) should be recognised and appropriately remunerated, with sessional/whole time equivalent time allocated.	NHS Boards	March 2024

Developing the Optimal Workforce (Plan, Attract)

Recommendations	Owner	Timescale
Recommendation 5 – Local Identify and review what additional roles and resources are required within the AMS workforce to ensure peer/undergraduate/ care home staff education, supporting infection management and enabling clinical audit, quality improvement and data collection. Consider the wider IPC provision and development needs within AMS and HP staffing in terms of: • Assessing current education/training needs of existing roles as well as the needs of those in new/emergent roles to support progression from generalist to specialist. • Considering the on-going development needs of those in AMS, HP and IPC specialist roles.	NHS Boards	March 2024

Developing the Optimal Workforce (Plan, Attract)

Recommendations	Owner	Timescale
Recommendation 6 – Local Review the current HP IPC roles and consider what additional roles and resources are required.	NHS Boards	March 2024
Recommendation 7 – Local Consideration of the built environment has been a big part of the workload during the pandemic, with healthcare scientists playing a significant role in this, with issues such as ventilation being at the fore. Review of this workforce should consider how this specialism could be further incorporated into teams to enable future proofing.	NHS Boards	March 2024

Developing the Optimal Workforce (Plan, Attract)

Recommendations	Owner	Timescale
Recommendation 8 – National Improvement is needed in the quality and coverage of national-level workforce data, the identification of Workforce Staffing Tools/ Methodologies to capture workload and identify workforce requirements with consideration being given to revisiting the WHO Core Components in terms of minimum requirements for a functional IPC programme at the national and facility level7. For AMS workforce planning consideration should be given to the 2022 SAPG review and recommendations (referenced in appendix 2).	SG to lead discussions	September 2023
Recommendation 9 – National/Regional/ Local IPC education and workforce leads to collaborate on a video promoting IPC as a career option.	CNOD HAI Strategy	March 2023

Developing the Optimal Workforce (Plan, Attract)

Recommendations	Owner	Timescale
Recommendation 10 – National/Regional/ Local There is a need to establish IPC networks, incorporating HP, and strengthen AMS networks (including nursing and pharmacy via SANG and ASAP) to support staff in these services to ensure shared learning and cross-organisational links to be able to effect change and retain staff as well as providing mentorship and clinical peer support. This has been a weekly way of working between NSS ARHAI and the boards during the pandemic and requires to be formalised and built upon now. SAPG continues to provide key national AMS leadership via its constituent AMTs, across disciplines and across Health and Social care. Its future role should be secured and strengthened to ensure optimal AMS in Scotland.	CNOD HAI Strategy	March 2023

eSystems (Plan and Nurture)

Recommendations	Owner	Timescale
Recommendation 11 – Regional Consideration is required around the provision of a formal framework, involving key stakeholders, which support the resourcing and resilience of some key IPC/ service functions within remote and rural boards.	Board Regional Planning Groups	September 2023
Recommendation 12 – National Set up programme Board to scope out and develop a business case for a national IPC surveillance eSystem for Scotland.	SG	December 2022
Recommendation 13 – Local Boards should ensure staff are signposted and supported to higher educational materials and national resources via NES with regards to AMS, HP and IPC, to support their ongoing professional development needs.	NHS Boards	March 2023

Developing the Optimal Workforce (Plan, Attract)

Recommendations	Owner	Timescale
Recommendation 14 – National NES to undertake a gap analysis to review the current educational pathway and identify key priorities for development to meet future and evolving needs.	NES	March 2023
Recommendation 15 NES will undertake a review of the existing IPC frameworks for the IPC workforce, as well as creation of an AMS framework.	NES	March 2023

Part 9:

Next steps

The Scottish Government would welcome your engagement in taking these recommendations forward and will link in with stakeholders to seek progress updates on these recommendations, as well as informing stakeholders on Scottish Government progress as part of our HAI Strategy refresh. HAI Policy and Strategy Team will continue to offer guidance and support around the development of local integrated service delivery plans and can be contacted at: HAI_Policy_Unit@gov.scot.

Part 9:

References

1. McLean. The Vale of Leven Hospital Inquiry Report: accessed via website **9781784128449.pdf (nls.uk)** (2014) on 07/02/22

2. Scottish Government. Queen Elizabeth University Hospital Oversight Board : accessed via website **Queen Elizabeth University Hospital/ NHS Greater Glasgow and Clyde Oversight Board: final report - gov.scot (www.gov.scot)** (2021) on 07/02/22

3. World Health Organisation. **Guidelines on Core Components of Infection Prevention and Control at the National and Acute Health Care Facility Level: accessed via website Guidelines on core components of infection prevention and control programmes at the national and acute health care facility level (who.int) (2016) on 07/02/22**

4. Manoukian S, Stewart S, Graves N, Mason H, Robertson C, Kennedy S, Pan J, Haahr L, Dancer SJ, Cook B, Reilly J. Evaluating the post-discharge cost of healthcare-associated infection in NHS Scotland. Journal of Hospital Infection, 114, pp51-58, 2021

5. World Health Organisation. Executive Board Infection Prevention & Control Director General Report: Executive Board, 150th Session, 2022

6. Health Protection Scotland. National Point Prevalence Survey of Healthcare Associated Infection and Antimicrobial Prescribing. May 2016

7. Infection Prevention Society. Competencies Framework for Infection Prevention & Control Practitioners: accessed via website **IPS-Competencies-Framework-V2.3-Final-June-2021 (1).pdf accessed on 07/02/22**

8. Scottish Government. Enabling, Connecting and Empowering: Care in the Digital Age – Scotland's Digital Health and Care Strategy. Accessed via website **enabling-connecting-empowering-care-digital-age (1).pdf 2021 on 07/2/22**

Annex

Summary of Actions

Boards' local integrated service delivery plans (LISDP) for Infection Services (AMS/HP/IPC): checklist for inclusion

The key to achieving our ambitions, vision, outcomes and values for the workforce is to give appropriate attention to each of the "five pillars" of workforce management: **Plan, Attract, Train, Employ, Nurture**. Details of these are set out in the National Workforce Strategy for Health and Social Care in Scotland. Each of these pillars should be included in the plans that Boards make to operationalise this workforce plan in their own context. **The following is a checklist of expected inclusions in your LISDP:**

Plan

- Statement of what AMS, HP and IPC services are required in your area.
- Statement of which service needs are currently being met and any unmet needs.

Note: Plans should be based on the use of Workload and Workforce planning tools and methodologies where they exist.

Attract

- Statement of supply and demand issues facing the local workforce currently.
- Statement of supply and demand issues likely to face this workforce in the future.

Note: Consideration should be given as to whether the service needs are being fully addressed by current recruitment mechanisms, including the need for consideration of the requirement for out of hours and 7-day service cover bearing in mind that more flexible shift patterns may help recruitment and retention.

Train

- Statement clarifying the commitment to regular development to ensure resilience, sustainability and succession planning relating to expertise of this workforce.
- Statement clarifying how built healthcare environment expertise is secured, be that through internal development and/or by access to national-level support.

Note: Consideration should be given to the level of practice (informed to expert/advanced) required within the various specialist posts. Any specialist training and development should be aligned to the individual post holder's required level of practice.

Employ

- Statement confirming that the leadership and management of these staff groups is of appropriate seniority, with the ability to engage at Board level and have Director-level access.
- Statement clarifying the governance arrangement for each of these services and associated workforces.

Note: Plans should be based on the use of Workload and Workforce planning tools and methodologies where they exist.

Nurture

- Statement clarifying the data analysts support for this workforce, including networking and mentoring of IPC teams by data specialists to ensure optimal use of data.
- Statement on new/emerging roles identified, clearly defined and details of how they are being embedded fully in existing teams and add value and whether there has been consideration given to whether they are positioned locally, regionally or nationally.

Note: Consideration is needed to the optimum configuration of these particular skill sets for the particular area, whether these are specialist posts or part of the ongoing development of their wider teams.

Annex 2:

Supporting documents for workforce planning

Planning for aspects of the workforce

1. National Workforce Strategy **Health and social care: national workforce strategy - gov.scot (www.gov.scot)**

2. Scottish Antimicrobial Prescribing Group (SAPG) review of Antimicrobial Management Team Workforce **20220530-sapg-workforce-report-v41.pdf**

3. NSS Diagnostic Steering Group - Scotland's Future Laboratory Workforce **DSG-WFP-Final-Report-v1.pdf (scot.nhs.uk)**

4. Factors influencing the stewardship activities of antimicrobial teams; a national cross-sectional study **Factors influencing the stewardship activities of Antimicrobial Management Teams: a national cross-sectional survey - PubMed (nih.gov)**

5. Scottish Microbiology and Virology Network (SMVN) Infection Control Doctors' sub-group paper on "The Infection Prevention and Control Doctor within Scotland" (available on request

6. Public health Scotland (PHS) Review of Public Health Workforce – not yet published. Link to **2015 Review of Public Health in Scotland 2015 Review of Public Health in Scotland: Strengthening the Function and re-focusing action for a healthier Scotland - gov.scot (www.gov.scot)**

Annex 2:

Supporting documents for workforce planning

Education and training

1. National Infection Prevention and Control Manual **National Infection Prevention and Control Manual: Home (scot.nhs.uk)**

2. NES IPC Zone **Infection Prevention and Control (IPC) Zone | Turas | Learn (nhs.scot)**

3. All Wales Education Framework: **https://heiw.nhs.wales/files/ipc-framework-final-nbsp/**

4. Infection Prevention Society (IPS) Competencies Framework for IPC Practitioners **IPS Competencies Framework | IPS**

5. NHS England IPC Core Capabilities Framework - not yet published. Further information on work **Infection Prevention and Control | Info Hub | Resources | Skills for Health**

6. National Learning and Development Strategy for the Specialist Healthcare Built Environment Workforce **HBE Learning and Development Strategy September 2021 | National Services Scotland (nhs.scot)**

NHS Fife
Terms of Reference

Local Integrated Service Delivery Plan for Infection Services (AMS/HP/IPC)
Steering Group

Version Number:	0.2
Date:	07.06.23

Published Month Year

www.nhsfife.org

Document Control Sheet

Key Information:

Title	Local Integrated Service Delivery Plan (LISDP) Steering Group Terms of Reference
Date published / issued	07/06/23
Date effective from	07/06/23
Version / Issue number	0.1
Document type	Terms of Reference
Document status	Draft
Author(s)	Janette Keenan; Julia Cook, Infection Control Manager
Owner	Janette Keenan, HAI Executive Lead
Approver	LISDP Steering Group
Contact	Julia Cook
File name	Y:\

Revision History:

Version	Date	Summary of Changes	Name	Changes marked
0.1	07/06/23	Created	JK JC	
0.2	16/08/23	Names of reps added	JK	N/A

Approvals: This document requires the following signed approvals

Name	Date	Version
LISDP Steering Group		
Infection Control Committee	09/08/23	0.1
Strategic Workforce Planning Group		

Distribution: This document has been distributed to

Name	Date	Version
LISDP Steering Group		
Infection Control Committee	09/08/23	0.1
Strategic Workforce Planning Group		

Linked Documentation

Name	Document File Path
The Infection Prevention Workforce: Strategic Plan 2022-2024	
LISDP	

Background

The Infection Prevention Workforce: Strategic Plan 2022-2024

A review of the AMS and IPC Workforce was commissioned in 2020 by the Chief Nursing Officer. It fulfils a key commitment in the UK Government National Action Plan (NAP) for Antimicrobial Resistance (AMR) 2019-24: to assess current and future workforce needs to ensure capability and capacity for strong IPC and AMS across health and care settings; and develop future workforce targets based on the results of this assessment.

The projected demand for workforce over the next decade, make clear that we must not only recover from the pandemic and grow the workforce but also transform how we work.

We need to develop capacity and capability in our AMS, HP (limited to the IPC element of health protection) and IPC workforce using a range of approaches which include, but are not confined to, role clarification and career pathways, exploring opportunities to build on the relationships that currently exist, creation of a learning system to support this specialist workforce and ensuring there is capacity, which can be flexed to meet the needs of the ever-evolving service.

It is acknowledged that the COVID-19 pandemic placed additional pressure on both the HP and IPC teams locally and nationally due to there being a requirement to provide specialist HP and IPC advice to primary care areas such as dental and general practice, with HP teams providing support in the wider community, and IPC teams supporting Health Protection with outbreak management and providing general advice on IPC practice to care homes and care at home.

The pandemic has highlighted the need for this workforce to be broad based, flexible and adaptable and favours a future approach to training and recruitment, which recognises breadth of experience as being as important as an individual specialist contribution.

This plan provides a framework through which we can work together to meet our goal of having: an appropriately skilled, resilient, sustainable and confident workforce working in an integrated way and with all appropriate disciplines, delivering evidence-based advice, guidance and interventions appropriate to localised need in both acute and community settings.

Purpose

The purpose of this document is to outline the Terms of Reference for the NHS Fife Local Integrated Service Delivery Plan for Infection Services (LISDP) Steering Group.

The LISDP Steering Group will provide strategic direction, leadership and will function as the competent authority to make practical and timely decisions, to ensure the development and implementation of a LISDP for the IPC Workforce.

The LISDP Steering Group will ensure strategic alignment to the corporate objectives of NHS Fife, the NHS Scotland IPC Workforce Plan 2022-24 and the HAI Interim Strategy 2023 - 2025.

Scope

The aim of the LISDP Steering Group is to ensure NHS Fife successfully delivers the NHS Scotland Infection Prevention Workforce: Strategic Plan 2022- 2024. The Steering Group will focus on areas of:

- role clarification and career pathways
- exploring opportunities to build on the relationships that currently exist
- creation of a learning system to support this specialist workforce and ensuring there is capacity, which can be flexed to meet the needs of the ever-evolving service

Membership

Title	Name	Email address
HAI Executive Lead (co-chair)	Janette Keenan	janette.keenan@nhs.scot
Infection Control Manager (co-chair)	Julia Cook	julia.cook@nhs.scot
Infection Control Doctor	*Dr Morris*	tbc
Infection Control Lead Nurse	*Lizzy Dunstan*	tbc
Consultant Microbiologist, AMR Lead	David Griffith	david.griffith2@nhs.scot
Lead Clinical Pharmacist - Medicine	Briana MacKerron	briana.mackerron@nhs.scot
Head of Laboratory Services	Robyn Gunn	robyn.gunn@nhs.scot
Health Protection	Fiona Bellamy	
Director of Finance (when required)	Margo McGurk	margo.mcgurk@nhs.scot
Primary Care	Chris Conroy	
Workforce Directorate Rep	Brian McKenna	brian.mckenna@nhs.scot
Staff Side Rep	*Wilma Brown*	tbc
Estates Rep (built environment)	*Neil McCormick*	tbc
Acute Services Division Rep	*Claire Dobson*	tbc
Director of Nursing HSCP	Lynn Barker	Lynn.barker@nhs.scot
The Co-chairs of the Steering Group reserve the right to co-opt or invite members to the team as required		

Meetings

Frequency

The Steering Group will meet monthly in first instance being mindful of national IPC Workforce Plan timeframes

Agenda and Papers

The agenda and supporting papers will be sent out at least 5 working days in advance of meetings.
Meetings of the LISDP Steering Group will be quorate when at least 6 members are present.
If a member cannot attend, then a deputy should be nominated to represent them at the meeting. If unable to attend then a member should make comments on the papers, if required. They must also inform the Steering Group who will attend as their deputy.
Steering Group decisions will stand if the quorum attendance has been met. If quorum is not met, then decisions will be circulated for agreement with a specified time period for response. Where there is non-agreement and/or quick decisions are required to support progress then the overall decision maker is a co-chair of the group.

Minutes

Minutes will be kept of proceedings and submitted for approval at the next meeting. Minutes will be submitted to the Infection Control Committee and Strategic Workforce Planning Group for noting. Due to the timing and scheduling of meetings, minutes may be presented in draft form to ensure awareness of topics discussed, considered and decisions taken.
The Co-chair of the Steering Group will seek approval of the minutes at each meeting.

Remit

Objectives

- Overseeing, directing, and monitoring the implementation of the LIDSP within NHS Fife and the H&SCP, with an overview of the implementation of the interim HAI strategy
- Provide direction to ensure the LISDP development is effectively managed and remains within the timeframe and available resources.
- Give appropriate attention to each of the "five pillars" of workforce management: **Plan, Attract, Train, Employ, Nurture** as detailed in the National Workforce Strategy for Health and Social Care in Scotland.
- Include:

PLAN

- Statement of what AMS, HP and IPC services are required in our area.
- Statement of which service needs are currently being met and any unmet needs. (Plans should be based on the use of Workload and Workforce planning tools and methodologies where they exist)

ATTRACT

- Statement of supply and demand issues facing the local workforce currently.
- Statement of supply and demand issues likely to face this workforce in the future. (Consideration should be given as to whether the service needs are being fully addressed by current recruitment mechanisms, including the need for consideration of the requirement for out of hours and 7-day service cover bearing in mind that more flexible shift patterns may help recruitment and retention

TRAIN

- Statement clarifying the commitment to regular development to ensure resilience, sustainability and succession planning relating to expertise of this workforce.
- Statement clarifying how built healthcare environment expertise is secured, be that through internal development and/or by access to national-level support. (Consideration should be given to the level of practice (informed to expert/advanced) required within the various specialist posts. Any specialist training and development should be aligned to the individual post holder's required level of practice).

EMPLOY

- Statement confirming that the leadership and management of these staff groups is of appropriate seniority, with the ability to engage at Board level and have Director-level access.
- Statement clarifying the governance arrangement for each of these services and associated workforces. (Plans should be based on the use of Workload and Workforce planning tools and methodologies where they exist).

NURTURE

- Statement clarifying the data analysts support for this workforce, including networking and mentoring of IPC teams by data specialists to ensure optimal use of data.
- Statement on new/emerging roles identified, clearly defined and details of how they are being embedded fully in existing teams and add value and whether there has been consideration given to whether they are positioned locally.

Authority The LISDP Steering Group is delegated by EDG to fulfil the remit described above.
Accountability The LISDP Steering Group will report to the Infection Control Committee and Strategic Workforce Planning Group. Updates will be provided to Clinical and Staff Governance Committees and Acute and HSCP Senior Leadership Team meetings.

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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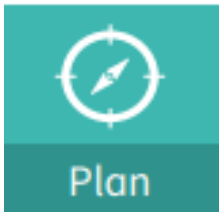
NHS Fife

LOCAL INTEGRATED SERVICE DELIVERY PLAN

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



Plan Plans should be based on the use of Workload and Workforce planning tools and methodologies where they exist.	
Statement of what AMS, HP and IPC services are required in Fife.	
Statement of which service needs are currently being met and any unmet needs	

Attract

Consideration should be given as to whether the service needs are being fully addressed by current recruitment mechanisms, including the need for consideration of the requirement for out of hours and 7-day service cover bearing in mind that more flexible shift patterns may help recruitment and retention.

Statement of supply and demand issues facing the local workforce currently.	
Statement of supply and demand issues likely to face this workforce in the future.	

Train

Consideration should be given to the level of practice (informed to expert/advanced) required within the various specialist posts. Any specialist training and development should be aligned to the individual post holder's required level of practice.

Statement clarifying the commitment to regular development to ensure resilience, sustainability and succession planning relating to expertise of this workforce.	
Statement clarifying how built healthcare environment expertise is secured, be that through internal development and/or by access to national-level support.	

Employ Plans should be based on the use of Workload and Workforce planning tools and methodologies where they exist.	
Statement confirming that the leadership and management of these staff groups is of appropriate seniority, with the ability to engage at Board level and have Director-level access.	
Statement clarifying the governance arrangement for each of these services and associated workforces.	

Nurture Consideration is needed to the optimum configuration of these particular skill sets for the particular area, whether these are specialist posts or part of the ongoing development of their wider teams.	
Statement clarifying the data analysts support for this workforce, including networking and mentoring of IPC teams by data specialists to ensure optimal use of data.	
Statement on new/emerging roles identified, clearly defined and details of how they are being embedded fully in existing teams and add value and whether there has been consideration given to whether they are positioned locally, regionally, or nationally.	

Summary of Recommendations and Actions Plan

KEY to STATUS:				
Actions complete. Recommendations met	Actions underway within timeframe. Recommendation will be met	Actions underway. Will not meet deadline. Recommendation will be met	Actions underway. Will not meet deadline. Recommendation at risk	Action not yet commenced

Local and National delivery and monitoring (Plan, Employ)

1a	Each Board should consider having a Clinical Lead for Infection Prevention and Control with overarching responsibility for IPC and AMR across the Health and Social Care Partnership and direct line of communication to the Executive Team.	NHS Board	March 2024 Sept 2024

Ref	Actions	Lead	Review	Progress / Update	Status
1a.1	Describe current governance and accountability mechanisms in relation to IPC, AMR and HP (in relation to IPC arrangements)	SG	Aug 23	**22.05.23** SzG will take forward: ICM; AMR lead; HP lead	
1a.2	Review national core role descriptor	SG	Aug 23	**22.05.23** Awaiting national outcome – expected August / September 2023	
1a.3	Prepare report for Board's consideration	JK JC	Sep 23	**22.05.23** Report will reference governance and accountability mechanisms and national core role descriptor	

1b	Core Role Descriptor developed for Clinical Lead role	CNOD	March 2023 Sept 23
1b.1	**Update:** **22.05.23** Delay - workshops began 25.04/2023; potentially will be published August/September 2023		

Developing the Optimal Workforce (Plan, Attract)

2	Identify and review the current specialist IPC roles – ICD, IPC specialists, surveillance, healthcare scientist (such as scientists working within the microbiology lab and registered with a professional body that supports the work of IPC through analysis of environmental samples such as water results), epidemiologist, as well as HAI Executive Lead and IPC specialist needs, determining which of these roles can be filled by healthcare professionals from backgrounds that have not traditionally worked in these specialist roles and considering entry level posts.	**NHS Board**	March 2024

Ref	Actions	Lead	Review	Progress / Update	Status
2.1	Identify and review current specialist roles: 1. ICD 2. IPCNs 3. Surveillance 4. Healthcare Scientists 5. Epidemiologist 6. HAI Exec Lead 7. Other IPC specialists	SG	Aug 23	**22.05.23** **a) ICD** **Situation** A number of health boards in Scotland are finding it difficult to recruit to consultant microbiology posts. Fife has gone out to advert 3 times and not had one suitable candidate apply. This is likely to impact on recruiting to ICD posts which are normally filled by consultant microbiologist. **Background** Approximately 7 years ago the training in microbiology changed such that clinical microbiology was no longer a training specialty in itself. This meant that microbiology training was joined with another specialty. This is most commonly infectious diseases. **Assessment** a) Fife is in the lucky position to have the ICD positions filled so there is no immediate issue. However with many of the joint trainees not wanting to undertake infection control this situation will change in the future especially when current ICDs retire. b) **IPCNs:** 1WTE band 7; 100 band 6s; Care home IPCNs: 1 band 7; 4 band 6. Considering band 4 Assistant Practitioner role and Band 5 role c) NHS Fife IPCT has been progressive and has a Midwife, Paediatric Nurse and Mental Health Nurse as well and non-clinical admin support for surveillance d) Labs – staffing challenge e) . f) HAI Exec Lead is Executive Director of Nursing g) A deputy ICM role was trialled when there were challenges recruiting to Band 8A Lead IPCN; AMR staffing challenges	
2.2	Consider core role descriptors	SG	Aug 23	**22.05.23** Awaiting national outcome – expected August / September 2023	
2.3	Prepare SBAR report for EDG	JK JC	Sep 23	**22.05.23** Report will reference governance and accountability mechanisms and national core role descriptor	

3	Review the provision of IPC support available to Primary Care, including general practice and dental practice, and consider how these settings can be supported in the future, e.g. the use of peripatetic IPC practitioners. We would expect Boards to link in with professional groups and the Primary Care workforce specialists in these area when undertaking the review			**NHS Board**	March 2024
Ref	**Actions**	**Lead**	**Review**	**Progress / Update**	**Status**
3.1	Map out current support offered to Board Managed Services (hospital dental services)	IPCT	Oct 23	**22.05.23** Strategic level discussions with HPT and IPCT required	
3.2	Arrange strategic level discussions with HPT and IPCT	SG	Oct 23		
3.3	Link with professional groups; Primary Care workforce lead	SG	Oct 23		

4	Identify and review the current AMS service delivery roles – Antimicrobial Team (AMT) Leader, Antimicrobial Pharmacists and Pharmacy technicians, specialist antimicrobial nurses and dedicated data analysis resource for surveillance. AMS work (including stewardship clinical activity, interventions and communication, diagnostic stewardship and guideline development/ assurance and surveillance) should be recognised and appropriately remunerated, with sessional/whole time equivalent time allocated.			**NHS Board**	March 2024
Ref	**Actions**	**Lead**	**Review**	**Progress / Update**	**Status**
4.1	Arrange strategic discussion with AMT Leader, DoP, HAI Executive lead and Infection Control Manager	SG	Nov 23		
4.2	Identify and review current AMS service delivery role and structure	SG	Nov 23	**22.05.23** (Note current pause to AMR Group meetings - workforce challenges)	
4.3	Propose model for AMS work, including recognition for work	SG	Nov 23		

5	Identify and review what additional roles and resources are required within the AMS workforce to ensure peer/undergraduate/ care home staff education, supporting infection management and enabling clinical audit, quality improvement and data collection. Consider the wider IPC provision and development needs within AMS and HP staffing in terms of: • Assessing current education/training needs of existing roles as well as the needs of those in new/emergent roles to support progression from generalist to specialist. • Considering the on-going development needs of those in AMS, HP and IPC specialist roles.	**NHS Board**	March 2024

Ref	Actions	Lead	Review	Progress / Update	Status
5.1	Arrange strategic discussion with AMT Leader, DoP, HAI Executive lead and Infection Control Manager	SG	Nov 23		
5.2	Review training requirements of the IPCNs and Surveillance, Microbiologists / ICDs, AMR and HP - to provide feedback for their ongoing development needs	IPCT	Nov 23		
5.3	Identify and review existing roles and available resources within AMS workforce	SG	Nov 23		
5.4	Identify and review what additional roles and resources are required	SG	Nov 23		

6	Review the current HP IPC roles and consider what additional roles and resources are required.	**NHS Board**	March 2024

Ref	Actions	Lead	Review	Progress / Update	Status
6.1	Review current HP IPC roles	HPT	Oct 23		
6.2	Consider and propose what additional roles and resources are required	SG	Oct 23		
6.3	HPT to provide feedback on their ongoing development needs	HPT	Oct 23		

7	Consideration of the built environment has been a big part of the workload during the pandemic, with healthcare scientists playing a significant role in this, with issues such as ventilation being at the fore. Review of this workforce should consider how this specialism could be further incorporated into teams to enable future proofing.			**NHS Board**	March 2024
Ref	**Actions**	**Lead**	**Review**	**Progress / Update**	**Status**
7.1	Review current 'built environment' workforce	SG	Oct 23	**22.05.23** • NHS Fife developed and recruited a SIPCN Band 7 0.8 WTE September 2022 • Consultant Microbiologist and ICD: 4 PAs for water, decontamination and built environment	
7.2	Develop training and professional development plan to ensure ongoing training and support to ensure resilience within the IPCT in relation to expert knowledge and experience	IPCT	Oct 23	**22.05.23** This is an ongoing action for the IPCT with professional development and ongoing training requirements to upskill current workforce	
7.3	Consider how this specialism could be incorporated into teams	SG	Oct 23		

8	Improvement is needed in the quality and coverage of national-level workforce data, the identification of Workforce Staffing Tools/ Methodologies to capture workload and identify workforce requirements with consideration being given to revisiting the WHO Core Components in terms of minimum requirements for a functional IPC programme at the national and facility level7. For AMS workforce planning consideration should be given to the 2022 SAPG review and recommendations	**SG to lead discussion**	Sep 2023
8.1	**Update:** **22.05.23** Awaiting update from SG discussions		
8.1.1	**Update:** **12.06.23 GJNH** **a)** Improvement is needed in the quality and coverage of national-level workforce data	• Health Workforce working towards this • Systems do not currently have the capability required • National Workforce Plan intends to capture data across Scotland	
8.1.2	**b)** the identification of Workforce Staffing Tools/ Methodologies to capture workload and identify workforce requirements	• Second stakeholder event before winter • Demonstration of workforce tools to meet needs of ICDs, microbiologists, nurse specialists	
8.1.3	**c)** For AMS workforce planning consideration should be given to the 2022 SAPG review and recommendations	• Considered inclusion of AMS roles in the Role Descriptor event • NES / SAPG agreed AMS role descriptors can remain unchanged for now	

9	IPC education and workforce leads to collaborate on a video promoting IPC as a career option.	**CNOD**	March 2023
9.1	**Update:** **22.05.23** Awaiting update from CNOD **Update:** **12.06.23 GJNH** • Agreement from the 4 CNOs • Still to confirm the best route for production • Revised timeline to be confirmed		

10	There is a need to establish IPC networks, incorporating HP, and strengthen AMS networks (including nursing and pharmacy via SANG and ASAP) to support staff in these services to ensure shared learning and crossorganisational links to be able to effect change and retain staff as well as providing mentorship and clinical peer support. This has been a weekly way of working between NSS ARHAI and the boards during the pandemic and requires to be formalised and built upon now. SAPG continues to provide key national AMS leadership via its constituent AMTs, across disciplines and across Health and Social care. Its future role should be secured and strengthened to ensure optimal AMS in Scotland.	**CNOD**	March 2023
10.1	**Update:** **22.05.23** There has been no regular meetings in 2023 with ARHAI Scotland and Boards; a monthly meeting to recommence May/June 2023 - DTBC		
10.1.1	**Update:** **12.06.23 GJNH** There is a need to establish IPC networks, incorporating HP, and strengthen AMS networks (including nursing and pharmacy via SANG and ASAP)	• ARHAI running a monthly surgery for ICMs, ICNs, ICDs • Started end of March 2023	
10.1.2	SAPG continues to provide key national AMS leadership via its constituent AMTs, across disciplines and across Health and Social care. Its future role should be secured and strengthened to ensure optimal AMS in Scotland.	• SG AMR team reviewing the role of a strategic group in line with the new 2024 – 2029 NAP (for a One health perspective) for all AMR stakeholders • Governance review to be completed in line with the new NAP	

11	Consideration is required around the provision of a formal framework, involving key stakeholders, which support the resourcing and resilience of some key IPC/ service functions within remote and rural boards.	**Regional Planning Group**	Sep 2023
11.1	**Update:** **22.05.23** HPT moved to an East Region Model. Awaiting further update from Regional Planning Group		

12	Set up programme Board to scope out and develop a business case for a national IPC surveillance eSystem for Scotland.	**SG**	Dec 2022
12.1	**Update:** **22.05.23** Programme yet to be established; Boards to renegotiate current ICNET contract which end December 2023 **Update:** **12.06.23 GJNH** • Boards to roll over current contracts • SG to provide support either directly or via NSS • Allows time for creation of a new minimum national specification		

13	Boards should ensure staff are signposted and supported to higher educational materials and national resources via NES with regards to AMS, HP and IPC, to support their ongoing professional development needs.			**NHS Board**	March 2023
Ref	**Actions**	**Lead**	**Review**	**Progress / Update**	**Status**
13.1	Ensure staff are signposted and supported to higher education materials via NES (consider via PPD, Medical Education…)	OG	Sep 23	**22.05.23** In place for IPC	

14	NES to undertake a gap analysis to review the current educational pathway and identify key priorities for development to meet future and evolving needs.	**NES**	March 2023
14.1	**Update:** **22.05.23** Not published - ? Delay due to core role descriptors development		

15	NES will undertake a review of the existing IPC frameworks for the IPC workforce, as well as creation of an AMS framework.	**NES**	March 2023
15.1	**Update:** **22.05.23** HPN Framework updated December 2022; IPCT and AMR not delivered (delay due to core role descriptors). National meetings have commenced		

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**8 September 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:

- Discussion
- Assurance

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 June, although there are some measures with a significant time lag and a few which are available up to the end of July.

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	6.91 per 1,000 TOBD	Achieving
Pressure Ulcers [2]	Monthly	0.89 per 1,000 TOBD	Not achieving
SAB (HAI/HCAI)	Monthly	18.8 per 100,000 TOBD	Achieving
ECB (HAI/HCAI)	Monthly	33.0 per 100,000 TOBD	Achieving
C Diff (HAI/HCAI)	Monthly	6.5 per 100,000 TOBD	Not 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 10% 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 June IPQR will be available for discussion at the meeting on 08 September.

2.3.8 Route to the Meeting

The IPQR was ratified by EDG on 17 August and approved for release by the Director of Finance & Strategy.

2.4 Recommendation

The report is being presented to the CG Committee for:

- **Discussion** – Examine and consider the NHS Fife performance as summarised in the IPQR
- **Assurance**

3 List of appendices

Appendix 1 – Integrated Performance & Quality Report

Appendix 2 – Deep Dive: Pressure Ulcers

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Fife Integrated Performance & Quality Report

CLINICAL GOVERNANCE

Produced in August 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
15 August 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.

Corporate Risk 3 - COVID 19 Pandemic - Risk Rating Reduced

Following review by the Public Health and Wellbeing Committee, the current rating of this risk is reduced from Moderate(12) to Moderate(9) in light of the continued effectiveness of vaccination and the reduced impact of illness in the population.

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	Jun-23	44	○	▼	▲	●	
	Major/Extreme Adverse Events - % Actions Closed on Time	50%	Month	Jun-23	39.1%	●	▲	▼	●	
	HSMR	N/A	Year Ending	Mar-23	0.96	●	–	–	●	
	Inpatient Falls	6.91	Month	Jun-23	6.83	○	▼	▲	●	
	Inpatient Falls with Harm	1.65	Month	Jun-23	1.52	○	▼	▼	●	
	Pressure Ulcers	0.89	Month	Jun-23	1.05	○	▼	▲	●	
	SAB - HAI/HCAI	18.8	Month	Jun-23	10.3	○	▲	▲	●	QE Mar-22
	C Diff - HAI/HCAI	6.5	Month	Jun-23	17.2	○	▼	▼	●	QE Mar-22
	ECB - HAI/HCAI	33.0	Month	Jun-23	17.2	○	▲	▲	●	QE Mar-22
	S1 Complaints Closed in Month on Time	80%	Month	Jun-23	64.1%	●	▲	▲	●	2021/22
	S2 Complaints Closed in Month on Time	50%	Month	Jun-23	16.2%	○	▲	▲	●	2021/22
	S2 Complaints Due in Month and Closed On Time	N/A	Month	Jun-23	17.1%	●	▲	▲	●	
Operational Performance	IVF Treatment Waiting Times	90%	Month	Mar-23	100.0%	●	◀▶	◀▶	●	
	4-Hour Emergency Access (A&E)	95%	Month	Jul-23	76.0%	○	▼	▲	●	Jun-23
	4-Hour Emergency Access (ED)	82.5%	Month	Jul-23	69.0%	●	▼	▲	●	Jun-23
	Patient TTG % <= 12 Weeks	100%	Month	Jun-23	44.4%	●	▲	▼	●	Mar-23
	New Outpatients % <= 12 Weeks	95%	Month	Jun-23	48.3%	●	▼	▼	●	Mar-23
	Diagnostics % <= 6 Weeks	100%	Month	Jun-23	47.0%	●	▼	▼	●	Mar-23
	Cancer 31-Day DTT	95%	Month	Jun-23	97.6%	○	▲	▼	●	QE Mar-23
	Cancer 62-Day RTT	95%	Month	Jun-23	74.4%	○	▼	▼	●	QE Mar-23
	Detect Cancer Early	29%	Year Ending	Dec-22	27.6%	●	▼	▲	●	2020, 2021
	Freedom of Information Requests	85%	Month	Jul-23	92.0%	●	▲	▲	●	
	Delayed Discharge % Bed Days Lost (All)	N/A	Month	Jul-23	9.7%	●	▼	▲	●	QE Dec-22
	Delayed Discharge % Bed Days Lost (Standard)	5%	Month	Jul-23	6.1%	○	▼	▲	●	QE Dec-22
	Antenatal Access	80%	Month	Mar-23	86.1%	●	▲	▲	●	CY 2022
Finance	Revenue Resource Limit Performance	-	Month	Jul-23	(£10.98m)	●	–	–	●	
	Capital Resource Limit Performance	£11.17m	Month	Jul-23	£1.451m	●	–	–	●	
Staff Governance	Sickness Absence	4.00%	Month	Jun-23	6.61%	○	▲	▼	●	YE May-23
	Personal Development Plan & Review (PDPR)	80%	Month	Jul-23	40.4%	●	▲	▲	●	
Public Health & Wellbeing	Smoking Cessation (FY 2022/23)	473	YTD	Mar-23	301	●	–	–	●	YT Sep-22
	CAMHS Waiting Times	90%	Month	Jun-23	74.1%	○	▲	▲	●	QE Mar-23
	Psychological Therapies Waiting Times	90%	Month	Jun-23	67.5%	○	▼	▼	●	QE Mar-23
	Drugs & Alcohol Waiting Times	90%	Month	May-23	89.6%	●	▲	▼	●	QE Mar-23
	Immunisation: 6-in-1 at Age 12 Months	95%	Quarter	Mar-23	92.5%	○	▼	▼	●	QE Mar-22
	Immunisation: MMR2 at 5 Years	92%	Quarter	Mar-23	86.4%	○	▲	▼	●	QE Mar-22

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

		Month End			Quarter End	Quarter End	Quarter End	Quarter End
		Apr-23	May-23	Jun-23	Jun-23	Sep-23	Dec-23	Mar-24
ED 4-hour Performance (VHK only)	Projected	67.9%	69.1%	70.6%				
	Actual	64.7%	66.5%	71.3%				
	Variance	-3.2%	-2.6%	0.7%				
Elective Activity Diagnostics	Projected	5,121	5,121	5,121	15,363	15,363	15,363	15,363
	Actual	4,166	4,393	4,207	12,766			
	Variance	-955	-728	-914	-2,597			
Elective Activity New Outpatients	Projected	7,573	7,372	7,364	22,309	22,337	22,274	22,308
	Actual	6,092	7,583	7,550	21,225			
	Variance	-1,481	211	186	-1,084			
Elective Activity TTG	Projected	1,138	1,139	1,139	3,416	3,433	3,487	3,492
	Actual	957	1,204	1,242	3,403			
	Variance	-181	65	103	-13			
Long Waits Diagnostics > 26 weeks	Projected	140	122	109	109	63	10	0
	Actual	164	171	171	171			
	Variance	24	49	62	62			
Long Waits New Outpatients > 104 weeks	Projected	0	0	0	0	74	212	352
	Actual	0	0	1	1			
	Variance	0	0	1	1			
Long Waits New Outpatients > 78 weeks	Projected	77	87	150	150	339	849	1358
	Actual	73	92	85	85			
	Variance	-4	5	-65	-65			
Long Waits TTG > 104 weeks	Projected	17	15	16	16	67	173	351
	Actual	14	15	20	20			
	Variance	-3	0	4	4			
Long Waits TTG > 78 weeks	Projected	99	128	159	159	305	547	893
	Actual	79	88	84	84			
	Variance	-20	-40	-75	-75			
Cataracts Average per 1/2 day session	Projected				4.5	4.5	4.5	4.5
	Actual							
	Variance				-4.5			
Arthroplasty 4 joint sessions	Projected				25.0%	25.0%	25.0%	25.0%
	Actual	6.0%	12.0%	12.0%	10.0%			
	Variance				-15.0%			
Same Day Procedures Knee Arthroplasty	Projected				1.9%	1.9%	1.9%	1.9%
	Actual							
	Variance				-1.9%			
Same Day Procedures Hip Arthroplasty	Projected				4.3%	4.3%	4.3%	4.3%
	Actual							
	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%			
	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%			
	Variance				-4.4%			
CAMHS 18 Weeks RTT	Projected	85.0%	85.0%	85.0%				
	Actual	85.3%	84.8%	76.2%				
	Variance	0.3%	-0.2%	-8.8%				
CAMHS Waiting List <= 18 weeks	Projected	213	209	216	216	228	235	200
	Actual	249	268	244	244			
	Variance	36	59	28	28			
CAMHS Waiting List > 18 weeks	Projected	71	89	116	116	98	42	0
	Actual	43	48	70	70			
	Variance	-28	-41	-46	-46			
CAMHS Waiting List > 52 weeks	Projected	0	0	0	0	0	0	0
	Actual	0	0	0	0			
	Variance	0	0	0	0			
Psychological Therapies 18 Weeks RTT	Projected	67.5%	69.4%	66.1%				
	Actual	56.2%	58.5%	55.5%				
	Variance	-11.3%	-10.9%	-10.6%				
Psychological Therapies Waiting List <= 18 weeks	Projected	888	888	888	888	888	888	888
	Actual	1448	1602	1460	1460			
	Variance	560	714	572	572			
Psychological Therapies Waiting List > 18 weeks	Projected	1394	1575	1660	1660	1569	1680	1604
	Actual	1128	1136	1173	1173			
	Variance	-266	-439	-487	-487			
Psychological Therapies Waiting List > 52 weeks	Projected	255	237	219	219	165	111	57
	Actual	248	286	273	273			
	Variance	-7	49	54	54			

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%**	**39.1%**

There were 44 major/extreme adverse events reported in June out of a total of 1,364 incidents, 66.6% 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 incident reported followed by Cardiac Arrest.

There were 18 actions relating to LAER/SAER closed on time in June, from total of 46. On average 40.3 actions have been closed per month in 2023 compared to 51.5 over the same period year prior. There was a total of 360 actions open at the end of June, with 46 (14.57%) being within time.

As part of the overall improvement work around cardiac arrest, changes have been requested to the reporting and reviewing process of cardiac arrest adverse events. Work has begun to move the cardiac arrest SBAR from a paper to a fully electronic process to improve the timescales around completion of the SBAR and make the process more streamlined and accessible. The change mirrors the current successful electronic process used for tissue viability adverse events. Timescale for completion of the work is 1st September 2023.

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 patient falls rate by 10% in FY 2023/24 compared to the target for FY 2021/22*	**6.91**	**6.80**

The number of inpatient falls in total was 188 in June, up from 176 the month prior. This equates to a rate of 6.80 falls per 1,000 Occupied Bed Days (OBD). This is just on the right side of the target of 6.91.

The number of falls within Acute Services increased to 84 from 75 the month prior. This equates to a rate of 6.68 per 1,000 OBD.

The number of falls within HSCP increased slightly from 101 to 104. This equates to a rate of 6.89 per 1,00 OBD.

The majority of falls in the last 3 months (77.6%) were classified as 'No Harm' whilst 16.7% were classified as 'Minor Harm' and <3% were classified as 'Moderate Harm'. Falls classified as 'Major/Extreme Harm' accounted for 3.3% of the total falls.

New reduction in falls for 2023/2024 agreed locally at the Falls Steering Group on 9/8/23. 15% Falls with Harm and 15% for all Falls. National targets are defined by SPSP - these are to reduce all falls by 20% and falls with harm by 30% by the end of March 2024. A review of NHS Fife data indicated these targets would be challenging hence the local targets. The local workplan will be aligned to the national driver diagram and falls reduction change package.

Pressure Ulcers	*Reduce pressure ulcer rate by 20% in FY 2023/24 compared to the rate in FY 2022/23*	**0.89**	**1.08**

The total number of pressure ulcers in June 2023 was 30, equating to a rate of 1.08 per 1,000 Occupied Bed Days (OBD). This is an increase on the 0.87 reported in May 23 and takes it closer to the 24-month average. The number of pressure ulcers in Acute Services increased slightly from 19 in May to 20 in June (24-month average is 24.5 and rate is 1.59). In the same timeframe, the number of pressure ulcers in HSCP increased from 6 to 10 (24-month average is 7 and rate is 0.66).

Most pressure ulcers continue to be in Acute Services with 56 between Apr-Jun 2023 compared with 26 in HSCP.

ASD services continue to respond to all Grade 2 pressure ulcers and above. The "ward of the week" initiative is also going well with some areas still to cover. HSCP tissue viability team have recognised a slight increase in PU within community hospitals and are targeting support to the individual areas. The tissue viability teams from ASD and HSCP meet regularly and are working closely together to support each area, funding has been secured to support the training and education needs of the teams. Further education sessions for staff across NHS Fife are being planned with the teams working together to deliver this.

		Target	Current
SAB (MRSA/MSSA)	*We will reduce the rate of HAI/HCAI by 10% between March 2019 and March 2024*	**18.8**	**10.3**

The SAB infection rate decreased from 16.5 in May 2023 to 10.3 in June meaning that performance achieved target for the third month in a row.

Of the 52 HAI/HCAI reported in the last 12 months, 12 have been categorised as 'VAD'; 11 have been categorised as 'Other' or 'Not Known'; and 12 have been categorised as 'Other Sources'.

The most recent quarterly HAI report from Health Protection Scotland, covering the quarter ending March 2023, showed that NHS Fife was in the mid-range of all Mainland Health Boards, with a rate of 17.9 against a Scottish average of 19.1. This continues a pattern of being in the upper-range one quarter and in the mid-range the next.

Local and national intelligence highlights the following areas for focus; medical devices (including VADs) and non-vascular access medical devices, skin & soft tissue infections (including people who inject drugs (PWIDs).

NHS Fife continue to achieve rates for HAI/HCAI SABs below the National Scottish comparator. Another success is at the end of June 2023 NHS Fife attained 258 days since the last PVC related SAB. The IPCT have been working with D&I and HoN to improve compliance with ePVC and removal of PVCs at 72hours, focusing on targeted education and training and exploring digital information solutions to improve compliance.

Despite this achievement with PVCs so far in 2023, there has been an increase in dialysis line related SABs, with each case undergone a Complex Care Review (CCR) with a SAER on 26/6/23, cases multi-factorial with learning summaries to follow.

The IPCT performs the following actions:

• Enhanced surveillance and analysis of SAB data to understand the magnitude of the risks to patients in Fife

• Uses data such as the weekly ePVC compliance report to inform clinical practice improvements

• Continue to liaise and support Drug Addiction Services with PWID.

C Diff	*We will reduce the rate of HAI/HCAI by 10% between March 2019 and March 2024*	**6.5**	**17.2**

The C Diff infection rate increased from 16.5 in May 2023 to 17.2 in June and this remains high compared to the 24-month average of 9.82 but is still within control limits. There were 5 infections reported in June 2023 (equal to May 23) which takes the C Diff HCAI quarterly infection tally to 16 which is the highest on record.

9 of the 54 HAI/HCAI and Community infections in the past year were identified as 'recurring' infections. The most recent quarterly HAI report from Health Protection Scotland, covering the quarter ending March 2023, showed that NHS Fife was in the mid-range of all Mainland Health Boards at 13.4 and this was equal to the Scottish average.

National and local surveillance has identified NHS Fife in the mid-range of all Mainland Health Boards, equalling Scottish average HCAI CDI rates.

However, NHS Fife has seen a marked increase in the number of HCAI CDI cases in 2023 compared to the same time period the previous year.

Despite a key improvement aim to reduce the number of recurrent CDIs, this too has proven challenging in 2023.

NHS Fife continues to promote antimicrobial stewardship, with a Consultant Microbiologist establishing optimum antimicrobial therapy for patients at high risk of recurrent CDI, enhanced surveillance and analysis of risk factors for each CDI case.

ECB	*We will reduce the rate of HAI/HCAI by 25% between March 2019 and March 2024*	**33.0**	**17.2**

The number of infections decreased from 12 in May 2023 to 5 in June and the rate of infection decreased from 39.7 to 17.2 HAI/HCAI per 100,000 Occupied Bed Days (OBD). This is the lowest rate in the past 24 months and the best performance since March 2021.

Urinary Catheter related infections have been responsible for 25 of the 112 infections in the last year (22.3%) and remains a key focus for improvement work although the 'Not Known' category accounts for 26 infections (23.2%).

The most recent quarterly HAI report from Health Protection Scotland, covering the quarter ending March 2023, showed that NHS Fife (with a quarterly infection rate of 29.7) lay in the mid-range of Mainland Health Boards (as has been the case for the last 6 quarters) and was below the Scottish average of 37.3.

Achievements: June ECB rates were the lowest in the past 24 months. To sustain these improved rates the IPC team continue to liaise with the Urinary Catheter Improvement Group (UCIG) - last meeting held on 23rd June 2023. This group aims to minimise urinary catheters to prevent catheter associated healthcare infections and trauma associated with urinary catheters.

The findings of the CAUTI bundles in care homes project was also presented to UCIG. With further plans to work collaboratively with the Care Home Liaison Nurse Team and Bladder and Bowel Service for further implementation.

		Target	Current
Challenges: CAUTI insertion and maintenance bundles have now been installed onto Patientrack in February 2022 and were trialled on V54 ward. Amendments to the tool continue to be awaited by Patientrack before this can then be rolled out across the board.			
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%**	**16.2%**

There were 43 stage 2 complaints received in June, with 95.3% acknowledged within timescales, with 37 closed. Of those closed, 6 (16.2%) were within timescales with 13 greater than 80 days after deadline. 35 complaints were due in the month with 6 (17.1%) closed on time.

57% of live complaints have been open for more than 40 days with 34.5% open for more than 80 days.

42.3% of live complaints are awaiting statements with 33.1% approval of final response.

The Patient Experience Team (PET) officers ensure the Head of Complaints and outcomes are clearly defined at the initial stage of the complaint to help improve the quality of complaint responses. Further training to support this will be provided to PET officers.

The new complaint "complexity scoring" categories will be added to the Datix system, allowing all PET members to access this function. Once completed, the new complexity scoring system will be fully implemented, providing insight into the volume of complex complaints that NHS Fife receives and handles.

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.

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.

The Navigator commenced post at the end of May and supports data collection, chasing and tracking complaints, and providing administration and organisational support to the PET Officers.

Work is ongoing to progress the results and action of the MSForm 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.

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.

We continue to work with services, review new ways of working, and understand challenges. Regular meetings are being held with Acute to review processes and implement change, and this will also be explored with the Health & Social Care Partnership.

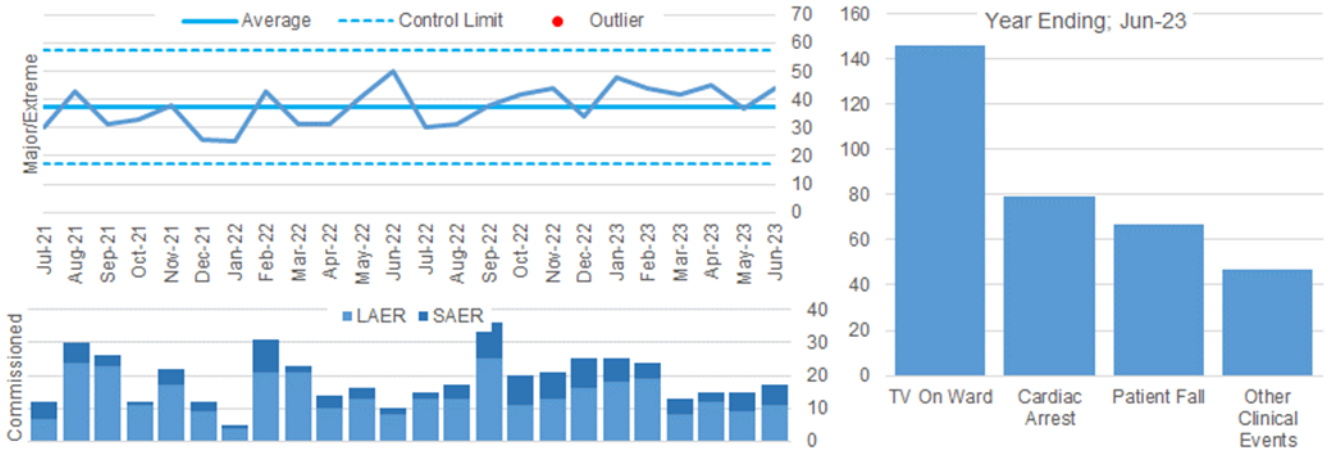
Clinical pressures improved in July 2023, and there was a focus on processing complaints. Week commencing 17 July 2023, 19 final response letters were sent; however, 11 new Stage 2 complaints were received that week.

Delays remain with obtaining statements and approval of final responses, and at the end of July 2023, 80% of all live complaints were awaiting statements or final approval by the Divisions. The number of live complaints remains unchanged between 140-150. There is an average of 40 complaints per month over 100 days, and this does not change despite closing on average 13 of these per month. This demonstrates clearing the continuous existing backlog of complaints is incredibly challenging.

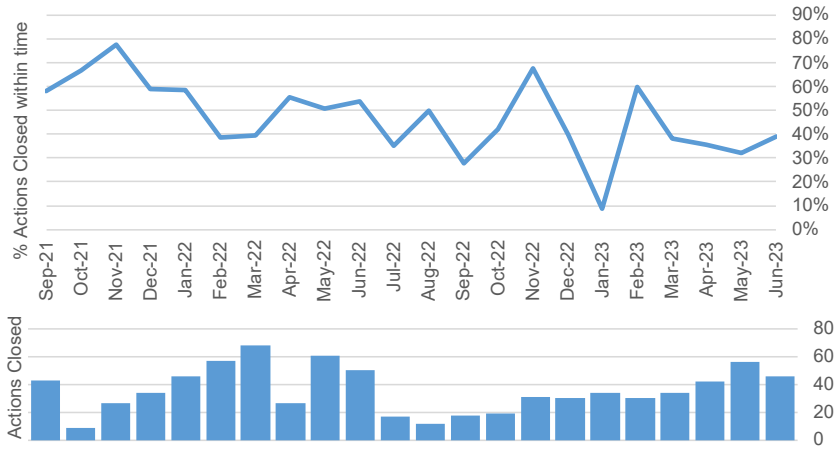
Historically the Band 6's PET Officers would have a mixed caseload of enquiries, concerns, Stage 1's and Stage 2's with at most 20 Stage 2's. There are 3.6 WTE Band 6 PET Officers, allowing them to work on a maximum of 74 Stage 2's. There are 143 stage 2 complaints open, which is a 93.4% increase in workload for the team. Compared with 2021/2022, there is also a 12.4% increase in the total number of complaint contacts (enquiries, concerns, stage 1's and stage 2's.

e. Performance Exception Reports

Adverse Events	Number 44



Actions from Significant and Local Adverse Event Reviews	Closure Rate 39.1%



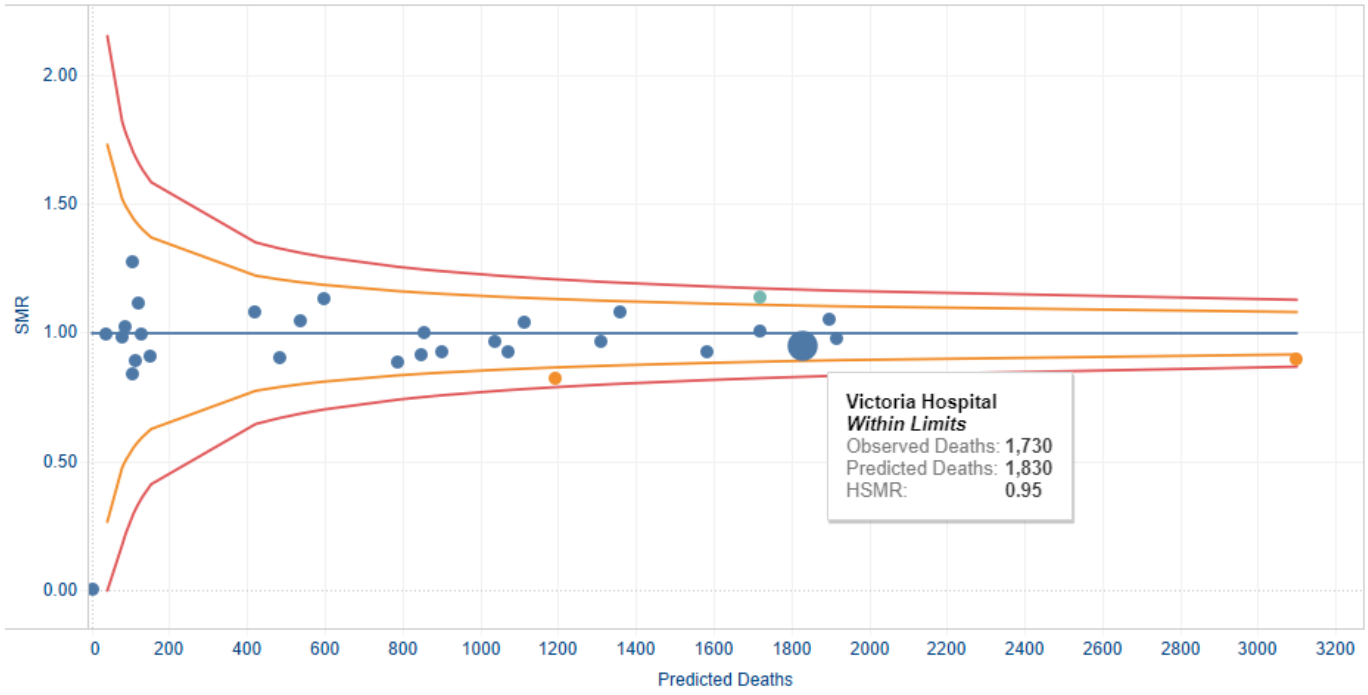
Key Deliverable	End Date
Off track / At risk / On track / Complete / Suspended	Proposed
Delivery of Clinical Governance Strategic Framework - Adverse Events	**Mar-24**
Key Milestones: Publication of updated Adverse Events Policy	Apr-23
Adverse Events Management Resource Pack uploaded to Blink	Sep-23
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

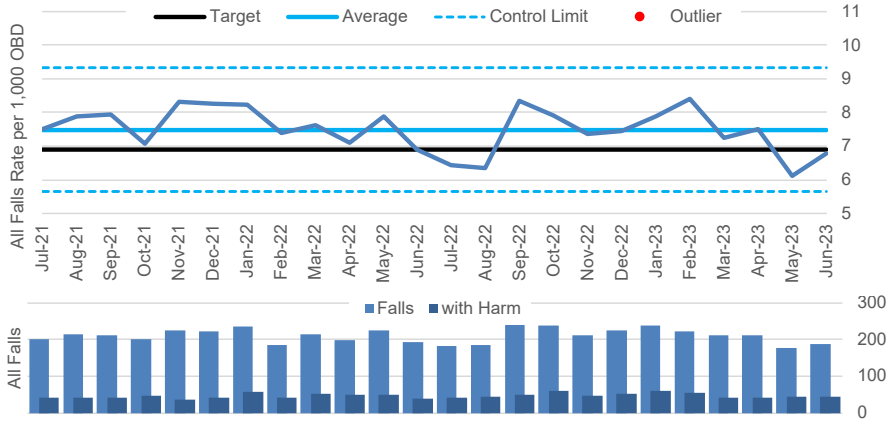
Data for 2021 and 2022 demonstrates a return to a typical ratio for NHS Fife, with the data for year ending December 2022 showing a ratio below the Scottish average.

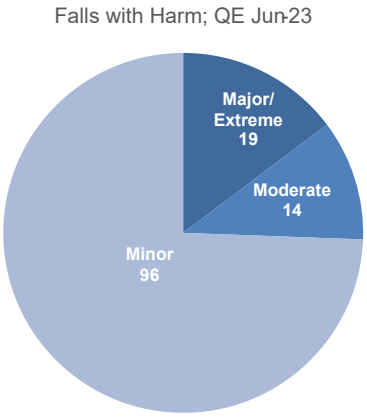
Inpatient Falls

Reduce Inpatient Falls rate per 1,000 Occupied Bed Days (OBD)
Target Rate (by end March 2023) = 6.91 per 1,000 OBD

Performance 6.80

Local Performance





Performance by Service Area

	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
NHS Fife	6.91	6.44	6.34	8.34	7.90	7.37	7.44	7.88	8.39	7.24	7.50	6.12	6.80
Acute	7.83	8.06	6.45	9.33	7.53	8.21	7.20	8.22	9.73	6.52	8.90	5.70	6.68
HSCP	6.08	4.97	6.25	7.47	8.24	6.64	7.65	7.58	7.28	7.82	6.33	6.48	6.89

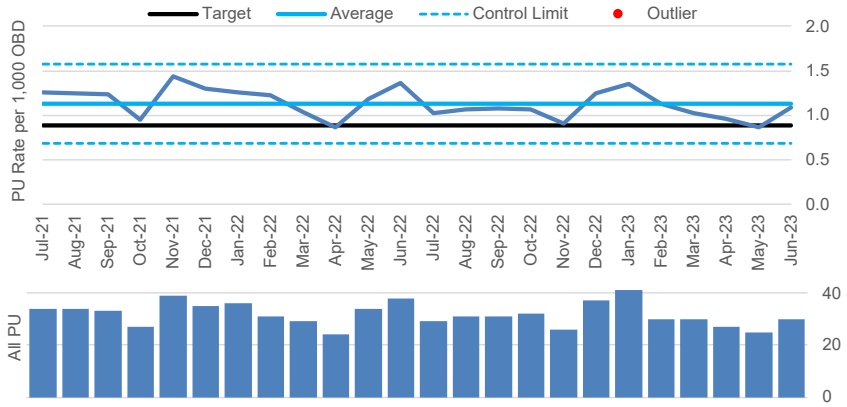
Key Deliverable	End Date
Off track / At risk / On track / Complete / Suspended	Proposed
Reduce Falls across all hospital inpatient setting	**Mar-24**
Key Milestones: Review and confirm falls link practitioners for each ward area on every hospital site.	Sep-23
Ensure that falls related data is discussed and displayed in the ward to strengthen awareness across multi-disciplinary team.	Sep-23
Rollout revised Falls toolkit including related policies e.g.: Boarding, Supervision, Bed rail.	Sep-23
Support shared learning from incidents and share good practice	Sep-23
Align all NHS work with the newly updated SPSP National Inpatient Falls driver diagrams	Mar-24
Develop a national Falls education module within TURAS system	Sep-23
Rollout new patient information leaflet and endeavour to audit the impact and benefit for patients	Sep-23

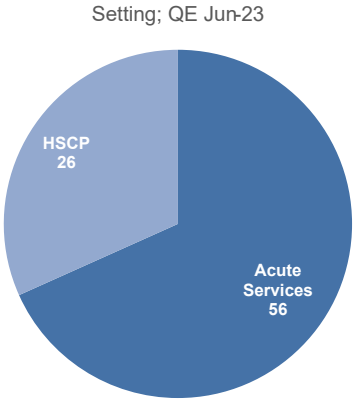
Pressure Ulcers

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 1.08

Local Performance





Performance by Service Area

	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
NHS Fife	1.37	1.02	1.07	1.08	1.07	0.91	1.24	1.35	1.13	1.02	0.96	0.87	1.08
Acute	2.05	1.48	1.69	1.94	1.97	1.28	2.29	2.39	2.33	1.82	1.33	1.44	1.59
HSCP	0.75	0.60	0.52	0.32	0.25	0.59	0.32	0.44	0.14	0.37	0.65	0.38	0.66

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	Aug-23

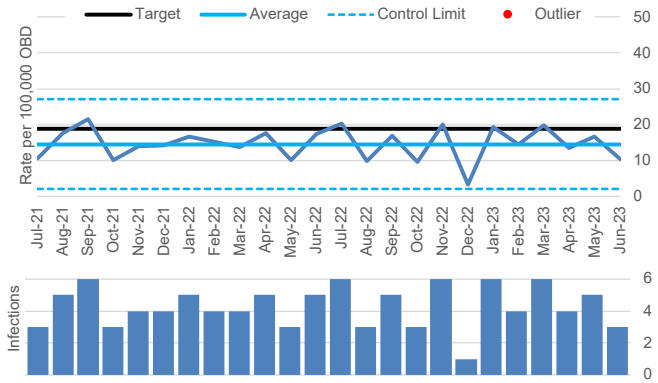
HAI/HCAI

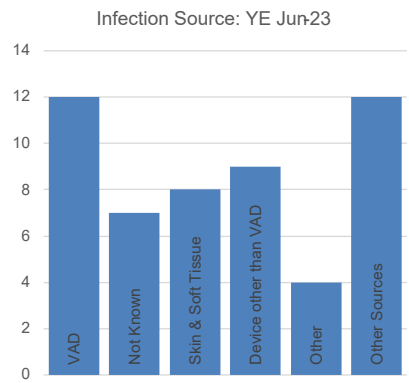
SAB

Reduce Hospital Infection Rate by 10% (baseline 2018/19) by the end of 2022/23

Performance 10.3

Local Performance





National Benchmarking

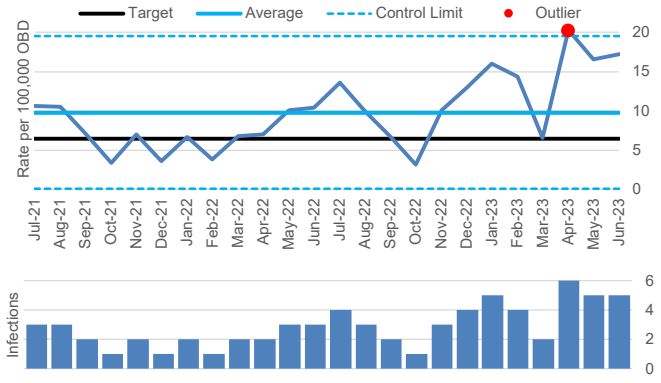
Quarter Ending	2020/21	2021/22				2022/23			
	Mar	Jun	Sep	Dec	Mar	Jun	Sep	Dec	Mar
NHS Fife	17.8	6.3	16.6	12.7	15.2	14.9	15.7	10.9	17.9
Scotland	18.4	18.6	18.3	17.3	16.3	17.3	17.1	19.2	19.1

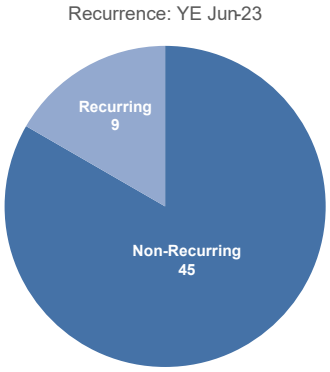
C Diff

Reduce Hospital Infection Rate by 10% (baseline 2018/19) by the end of 2022/23

Performance 17.2

Local Performance





National Benchmarking

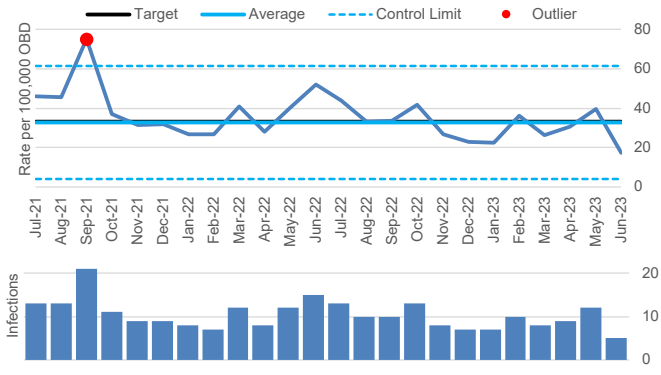
Quarter Ending	2020/21	2021/22				2022/23			
	Mar	Jun	Sep	Dec	Mar	Jun	Sep	Dec	Mar
NHS Fife	14.0	10.0	9.5	4.6	7.0	9.2	10.1	8.7	13.4
Scotland	15.8	14.6	16.8	13.3	12.6	14.3	13.1	13.5	13.4

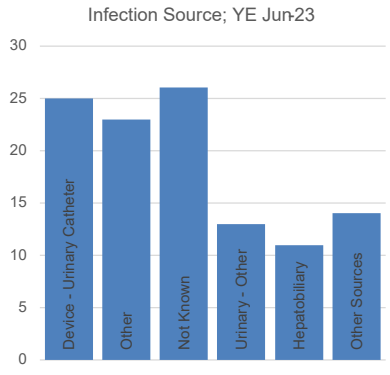
ECB

Reduce Hospital Infection Rate by 25% (baseline 2018/19) by the end of 2022/23

Performance 17.2

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

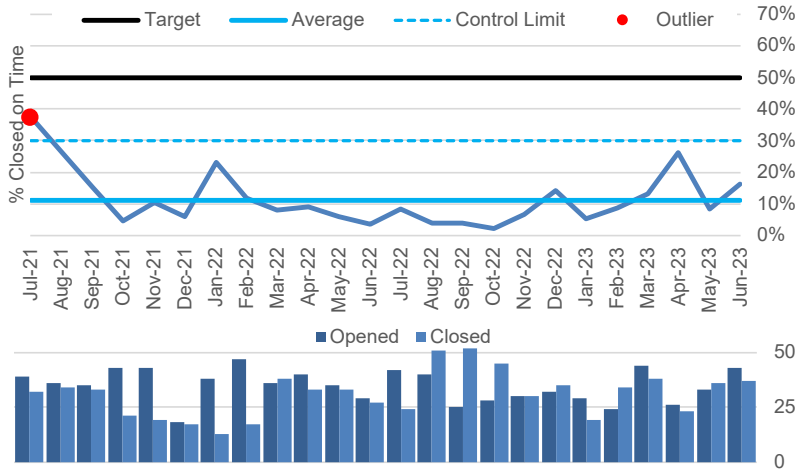
Key Deliverable		End Date
Off track / At risk / On track / Complete / Suspended		Proposed
Implement IPC Workforce Strategy 2022-24		**Sep-24**
Key Milestones	Complete a GAP analysis of the NHS Fife IPCT with regards to recommendations for local Boards	Apr-23
	Awaiting updates to national deliverables 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	Jul-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)	Sep-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	Sep-23
	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	Sep-23
	Complete QI project with D&I to improve data capture of ePVC	Sep-23
	Support roll-out of eCatheter insertion and maintenance bundles	Dec-23

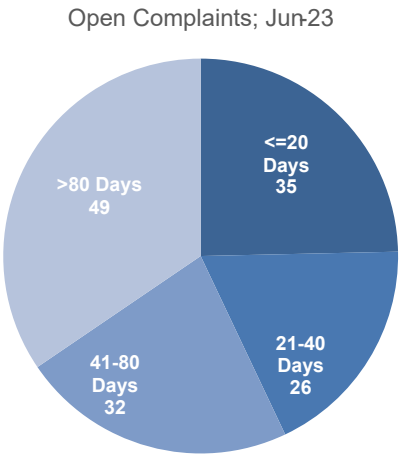
Complaints | Stage 2

At least 50% of Stage 2 complaints are completed within 20 working days by March 2023, rising to 65% by March 2024

Performance 16.2%

Local Performance





Performance by Service Area

		Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
NHS Fife	Opened in Month	42	40	25	28	30	32	29	24	44	26	33	43
	% Acknowledged on time	85.7%	87.5%	96.0%	96.4%	93.3%	96.9%	100.0%	95.8%	97.7%	96.2%	97.0%	95.3%
	Due in Month	30	47	37	21	30	27	32	30	28	38	29	35
	% Closed on time	3.3%	6.4%	5.4%	4.8%	3.3%	14.8%	6.3%	13.3%	14.3%	15.8%	6.9%	17.1%
	Closed in Month	24	51	52	45	30	35	19	34	38	23	36	37
	% Closed on time	8.3%	3.9%	3.8%	2.2%	6.7%	14.3%	5.3%	8.8%	13.2%	26.1%	8.3%	16.2%
Acute	Closed in Month	14	43	34	29	22	26	17	23	23	16	27	23
	% Closed on time	14.3%	2.3%	0.0%	0.0%	9.1%	19.2%	5.9%	13.0%	13.0%	31.3%	7.4%	21.7%
HSCP	Closed in Month	10	6	16	16	7	9	2	10	15	7	9	14
	% Closed on time	0.0%	0.0%	6.3%	6.3%	0.0%	0.0%	0.0%	0.0%	13.3%	14.3%	11.1%	7.1%

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	Aug-23
	Supportive escalation process to be implemented to highlight delays within the Model Complaint Handling Process	Oct-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 Milestones	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	Oct-23
	Identify test area prior to roll out	Oct-23
	Education and training	Oct-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:	**8 September 2023**
Title:	**Deep Dive: Pressure Ulcers**
Responsible Executive:	**Janette Keenan, Executive Director of Nursing**
Report Author:	**Lynn Barker, Director of Nursing, H&SCP**

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 NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of this report is to provide an in-depth review of harms featured as part of IPQR. This report focuses on Pressure Ulcer performance across NHS Fife, highlighting any causal factors, actions and improvement plans.

2.2 Background

Pressure ulcers are described as “an injury that breaks down the skin and underlying tissue. They are caused when an area of skin is placed under pressure and are sometimes known as ‘bed sores’ or ‘pressure sores’. Pressure ulcers can occur in any person, regardless of age, who has, for example, limited mobility, cognitive impairment, palliative and end of life care needs or is acutely ill. Other contributory factors include poorly controlled diabetes, poor bladder or bowel function, or poor nutrition and hydration”

To support pressure area management, the Tissue Viability toolkit is applied across the whole of NHS Fife for the prevention, assessment and management of pressure ulcers. This toolkit covers identification of vulnerable patients, applying a safety bundle for vulnerable patients, multi-disciplinary assessment involving the Tissue Viability team, the use of pressure ulcer relieving equipment, and interventions pre and post pressure ulcer.

All wards across NHS Fife are expected to carry out a top-to-toe inspection and complete a Pressure Ulcer Risk Assessment (PURA) within 6 hours of admission or transfer of a patient into the ward and daily thereafter. The Surface, Skin Inspection, Keep Moving, Incontinence and Nutrition (SSKIN) assessment must be completed if the person is deemed to be at risk of developing a pressure ulcer, it must be tailored to the individual needs of the person and is supported by the use of the comfort clock.

PURA and SSKIN bundle are currently being built on Patientrack which is expected to improve compliance within inpatient settings, and therefore improve outcomes for patients, it should be noted that these documents are also now available on MORSE for Nursing Teams to use within a community setting.

The current target rate for reducing Hospital Acquired Pressure Ulcer (HAPU) incidence for 2022/2023 is 25% by December 2023 which equates to a rate of 0.89. Fife Health and Social Care's (HSCP) pressure ulcer rate in June was 0.66. It may be worthwhile noting that the rate of Hospital Acquired Pressure Ulcer (HAPU) within the community inpatient wards, are low, with the median sitting at 0.42; a further reduction to the target rate has been agreed at 15% for 2023 / 2024. The target rate for reducing hospital acquired pressure ulcers within Victoria Hospital wards is 1.51 and current data as of 30/06/2023 the hospital was sitting at this rate.

2.3 Assessment

Anecdotal evidence suggests that the impact of the Covid-19 pandemic has led to an increased number of patients admitted to the hospital in a deconditioned state with increased frailty and/or acuity. These patients are at a higher risk of developing pressure ulcers.

The Scottish Ambulance Service (SAS) have reported an increase in response times with patients waiting longer for ambulances and higher turnaround times at Emergency Department (ED). This has resulted in patients spending prolonged periods of time on trolleys or chairs without pressure relieving equipment or provision of pressure area care, work continues with SAS to mitigate this risk. These conditions may contribute to patients having an increased risk of developing pressure ulcers; however the Tissue Viability team have given a provision of more than 30 Repose mattress overlays to ED to mitigate this risk where possible, and ensure there is immediate access to pressure relieving equipment for patients who may experience a prolonged wait on a trolley.

In the ED there can be at times increased waits for beds and these patients are transferred onto trolleys with pressure redistribution properties. In response to the delays in ED, the nursing team has developed and are testing Care Round checklist and documentation sheet. This is not a full PURA and skin bundle assessment but does include skin inspection.

A monthly Tissue Viability report is produced by the Planning & Performance team, shared across ASD and HSCP and discussed at the Tissue Viability Steering Group, held bi-monthly and chaired by HSCP Director of Nursing. This report is cascaded through clinical/professional structures to Senior Charge Nurses and Team Leaders in clinical areas and forms part of regular 1-1 discussions between the Heads of Nursing and the Lead Nurses. The TV Steering Group is currently undergoing some restructuring and review.

Pressure Ulcer damage is reported as

- All newly developed pressure ulcers of grade 2 or above
- All newly developed suspected deep tissue injury
- All newly developed pressure ulcers graded as "ungradeable"
- All new pressure ulcers acquired after admission/transfer in a healthcare setting where expert assessment and clinical history does not ascertain damage started prior to admission.

Please note that run chart & pareto data has been extracted from the monthly performance Tissue Viability report to end June 2023.

Chart 1

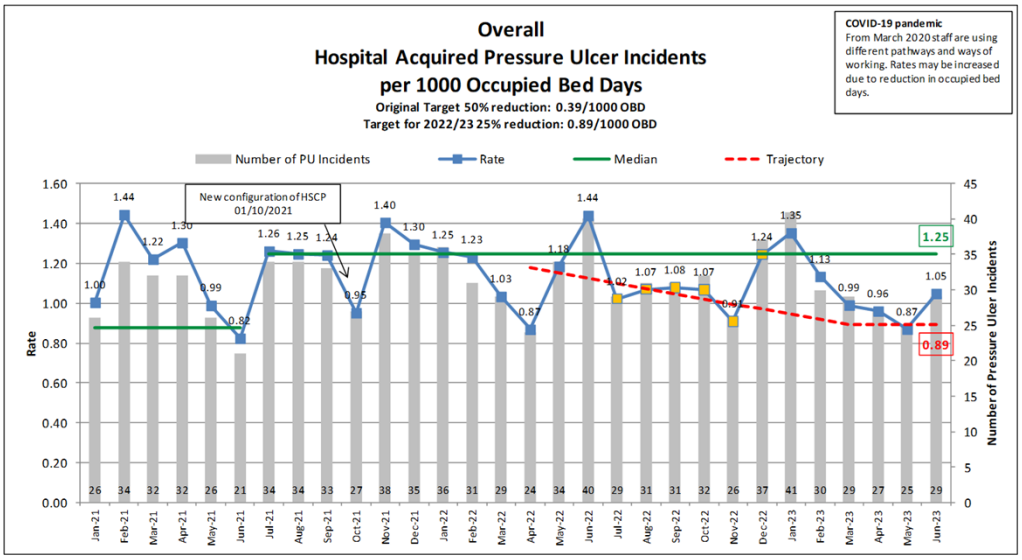


Chart 2

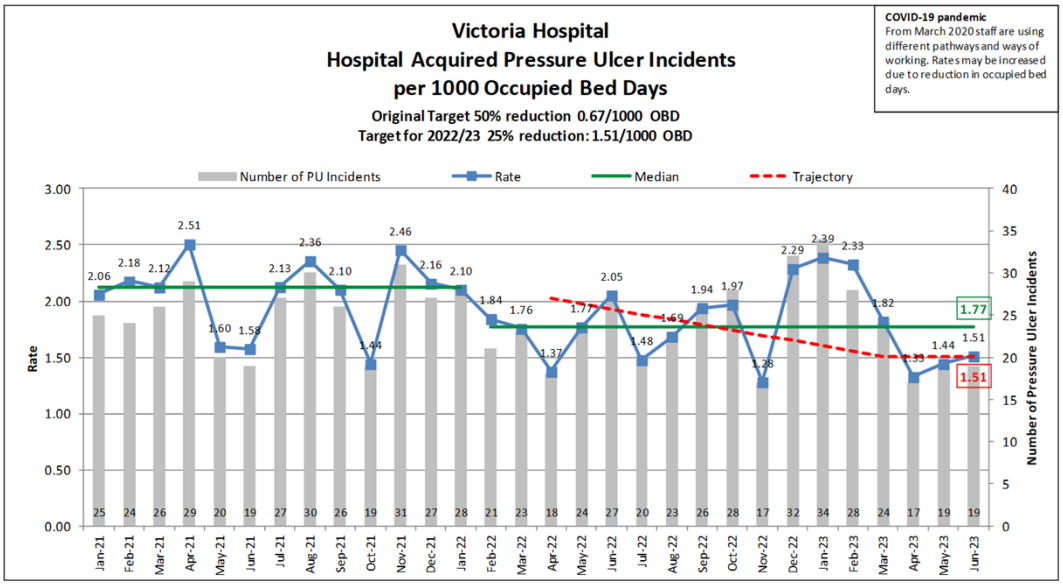
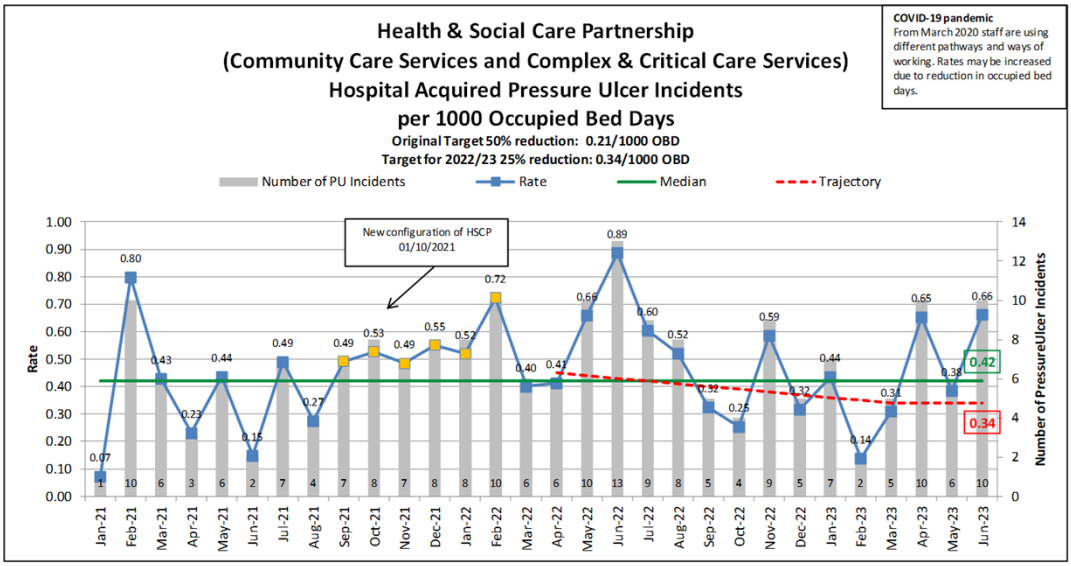


Chart 3



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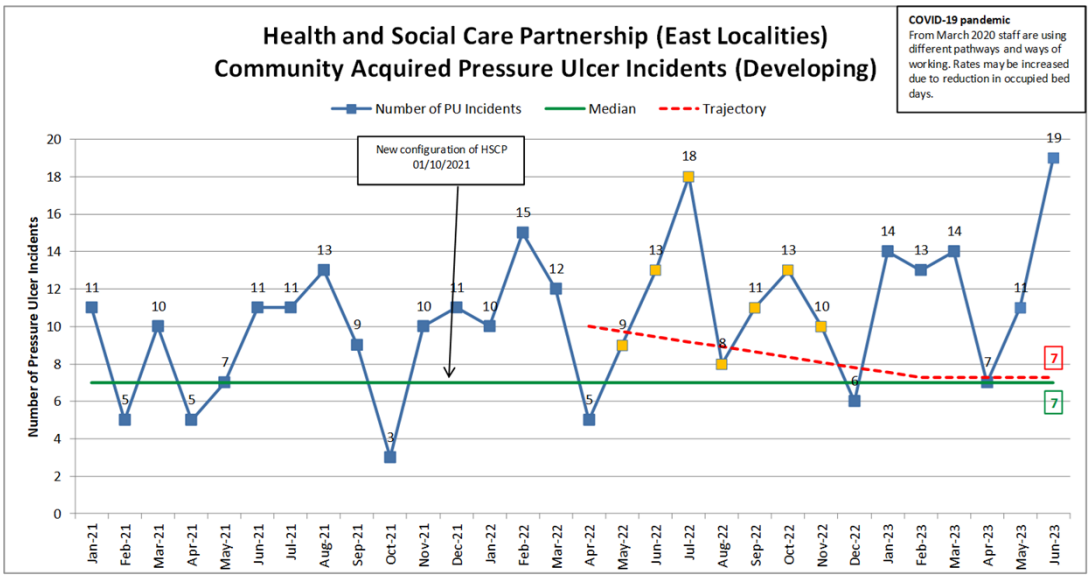
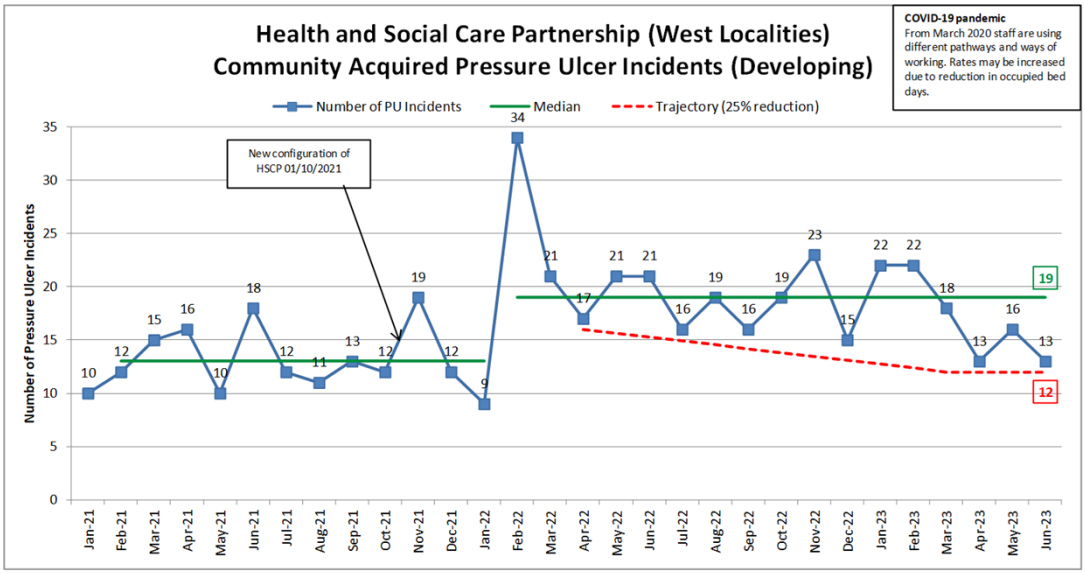


Chart 5



Please note data extracted for tables 1 & 2 extracted from Datix on 08/08/2023

Table 1: HSCP: Sub-category of Hospital Acquired PU (Jan to Jun 2023)

hospital acquired PU	total
On Ward or Caseload - Grade 2 Pressure Ulcer Developing (Grade as 'MODERATE')	27
On Ward or Caseload - Grade 3 Pressure Ulcer Developing (Grade as 'MAJOR')	5
On Ward or Caseload - Suspected Deep Tissue Injury (Grade as 'MODERATE' severity)	5
On Ward or Caseload - Ungradeable (Grade as 'MAJOR' severity)	2
On Ward or Caseload - Grade 4 Pressure Ulcer Developing (Grade as 'MAJOR')	1
On Ward or Caseload - Multiple Pressure Ulcers Developing	1
TOTAL	41

Table 1: ASD: Sub-category of Hospital Acquired PU (Jan to Jun 2023)

ASD - hospital acquired PU	total
On Ward or Caseload - Grade 2 Pressure Ulcer Developing (Grade as 'MODERATE')	103
On Ward or Caseload - Grade 3 Pressure Ulcer Developing (Grade as 'MAJOR')	9
On Ward or Caseload - Suspected Deep Tissue Injury (Grade as 'MODERATE' severity)	16
On Ward or Caseload - Ungradeable (Grade as 'MAJOR' severity)	6
On Ward or Caseload - Grade 4 Pressure Ulcer Developing (Grade as 'MAJOR')	0
On Ward or Caseload - Multiple Pressure Ulcers Developing	7
TOTAL	141

Table 3:

Community Acquired Pressure Ulcers	total
On Ward or Caseload - Grade 2 Pressure Ulcer Developing (Grade as 'MODERATE')	83
On Ward or Caseload - Suspected Deep Tissue Injury (Grade as 'MODERATE' severity)	45
On Ward or Caseload - Grade 3 Pressure Ulcer Developing (Grade as 'MAJOR')	29
On Ward or Caseload - Ungradeable (Grade as 'MAJOR' severity)	19
On Ward or Caseload - Multiple Pressure Ulcers Developing	8
On Ward or Caseload - Grade 4 Pressure Ulcer Developing (Grade as 'MAJOR')	2
TOTAL	186

Acute Services Division (ASD) Summary of Data

The 2022/2023 target rate for acute hospital acquired pressure ulcers is **1.**51 per 1000 OBD – **current rate is 1.51**. Following a sustained reduction in pressure ulcers from Feb-22 to Oct-22 the rate for hospital acquired pressure ulcers has remained at 1.77. A consecutive decrease occurred from Jan-23 to Apr-23. Current data demonstrates three data points below the median with a rise in pressure ulcers between April-23 and Jun-23. The top three areas reporting highest incidents during Apr-23 to Jun-23 are Ward 31 (Orthopaedic/Hip Fracture), Ward 43 (Medicine of the Elderly), Ward 53 (Medicine (Endocrine) and Ward 41 (Medicine for the Elderly).

Health and Social Care Partnership (HSCP) Summary of Data

The 2022/2023 target rate for HSCP inpatient wards is **0.34** per 1000 OBD – **current rate is 0.66**. A downward trend in pressure ulcers was noted from Jun-22 to Oct-22. A consecutive rise in hospital acquired pressure ulcers occurred from Feb-23 to Apr-23.

The top three ward areas reporting higher hospital acquired PU during April-June 2023 are Hospice VHK, Ward 2 Glenrothes and Ward 6 (Medicine for the Elderly), QMH.

Health and Social Care Partnership (HSCP) - Community Acquired PU

Community acquired pressure ulcers data is split between East and West localities. Data for East localities demonstrates a rise in pressure ulcers from Apr-23 to June-23, remaining above the median of 7. A sustained increase in pressure ulcers within West localities occurred from Feb-22 to Oct-22, increasing the median from 13 to 19. Current data demonstrates four data points below median from Mar-23 to Jun-23.

Quality Improvement (QI)

ASD

The TV team recently introduced a 'Ward of the Week' initiative which uses HAPU data directly from the monthly Tissue Viability report to provide a week of bespoke targeted education, audit and support to four clinical areas with the highest incidence rates. This has enabled the TV team to provide support to seven wards with a reach of more than 120 staff and students between April and June 2023. This is reviewed each month to identify wards that require this targeted approach to support as many staff as possible.

HSCP

Community inpatients wards continue to measure compliance with the skin bundle which incorporates key elements from the Prevention & Management of Pressure Ulcers. Compliance data enables teams to enhance good practice and identify opportunities to support staff with further education and training, and highlight potential improvement work. The inpatient wards also receive monthly ward data on pressure ulcers which is displayed within the ward areas. This information is used at morning safety huddles to allow staff to participate by raising issues and ideas for change.

Within care homes every resident should receive the right care in the right place, at the right time and collaboration across health and social care, as well as the independent and third sector organisations, will ensure this is delivered.

The Care Home Liaison Team (CHLT) work closely with TVN's, Podiatrists, DN's and Dermatology specialists to deliver education and support for care home staff.
Joint meetings between the specialist services, social care staff and care home nurses, take place regularly to plan education and learning sessions for care home staff across Fife.
There is a proposed test of change involving the use of the Care Inspectorate's 'Pressure Damage RED DAY Review Tool'. Participating care homes has yet to be agreed.

Community Nursing

Community District Nursing Teams use the Waterlow tool to assess patients and monthly documentation audits are undertaken with results fed back to Team Leaders for discussion and action. A retrospect case note audit is undertaken on three patient case notes per month, the purpose of which is study demographic information as well as information about decisions made, conversations held, and the care delivered. Information gained from this insight will be captured to support learning and identify improvement work.

Learning from LAERs resulted in a quality improvement project involving a test of change (PDSA) to improve completion of core documentation and timely ordering of equipment. Compliance with documentation has improved and collaborative working with TVN will support the roll out to District Nursing teams Fife-wide, incorporating a Skin bundle. In addition, there is early indication of a reduction in community acquired grade 3 pressure ulcers within the initial test location.

District Nursing has introduced a monthly Fife-wide LAER meeting to discuss acquired pressure ulcers with key learning identified and shared.

A Community Nursing Pressure Ulcer Group has been established to expand existing quality improvement projects.

Collaboration between Acute and Community Tissue Viability Nursing teams includes a weekly/biweekly meeting to discuss patients and work towards integration of the teams. This has supported the re-launch of the quarterly Tissue Viability newsletter on Sway and the creation of a Fife TV Twitter account for the sharing of knowledge, resources and wound related content.

Leadership and Governance

Outcome and process measure reports are monitored and reviewed by clinical teams to drive improvement. Monthly and weekly data is used at safety huddles and at team meetings with visible and supportive leadership at all levels. All pressure ulcers graded major or extreme undergo a review as per the Adverse Events policy with key learning that can lead to improvement activity. Each of the HSCP portfolio groups have now established operational Quality Assurance Matters Groups (QMAG) and learning from adverse events and feedback is discussed at these groups.

Within Fife HSCP, a Quality Matters Assurance Safety Huddle (QMASH) is held bi-weekly; the meeting is chaired by Fife HSCP Director of Nursing and is attended by the Heads of Service, Professional Leads and Senior Managers along with other key stakeholders and supported by the Clinical and Care Governance Team. The reports enable timely interventions through early identification of emerging themes and compliments the Excellence in Care, CAIR dashboard which continues to be rolled out across all areas.

Weekly “harm” data is shared and discussed at the meeting with each of the services; the report incorporates inpatient areas, District Nursing Teams, ICASS and Podiatry as well as providing pressure ulcer prevalence data across care homes. Any issues raised are incorporated in the QMASH action plan or devolved to the appropriate “sub-group” to drive improvement.

An Adverse Event Review Panel consisting of Senior Leadership membership was established in January 2023 to review major and extreme incidents within Fife HSCP to advise on the level of review to be undertaken. More recently LAER and SAER reports are now also reviewed by the multi-disciplinary panel to drive the quality of reports; a cluster of PU reviews was undertaken by the panel in June and fed back to the District Nursing Team to drive improvement.

Specialist Advice and Equipment

A range of specialist equipment is available on site across ASD and the Community Settings; there is no delay in accessing this. All mattresses in patient areas have been replaced with hybrid mattresses across the site which can be activated to provide combined foam and dynamic air functions, offering appropriate pressure offloading for up to grade 4 pressure damage. All trolleys within ED have been replaced with trolleys with pressure relieving properties and all mattresses within ICU had been replaced with specialist mattresses that have the technology to deflate individual cells under targeted areas of the body at particular risk which are beneficial when patients are nursed prone, however following some collaboration with IPCT and TV, these mattresses are under review. A short life working group met recently to ensure all areas across the Mental Health and Learning Disability wards had access to pressure relieving equipment. Although their numbers of pressure ulcer damage are very low, a procedure was put in place to ensure they had access to speciality equipment. Specialist advice from the Tissue Viability team is available, who are happy to give telephone advice, however, do require an online referral to be completed if further intervention is required. The Acute TV team are currently at full establishment following recruitment at the start of the year.

Education and Training

Prevention and Management of Pressure Ulcers education and CPR for feet is available on Turas learn and is a mandatory course for all clinical staff with patient contact, education and training on pressure ulcers is also part of NHS Fife induction. During the pandemic training was delivered virtually including several webinars and Senior Nurse Forum which focused on Pressure Ulcer Prevention and Management. The TV team recently held three well attended days of education aimed at a variety of clinical staff and

students, and covered topics ranging from pressure ulcer prevention, assessment and management, wound care for people who use drugs to how and when to refer to specialist wound related services. Approximately 200 people attended these study days. The network of TV Link Practitioners has been re-established with further dedicated training sessions to come later this year.

2.3.1 Quality/ Patient Care

Nursing staff levels are monitored using a safe to start tool in ASD and the HSCP (in testing phase) and reporting in staffing level using the OPAL tool. This is to ensure safe staffing in all areas and to ensure staffing is not negatively impacting on the quality and delivery of safe and effective patient care, including pressure area prevention and management. Whilst steps are taken to mitigate the risk of lower staffing levels, quality of care continues to be an organisational priority. The Tissue Viability Steering Group oversees the compliance with the Prevention and Management of Pressure Ulcer standards (Oct 2020). Process measures based on the skin bundles for hospital acquired pressure ulcers include key elements of the standards, enabling wards to monitor compliance on a weekly basis. Wards within Community care services have access to monthly quality assurance data, displayed within the ward areas. Quality assurance boards are developing for Mental Health inpatient wards. A similar tool to capture process measures is being tested across Community District Nursing teams, with plans to spread this further.

2.3.2 Workforce

Ongoing workforce challenges relating to vacancies, absences and covid 19 have contributed to the rate of improvement being delayed reducing pressure ulcer harm. However, NHS Fife continues to promote innovative recruitment initiatives: Mass recruitment event, international recruitment and Assistant Practitioner Roles. Communication and Promotion of recruitment campaigns through social media are also underway.

2.3.3 Financial

This paper does not seek to quantify specific costs but any damage to a person's skin may potentially lead to an extended inpatient stay, the requirement for the use of specialist equipment and longer term care requirements therefore carries a financial implication.

2.3.4 Risk Assessment/Management

All risk assessment and management are adhered to, and review of risk is discussed at the Tissue Viability Steering Group Monthly.

2.3.5 Equality and Diversity, including health inequalities

An impact assessment has not been completed because 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

The Tissue Viability Teams have pages on staff blink where staff can access both up to date documentation and information and education. The teams have set up a twitter account to engage more widely on tissue viability related topics.

2.3.8 Route to the Meeting

- NHS Fife Clinical Governance Oversight Group

2.4 Recommendation

- **Assurance**

3 List of appendices

None.

Report Contact
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NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**August 2023**
Title:	**Healthcare Associated Infection Report (HAIRT)**
Responsible Executive:	**Janette Owens, Director of Nursing**
Report Author:	**Julia Cook, Infection Control Manager**

1 Purpose

Update for Infection Prevention and Control for August 2023 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 August 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 August 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 (from 16 cases in Q1 2023 to 12 cases in Q2 2023). Awaiting national comparison.
- There have been 7 dialysis line related SABs since the start of 2023. This is a high number of cases. Renal services have been alerted, who have carried out Complex Care Reviews (CCRs) of each individual case. A `Super SAER `, meeting took place on 26th June, to discuss all of the findings.

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 June 2023 (n=33) is significantly higher than the number of cases during the same time-period the previous year (n=19). 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 July 2022 to June 2023, the number of CAUTI related ECBs (n=25) was lower than during the same time-frame the previous year (n=37).

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
- Patientrack CAUTI bundles have now been installed onto Patientrack and have now been trailed on V54 ward. Amendments to the tool are awaited by Patientrack, prior to this being rolled out across the board.
- CAUTI bundles have been implemented within 4 care homes, to optimise urinary catheter maintenance and the CAUTI algorithm. This work has been led by the IPC Care Home Senior IPCN for NHS Fife. The findings of the project were presented to the UCIG meeting on the 23rd June.

COVID-19 pandemic

- The weekly ARHAI Scotland nosocomial report has now ceased.

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

- 8 new ARHAI Scotland reportable outbreaks/incidents of COVID-19 which are detailed in the HAIRT

Hospital Inspection Team

No new inspections during the last reporting period.

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

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 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 August 2023

2.4 Recommendation

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

3 List of appendices

The following appendices are included with this report:

- Appendix 1 - Healthcare Associated Infection Report
- Appendix 2 - E. Coli Bacteraemia Report

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Infection Prevention
and Control Team

Fife Health & Social Care Partnership

NHS Fife

HAIRT Report

HAIRT Report for Infection Control Committee on 9th August 2023.

(Validated Data up to June 2023)

August 2023

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 12 cases in Q2 2023). Awaiting national comparison.

At the time of the most recent update (01/07/23), **258 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 July 2022 to June 2023, the number of CAUTI related ECBs (n=25) was lower than during the same time-frame the previous year (n=37).

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 June 23), there have been 5 PWID related SAB cases.

There have been 7 dialysis line related SABs since the start of 2023. This is a high number of cases, considering there were only 2 cases for the whole of 2022. Renal services have carried out Complex Care Reviews (CCRs) of each individual case, and a `Super SAER` meeting took place on 26th June, to discuss all of the findings.

CDI

The cumulative total of CDIs for the period Jan-end June 2023 (n=33) is significantly higher than the number of cases during the same time-period the previous year (n=19). There is also an increase in the number of HCAI (HAI+HCAI+Unknown) cases (Jan-Jun 23 n=27, Jan-Jun 22 n=13). IPCT will continue to monitor cases to assess if there is a sustained rise.

A CDI trigger in V22, the trigger tool and enhanced cleaning remained in place, until the ribotypes, of the 4 positive cases, were confirmed as being different.

Caesarean Section SSI/ Large Bowel Surgery SSI/ Orthopaedic Surgery SSI

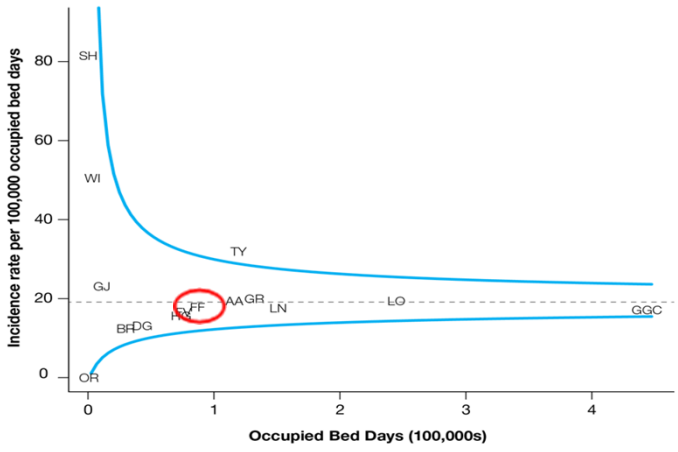
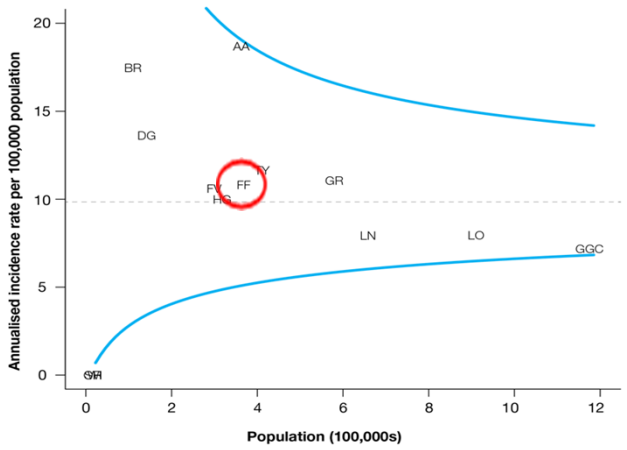
National surveillance programme for SSI has been paused due to the COVID-19 pandemic. DL (2023) 06 published February 2023 advises surgical site infection (SSI) and enhanced surveillance reporting remains paused for the time being.

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	12 HCAI/HAI 14 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 7 dialysis line related SABs during Jan-Jun 2023. Renal services carried out a CCR of each case and finding were discussed at a `Super SAER` meeting on 26th June 2023.

As of **01/07/2023** the number of days since the last confirmed SAB is as follows:	
CVC SABs	341 Days
PWID (IVDU)	45 Days
Renal Services Dialysis Line SABs	63 Days
Acute services PVC (Peripheral venous cannula) SABs	258 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%.

Awaiting national comparison 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%	N/K

CPE (Carbapenemase Producing Enterobacteriaceae)

From April 2018, CRA has also included screening for CPE.
NHS Fife achieved **100%** compliance with the **CPE** CRA for Q2 2023 (Apr-Jun)
This was **EQUAL** to the compliance rate in Q1 2023
Awaiting national comparison for Q2 2023.
CPE Critical risk assessment (CRA) screening KPI compliance summary:

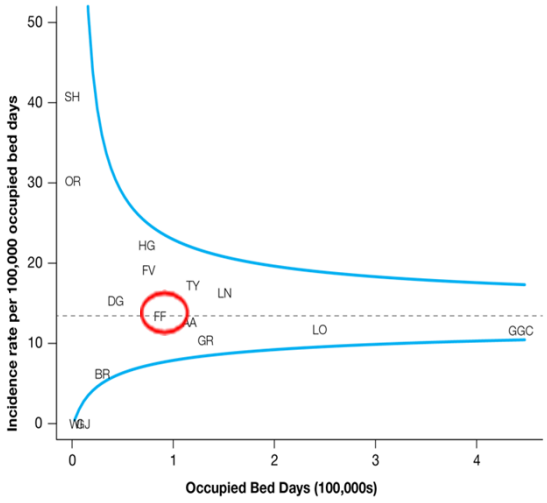
Quarter	Q1 2021 Jan-Mar	Q2 2021 Apr-Jun	Q3 2021 Jul-Sep	Q4 2021 Oct-Dec	Q1 2022 Jan-Mar	Q2 2022 Apr- Jun	Q3 2022 Jul-Sep	Q4 2022 Oct-Dec	Q1 2023 Jan-Mar	Q2 2023 Apr-Jun
Fife	88%	90%	100%	98%	100%	98%	100%	100%	100%	100%
Scotland	82%	83%	82%	80%	80%	79%	78%	76%	77%	N/K

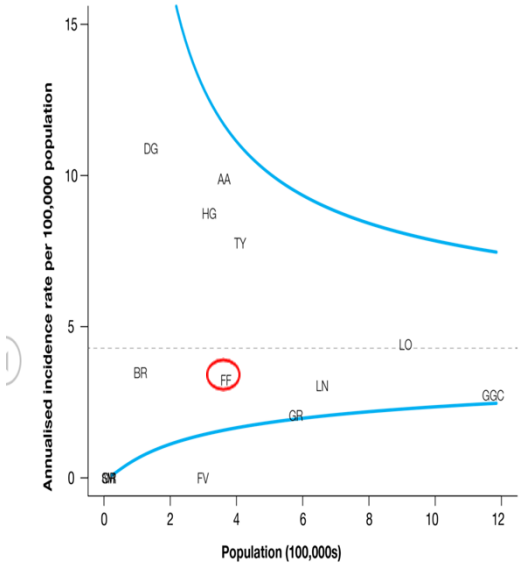
3 Clostridioides difficile Infection (CDI)

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

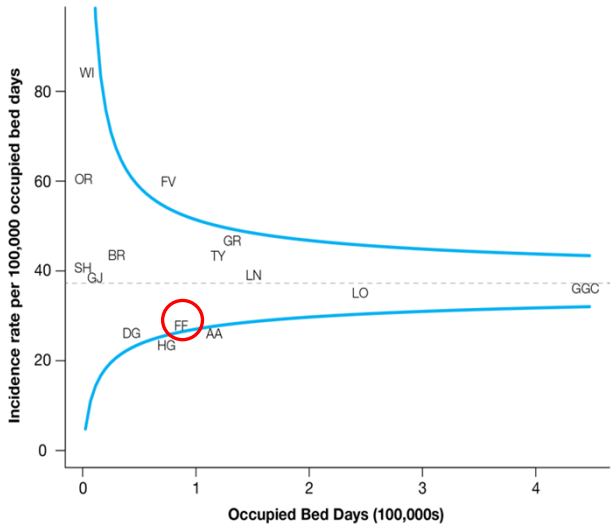
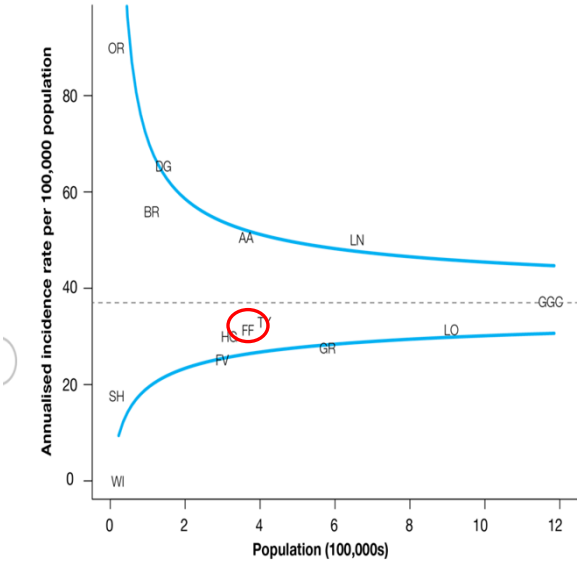
Follow up of all hospital and community cases continues to establish risk factors for CDI

- 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.
- Bezlotoxumab for recurrent CDI currently used in Fife.

4.0 Escherichia coli Bacteraemias (ECB)

4.1 Trends:

Escherichia coli Bacteraemias (ECB)				
Local Data: Q2 (Apr-Jun) 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 June 2023 there has been 9 CAUTI ECBs (7 from urinary & 2 from a supra-pubic catheter). 2 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.

CAUTI bundles have been implemented within 4 care homes, with the aim to roll out across all care

homes, to optimise urinary catheter maintenance and the CAUTI algorithm, to all care home residents. This work has been led by the IPC Care Home Senior IPCN for NHS Fife, however is now engrained within these care homes practice. The findings of the project were presented to the UCIG meeting on the 23rd June. A meeting is currently being organised to discuss further plans to work collaboratively with the Care Home Liaison Nurse Team and Bladder and Bowel Service for further implementation.

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).

May – end of June 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 May – June 2023, there has been 8 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
Cameron Hospital	Balcurvie ward		1	3	0
Cameron Hospital	Balcurvie ward	14/06/2023	0	2	1
Glenrothes Hospital	ward 3	14/04/2023	0	12	3
Stratheden Hospital	Cairnie Ward	28/04/2023	0	3	2
Victoria Hospital	V41	09/06/2023	0	3	3
Victoria Hospital	V6	03/05/2023	0	7	1
Victoria Hospital	V31	11/05/2023	0	3	3
Victoria Hospital	V42	09/06/2023	0	2	1

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 no inspections during this reporting period (May – end of June 2023)

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 / UnKnown	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	3	7	10	5	1	6	5	9	14

Cleaning Compliance (%) TOTAL FIFE												
	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23
Overall	96.4	96.3	96.1	95.6	96.2	96.2	96.0	96.4	95.9	95.9	95.9	95.9

Estates Monitoring Compliance (%) TOTAL FIFE												
	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23
Overall	96.0	96.6	96.2	96.3	96.6	96.6	96.6	96.3	96.3	96.5	96.5	96.0

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

Cleaning Compliance (%) Victoria Hospital												
	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23
Overall	95.7	96.5	95.9	95.6	95.6	96.3	95.9	96.6	95.8	96.1	95.6	96.1

Estates Monitoring Compliance (%) Victoria Hospital												
	Jul-22	Aug-22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23
Overall	96.8	97.4	97.1	97.1	97.6	97.2	97.1	96.5	97.5	97.5	97.3	97.0

Queen Margaret Hospital

	QMH		
	SAB >48hrs admx	CDI >48hrs admx	ECB >48hrs admx
Month	HAI	**HAI**	**HAI**
Apr-23	0	1	1
May-23	1	1	0
Jun-23	0	0	0

Cleaning Compliance (%) Queen Margaret's hospital												
	Jul-22	Aug-22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23
Overall	97.6	96.5	96.3	95.8	96.4	96.3	96.9	96.5	95.9	96.5	96.7	96.6

Estates Monitoring Compliance (%)Queen Margaret's hospital												
	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23
Overall	95.5	95.9	95.4	96.6	95.9	96.6	96.1	95.5	94.8	94.9	95.5	94.1

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

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	2	7	2	1	4	9

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/

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INTRODUCTION

The report has been prepared by Dr Keith Morris and 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.

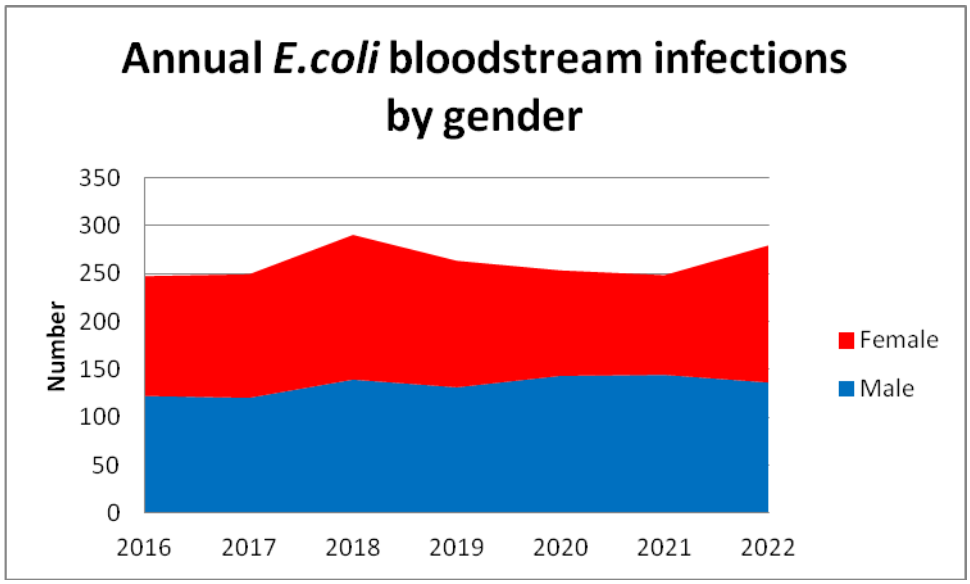

Figure 1: Trend in ECB by gender

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.

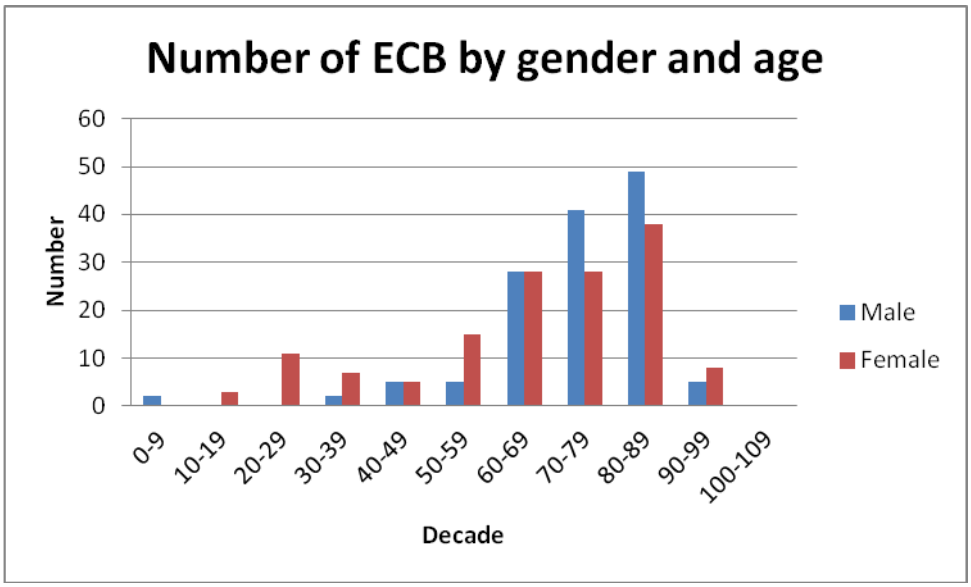

Figure 2 number of ECB by decade of life

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.

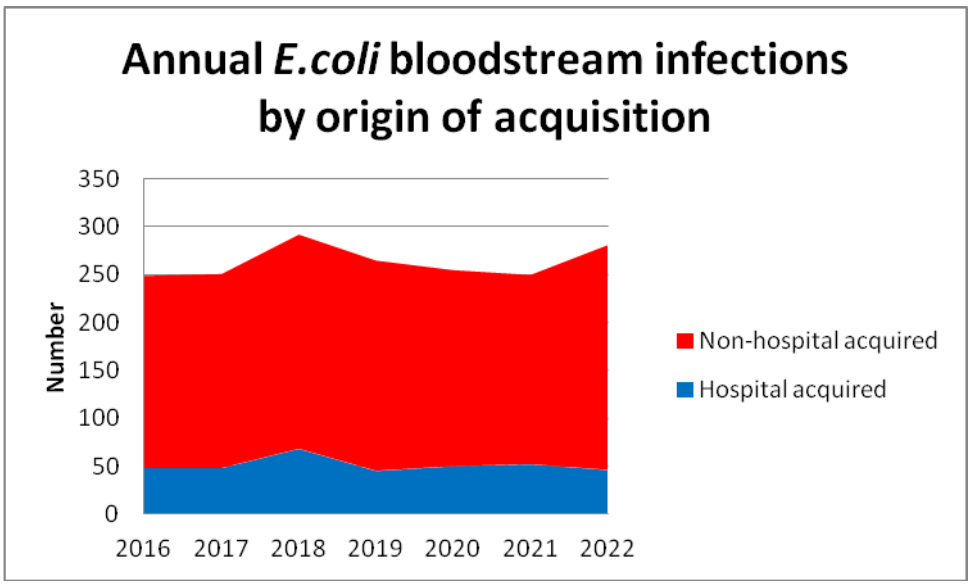

Figure 3: Annual ECB by origin of acquisition

Figure 4 presents data on the entry point of each hospital acquired ECB by system during 2022.

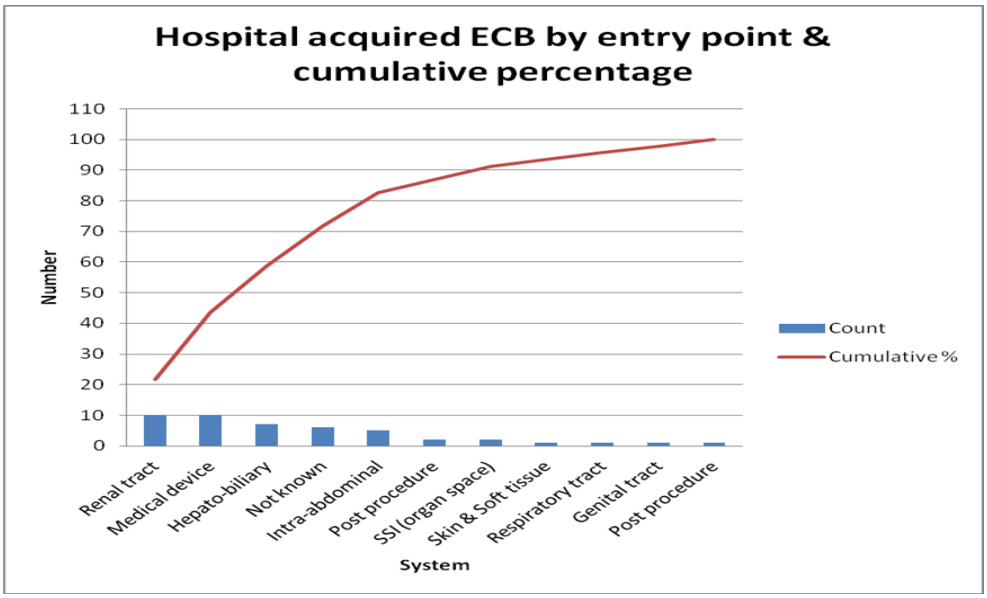

Figure 4: Pareto chart demonstrating the entry point by system of each hospital acquired ECB. More detail on the source of each ECB can be found in appendix 1.

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.

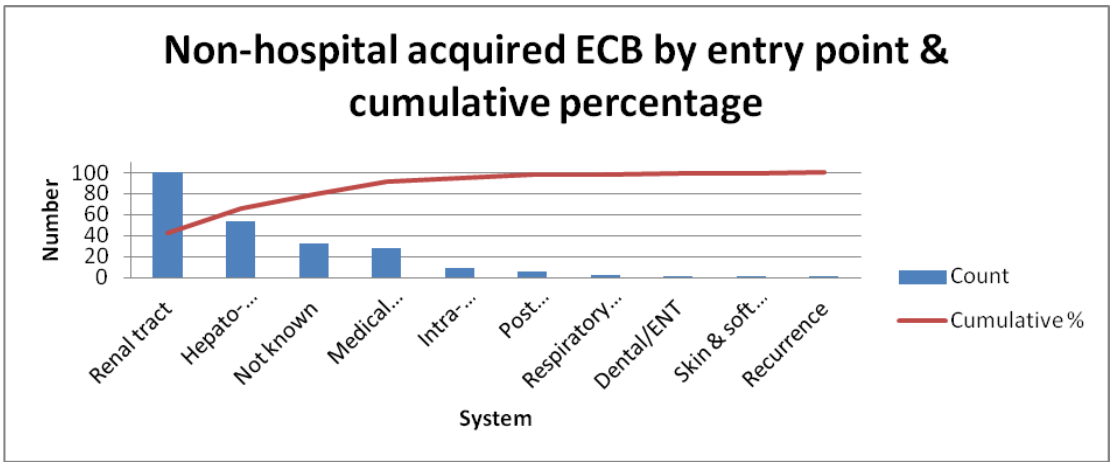

Figure 5: Pareto chart demonstrating the entry point by system of each non hospital acquired SAB.

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

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**8 September 2023**
Title:	**Deteriorating Patient Improvement Project Update**
Responsible Executive:	**Dr Chris McKenna, Medical Director**
Report Author:	**Dr Gavin Simpson, ICU Consultant and Chair Deteriorating Patient Group**

1 Purpose

This report is presented for:

- Discussion
- Assurance

This report relates to:

- Update on improvement work

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

At a previous meeting of NHS Fife Clinical Governance Oversight Group 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.

2.2 Background

Since 2020 the numbers of patients having a cardiac arrest has started to increase following many years of successive falls. SPSP/HIS reports on national cardiac arrest rates. NHS Fife has recently had its mean trend rate increased.

The deteriorating patient project seeks to relaunch ‘Know the Score’ project. This was improvement work that was started in 2015, prior to the pandemic that achieved a sustained reduction in cardiac arrests.

Cardiac Arrest rates is a reflection of how we manage all deteriorating patients within our healthcare system. Ensuring we reduce avoidable cardiac arrests means that we will reduce avoidable harm for patients in hospitals across NHS Fife. At its most extreme, patients who become seriously unwell can go on to have a cardiac arrest. Only around 20% of patients who have a cardiac arrest will survive to discharge. This work is important as it supports the delivery of safe, effective and person-centred care in NHS Fife.

2.3 Assessment

A working group has developed the project brief for this work (included in appendix one), which outlines the suggested approach. At this stage the working group is planning to establish this project for a period of a year (until September 2024) and is basing its plans on this timescale.

Reporting and Governance of this work will be through NHS Fife Clinical Governance Oversight Group, to the Clinical Governance Committee and the NHS Fife Board. It is suggested that NHS Fife Deteriorating Patient Group will provide expert clinical advice for this work.

The aim is that by September 2024 we will improve the management of deteriorating patients across all inpatient settings in NHS Fife. We will do this 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-obs 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.*
    - *Deteriorating patient Know the Score online training sessions.*
- *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.

2.3.1 Quality / Patient Care

This project is intended to improve the quality and safety of patient care.

2.3.2 Workforce

Key benefits for our workforce have been outlined in the project brief and include:

- Clarity of roles and responsibilities when working with acutely unwell patients.
- Improvements in workplace wellbeing by avoiding situations where a patient has deteriorated unexpectedly, or a patient has been resuscitated inappropriately.
- Clear documented planning and senior staff involvement in deteriorating patient management to support less experienced staff.
- Improved job satisfaction from working in a safer healthcare system.

2.3.3 Financial

No separate budget has been identified for this work. Staff time is being supported from existing budgets. Where additional non pay resources are required these will be negotiated from existing departmental budgets.

2.3.4 Risk Assessment / Management

A project brief has identified key risks. These and other emergent risks will be logged as part of a project risk register. Mitigations will be agreed and monitored at the project level. Where necessary, risks will be escalated through project governance systems.

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

This work aligns to strategic priority 2 within the NHS Fife Population Health and Wellbeing Strategy- *improve the quality of health and care services*. Full consideration to equality and diversity will be considered as part of the establishment of this project.

2.3.6 Climate Emergency & Sustainability Impact

It is not anticipated that this project will have an impact on NHS Fife's work on the Climate Emergency or Sustainability.

2.3.7 Communication, involvement, engagement and consultation

As part of the scoping work, the Deteriorating Patient Group is engaging with a wide range of stakeholders.

An engagement workshop took place on Wednesday 23rd August with over 50 staff from across NHS Fife participating. Health Improvement Scotland spoke at the event highlighting alignment with national improvement projects. There has been significant and receptive feedback. The information from this event will be used to guide development and

improvement work. A flash report is currently being drafted to communicate the highlights and significant points of interest which will be circulated to clinical teams across NHS Fife.

2.3.8 Route to the Meeting

This paper has been reviewed by members of the Deteriorating Patient Planning Group prior to submission to the Clinical Governance Oversight Group and Clinical Governance Committee.

2.4 Recommendation

The Clinical Governance Committee is asked to:

- **Discuss:** the contents of this paper recognising improvement work and aims.
- **Assurance:** note further updates, and review Deteriorating Patients Project Brief.

3 List of appendices

The following appendices are included with this report:

- Appendix No. 1, Deteriorating Patients Project Brief

Report Contact
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Deteriorating Patients

Project Brief

Author:	**Deteriorating Patient Delivery Group**
Contact:	**fife.qinetwork@nhs.scot**
Date:	**11 August 2023**
Version:	**v0.11**

Contents

1 Project Definition

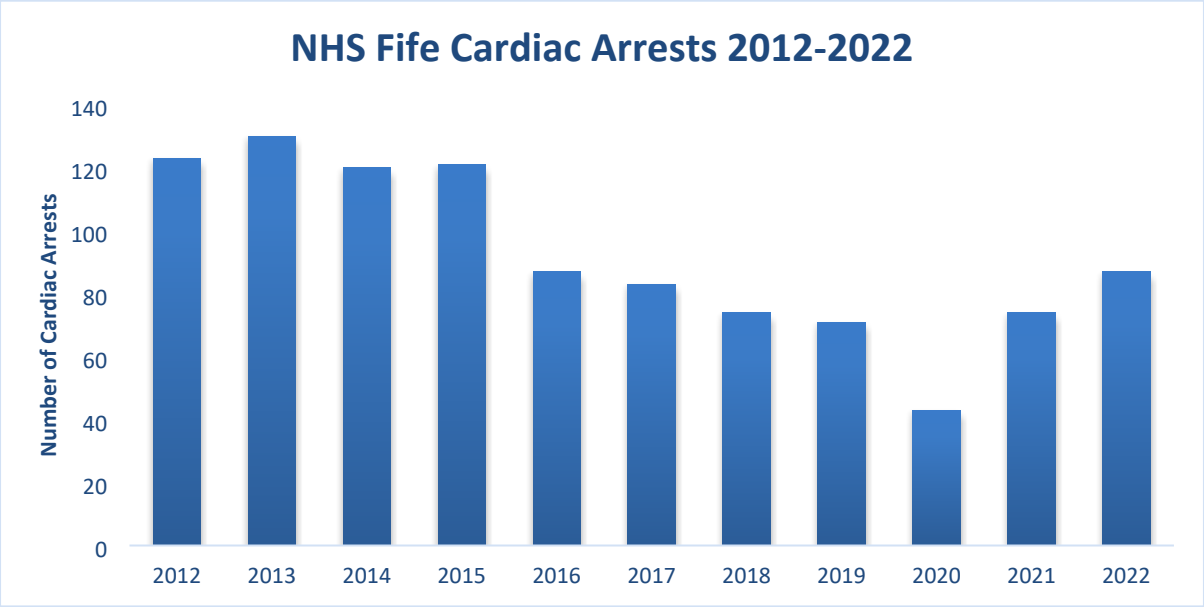
1.1 Background

In 2015 the national cardiac arrest audit data evidenced that NHS Fife had one of the highest cardiac arrest rates in the UK. Recognising the avoidable harm from this, through testing and improvement work, the 'Know the Score' project was introduced as a way of supporting a reduction in avoidable cardiac arrests.

'Know the Score' focuses improvement in the following 5 areas of clinical practice:

i. Improved recording of Patient Vital Observations using Patientrack Electronic-Observations (e-obs) and using Early Warning Scores (EWS) to identify patients who are deteriorating.
ii. Ensuring a structured response (SR) for patients identified as deteriorating. The response will depend on the level of deterioration but includes increasing observations frequency, escalation to senior colleagues involved in the care of patients, increasing the level of intervention provided to the patient where required and also clear communication and planning.
iii. Ensuring that where appropriate, decisions are made regarding cardiopulmonary resuscitation (CPR) and that these are recorded in line with the Do Not Attempt Cardio-Pulmonary Resuscitation (DNA-CPR) policy.
iv. Ensuring all patients with a DNA-CPR also has a Hospital Anticipatory Care Plan (HACP) which describes the wider plans for a patient care beyond cardio-pulmonary resuscitation.
v. Supporting ongoing learning through audit and comprehensive review of every cardiac arrest that occurs in NHS Fife.

Collectively this resulted in NHS Fife reducing the numbers of cardiac arrests as shown in the graph below.



In 2021 and 2022 following sustained falls in the cardiac arrests, the number has started to increase again. It is felt that necessary reprioritisation of resource and training during the Covid-19 Pandemic will have contributed to this overall change. For example, training for staff on the Know the Score principles stopped during this period. However, this current increase does not appear to be linked to increased patient acuity. The average 'sickness' of patients is quantified through monitoring patient EWS and this has not increased since 2020 on average per patient. However, analysis of gross acuity data shows that total acuity has increased as patient *numbers* have increased over this time.

The ongoing cardiac arrest review suggests several contributory causes for this increase in cardiac arrests:

- 33% of cardiac arrest cases have problems with communication identified. This includes:
    - Not documenting changes to the person's care plan, for example if a patient is to receive increased observations.
    - Failure to appropriately escalate patients showing signs of deterioration to senior colleagues responsible for the care of the patient.
- 20% - 40% of cardiac arrest patients should have had a DNA-CPR in place prior to their cardiac arrest.
- Problems identified in patient care are likely to have contributed to 11% of cardiac arrests. For example:
    - There has been a drop in completion of vital observations of around 7-10%. Across NHS Fife we take nearly 1 million patient observations per annum on all our admissions. We have reduced our compliance with completing observations which means we may be missing opportunities to identify patients who are deteriorating.
    - Patients not clerked in prior to their cardiac arrest.
    - Where a patient is identified as deteriorating, we haven't completed or written a structured response to communicate priorities.
    - Patients have not transferred to higher levels of care such as a high dependency unit (HDU) or Intensive Care Unit (ICU) which could have increased levels of intervention.
- Rates of HACP, completed when a DNA-CPR is in place, have fallen.

It is important to note that the overall survival following a Cardiac Arrest is low. Data from April 2022 - March 2023 show that overall survival to discharge after a cardiac arrest for NHS Fife is around 20% or 1 in 5 patients.

Furthermore, the increase in cardiac arrest rates reflects an overall problem with clinical systems in managing all patients and not only those that have cardiac arrests. Healthcare resource and its limits seem likely to be a common contributory factor. Fundamentals of deteriorating patient management, detection, communication and triage, need to be targeted to make improvements. This requires a system wide approach bringing together a range of colleagues.

This is not just a challenge in NHS Fife. Nationally there has also been an increase in cardiac arrests in hospitals across Scotland. The Scottish Patient Safety Programme (SPSP) is running a national improvement collaborative focussed on supporting the improvement and

management of deteriorating patients. The Scottish Intercollegiate Guideline Network (SIGN) has produced new guidelines on the Management of Acute Clinical Deterioration in Non-pregnant Adult Patients within Primary, Secondary and Community Care Settings (SIGN 167). The Know the Score principles align with both the SPSP work and SIGN 167.

The observed increase in the number of cardiac arrests was discussed at the NHS Fife Clinical Governance Oversight Group (NHSFCGOG). It was agreed that reducing the cardiac arrest rate was to be promoted as an immediate priority across the organisation. This project brief describes the initial remit of this work and outlines the proposed approach for improvement. Further scoping and engagement planning will refine and develop a more detailed project plan and milestones.

1.2 Project Aim

By September 2024 we will improve the management of deteriorating patents across all inpatient settings in acute and community hospitals across NHS Fife.

We will do this 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:
    i. Increasing our timely recording of Patient Vital Observations using Patientrack e-obs and using an Early Warning Score (EWS) such as Fife Early Warning Score (FEWS) or the NHS Scotland National Early Warning Score (NEWS2)
    ii. Embedding a structured response (SR) for patients identified with a high Early Warning Score.
    iii. Ensuring all appropriate patients have a completed DNA-CPR form.
    iv. Every patient with a DNA-CPR will have a HACP.
    v. 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 treatment they receive.

- Aligning with recommendations of national guidelines and approaches including SIGN 167 (Care of Deteriorating Patients) and the Scottish Patient Safety Programme.

Together we believe this will result in a reduction in the number of avoidable cardiac arrests across NHS Fife.

1.3 Project Deliverables

To achieve this we will:

- Establish a project delivery group to guide this work and ensure collaboration across NHS Fife.
- Utilise the existing Deteriorating Patient Group to support this work.
- Learn from what is already working both locally and nationally and scale this up.
- Actively engage with all clinical staff across NHS Fife to ensure Know the Score is communicated effectively.
- Test process changes to support improvements in practice, for example the use of Welch Allyn Monitors (a tool that enables collection and recording of patient observations directly into the electronic patient record).
- Provide a deteriorating patient toolkit for all inpatient wards.
- Deliver intensive improvement support to clinical teams to help them make changes that embed the principles and objectives of Know the Score.
- Work with Practice and Professional Development (PPD) to support roll out of a training package for all current and new clinical staff to ensure awareness of Know the Score.

The project will undertake further scoping to further develop and optimise these priorities.

1.4 Project Scope and Exclusions

In Scope:	Out of Scope:
Organisations: NHS Fife Services: All inpatient care provided across: • Acute Services Division (ASD) • Health and Social Care Partnership (HSCP) This covers inpatient wards across 10 sites. (Appendix one). People • Clinical teams working on inpatient areas including senior medical staff, junior doctors, nursing teams and allied health professionals (AHPs). • Corporate Services: ○ Clinical Governance ○ Communications ○ Digital & Information ○ NHS Fife Corporate PMO ○ Fife QI Network Systems / Processes: • Early Warning Score- we currently use the Fife Early Warning Score (FEWS) and we expect to migrate to the National Early Warning Score (NEWS2) before March 2025). • Electronic-Observations (e-obs) on Patientrack • DNA-CPR • HACP • Structured Response (SR) if patient is identified as deteriorating. • Escalation process for clinical teams.	Organisations: All other organisations providing health and care services. E.g. Care Homes or Care at Home. Services: All other services. For example- primary care and community services, outpatient services and services delivered in patients own homes. People: All people not listed as in scope Systems /Processes: All systems / processes not listed as in scope

1.5 Risks and Assumptions

1.5.1 Risks

The following risks have been identified at the outset of this work:

1. *Timescales*- there is a risk that the indicative timescales for this work are not achievable due to limited staff capacity both in the project team and in the wards due to operational pressures.

2. *Engagement*- there is a risk that staff do not or cannot engage with this work and this delays achievement of the project objectives.

3. *Resources*- there is a risk that the project does not have the all the resources it needs to deliver this work within the indicated timescales. This could include:
    a. Staff- this includes both supporting the project and staff working to deliver clinical care.
    b. Training to optimise staff skills such as DNA-CPR training.
    c. Ongoing administrative support to maintain data analysis, data production, cardiac arrest review system support.

Risks will be considered and logged as part of the project risk register. Mitigations will be agreed and monitored. Where necessary risks will be escalated via project governance routes.

1.5.2 Assumptions

The following assumptions have been made about this work:

1. *Engagement*- There is support for this work from across NHS Fife and it is an organisational priority.

2. *Support to deliver*- The following organisational resources to support this work have been identified:
    a. NHS Fife Corporate PMO will support the project management of this work and provide Quality Improvement support.
    b. There will be support from the Clinical Governance Team.
    c. 'Business-as-usual' data collection will continue by Clinical Governance Team to support monitoring of progress.
    d. Gavin Simpson (Chair of the Deteriorating Patients Group) will provide subject matter expertise and is overall lead for this project.
    e. Practice Professional Development (PPD) are delivering a Know the Score training package for all NHS Fife Staff.

1.6 Stakeholders

A full stakeholder analysis will be undertaken for this work and regularly reviewed. The following stakeholders have been identified for the initial stages of the project. Our stakeholders are likely to increase as the project progresses and our understanding grows.

	Responsible	Accountable	Consulted	Informed
NHS Fife Board				x
NHS Fife Clinical Governance Committee				x
Clinical Governance Oversight Group				x
NHS Fife Deteriorating Patient Group			x	
Deteriorating Patient SLWG/Advisory Group		x		
Deteriorating Patient Delivery Group	x			
Medical Staff			x	
Nursing, Midwifery and AHP Staff			x	

2 Outline Plan

The outline plan below identifies the indicative milestones to support this work. Further detailed project planning will be undertaken as part of the project set up.

NB: ◆ denotes expected milestones for this work.

High level Milestones	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24
1. Project Set Up				◆											
Develop project brief and sign off															
Establish the Deteriorating Patient project group															
Identify clinical areas for intensive improvement support.															
Hold engagement workshop with all stakeholders															
Prepare detailed project plan and sign off															
2. Delivery													◆		
Implement improvement work															
3. Close-Out and Next Steps															◆
Undertake close of phase 1 of this project.															
Identify next steps (e.g. Business as usual, further project etc)															

3 Expected Benefits

The expected benefits of this work are summarised below:

Patients

- Acutely unwell patients will receive timely effective care preventing avoidable deterioration.
- Patients will be supported to access person centred care that meets their needs.
- There will be better identification of patients who are at the end of life who can be supported to make plans based on what matters to them.
- Assurance that NHS Fife is a safe environment to be a patient.

Staff

- Clarity of roles and responsibilities when working with acutely unwell patients.
- Improvements in workplace wellbeing by avoiding situations where a patient has deteriorated unexpectedly and providing support and planning when a patient does deteriorate.
- Avoiding inappropriate cardiopulmonary resuscitation events.
- Clear documented planning and senior staff involvement in deteriorating patient management to support less experienced staff.
- Improved job satisfaction from working in a safer healthcare system.

NHS Fife

- Increased assurance that the organisation is operating safely.
- Reputational benefits of being a safer organisation.
- Reduction in managing the work associated with ‘failure demand’, for example, responding to complaints, supporting staff, completion and investigations in Datix and completing reviews of resuscitation.
- Ability to contribute to national reporting collaboration for deteriorating patients and provide detailed performance assurance.
- Deliver compliance with SIGN guidelines 167 published June 2023

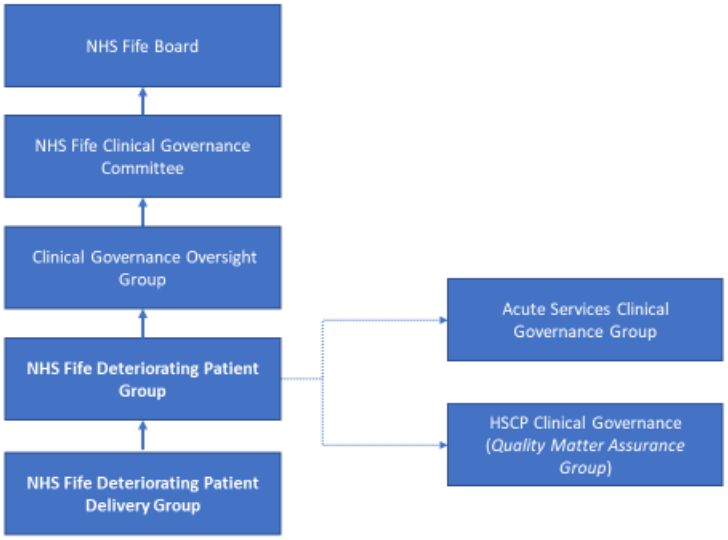
4 Method of Approach

We will use a quality improvement approach to support this work, with assurance that participants are given time, permission, skills, and resources to identify and make improvements. QI involves a systematic and coordinated approach to problem solving using specific tools with the aim of bringing about measurable improvements. This will be supported by robust project management and reporting.

5 Resources/Skill Requirements

Resource/Skill Required	Who will deliver
Project planning, delivery and reporting using a range of project management tools (Brief/Plans etc)	NHS Fife Corporate PMO
QI methodology	NHS Fife Corporate PMO
Meeting scheduling, action tracking/ management and risk recording	NHS Fife Corporate PMO
Develop deteriorating patient toolkit	NHS Fife Clinical Governance
Deteriorating patient box rollout to all acute wards	NHS Fife Clinical Governance
Data reporting	Clinical Governance
Linkages across Fife HSCP	Fife HSCP Clinical Governance
Provide advice and guidance to support the implementation of this project	NHS Fife Deteriorating Patient Group

6 Governance



- This work will be led and managed on a day-to-day basis by a delivery group. This will be chaired by Shirley-Anne Savage and a terms of reference for this group will be developed.
- The strategic oversight of this work will be supported by the existing NHS Fife Deteriorating Patient Group. This will ensure that there are connections to the clinical governance groups across ASD and HSCP.
- The work will be accountable to the NHS Fife Board via the Clinical Governance Committee.

7 Costs/Budgets

No separate budget has been identified for this work. Staff time is being supported from existing budgets. Where additional non pay resources are required these will be negotiated from existing departmental budgets.

Document Control Sheet

9.1 Key Information

Title	Deteriorating Patients Improvement Project
Date Published / Issued	23/06/2023
Date Effective From	
Version / Issue Number	V0.10
Document Type	Project Brief
Document Status	Draft
Author	Claire Berry/ Tom McCarthy
Owner	NHS Fife Deteriorating Patient Delivery Group
Approver	Clinical Governance Oversight Group
Approved by and Date	Not currently approved
Contact	fife.qinetwork@nhs.scot
File Location	T:\NHS Fife Corporate PMO\PROJECTS\8. QI NETWORK\9. Projects\Deteriorating Patients\1. Project Documentation\Project Brief

9.2 Revision History

Version	Date	Summary of Changes	Name	Changes Marked
0.1- 0.11	11/08/23	Range of edits to develop this current draft	NHS Fife Deteriorating Patient Delivery Group	No.

9.3 Approvals

This document requires the following signed approvals:

Version	Date	Name	Role	Signature

9.4 Distribution

This document has been distributed to:

Version	Date of Issue	Name	Role / Area

9.5 Linked Documentation

Document Title:	Document File Path:

Appendix One: All Hospitals in Scope

1. Victoria Hospital Kirkcaldy (VHK)
2. Queen Margaret Hospital (QMH)
3. Adamson Hospital
4. Cameron Hospital
5. Glenrothes Hospital
6. Lynebank Hospital
7. Randolph Wemyss Hospital
8. St Andrews Community Hospital
9. Stratheden Hospital
10. Whytemans Brae Hospital

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**8 September 2023**
Title:	**Information Governance and Security Steering Group Update**
Responsible Executive:	**Margo McGurk – Director of Finance and Strategy - SIRO**
Report Author:	**Alistair Graham – Associate Director of Digital & Information**

1 Purpose

This is presented for:

- Assurance

This report relates to a:

- Government policy/directive
- Legal requirement
- Local policy

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

- Safe
- Effective

2 Report summary

2.1 Situation

The Information Governance & Security (IG&S) Steering Group, through this report, provides oversight of its work and assurance for the key priorities for the 2023-24 period. The report is the first of two reports for the financial year 2023-24, with the next report scheduled for the March 2024 meeting of Clinical Governance Committee.

The Steering Group continue to support the tasks, activities and projects that are key to the continuous improvement, mitigation of risk and evidence of improved controls for the areas of IG&S.

Following a review of the Information Commissioners Office (ICO) Accountability Framework and the Scottish Public Sector Cyber Resilience Framework (SPSCRF), (which incorporates the Network Information Security Directive (NISD)), the IG&S Steering Group agreed to a

revised Accountability and Assurance Framework, to provide a unified view of the current controls, actions and activities undertaken across NHS Fife as we evidence our performance for compliance. The executive summary of the first IG&S Accountability and Assurance Framework is provided in Appendix 1.

Reporting to the Steering Group covers the following areas: -

- Leadership and Oversight
- Policies and Procedures
- Training and Awareness
- Individuals Rights
- Transparency
- Records of processing on a lawful basis
- Contracts and data sharing
- Risks and DPIA
- Records Management and Security
- Breach Response and monitoring

The prioritisation of activities is based on the outcome of the ICO external audit, completed in March 2023, the current risk profile within IG&S, through direct instruction by competent or audit authority or via the guidance of the IG&S Steering Group. The activities will further be enhanced on completion of the NIS Audit Programme 2023.

The report is intended to provide **assurance** to the Committee.

2.2 Background

ICO Audit

The Information Commissioner is responsible for enforcing and promoting compliance with the UK General Data Protection Regulation (UK GDPR), the Data Protection Act 2018 (DPA18) and other data protection legislation. Section 146 of the DPA18 provides the Information Commissioner's Office (ICO) with the power to conduct compulsory audits through the issue of assessment notices. Section 129 of the DPA18 allows the ICO to carry out consensual audits.

NHS Fife (NHSF) was audited in March 2023, as part of a wider project looking at data protection compliance across the wider NHS in Scotland (NHSS), consisting of 22 audits of Territorial Health Boards and Special Boards in Scotland. The scope of the audits takes into account the Information Governance leads input regarding current data protection risks identified across NHSS as a whole as well as risks identified from ICO intelligence. A summary report for NHSS will be provided and is still to be published.

The purpose of the NHSF audit is to provide the Information Commissioner and NHSF with an independent assurance of the extent to which NHSF, within the scope of this agreed audit, is complying with data protection legislation.

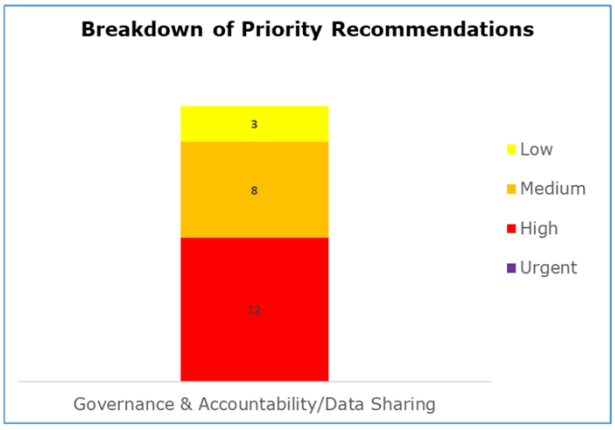
It was agreed that the audit would focus on the following area:

> The extent to which information governance accountability, policies and procedures, and information sharing agreements and logs which comply with the principles of all data protection legislation are in place and in operation throughout the organisation.

The ICO final report provided a rating indicator assessed against four levels of assurance - Very Limited, Limited, Reasonable and High. The summary rating from the ICO, following their audit, indicated a **reasonable assurance** rating for NHS Fife:-

Scope area	Assurance Rating	Overall Opinion
Governance & Accountability/Data Sharing	**Reasonable***	There is a reasonable level of assurance that processes and procedures are in place and are delivering data protection compliance. The audit has identified some scope for improvement in existing arrangements to reduce the risk of non-compliance with data protection legislation.

The audit report went on to identify 23 action points based on a priority recommendation. The chart below shows a breakdown of the priorities assigned to the ICO priority recommendation: -



The recommendations have now been incorporated into the IG&S Accountability and Assurance Framework report and progress will be monitored by the IG&S Steering Group.

Risk Management

Through work guided by the IG&S Steering Group meetings in January 2023 and April 2023, it was agreed to the use the Board risk appetite description as part of its responsibilities for effective risk management. The steering group considered these descriptors and agreed the following levels of risk tolerance level for categories of risk:-

Risk Category	Tolerance Level
Data Breaches	LOW
Infrastructure	MODERATE
Access Controls	MODERATE
Information Assets	MODERATE
Supplier Management	MODERATE
Threats and Vulnerabilities	LOW
Operational Performance	LOW

This work ensures that IG&S Steering Group can support the risk mitigation activities.

The summary risk position in July 2023 is: -

Categorisation	Tolerance	Total Risks	Current Risk Level Breakdown		
			High	Moderate	Low
Data Breaches	Low	11	1	10	0
Infrastructure	Moderate	5	1	2	2
Access Controls	Moderate	4	0	3	1
Information Assets	Moderate	6	2	3	1
Supplier Management	Moderate	1	0	0	1
Threats and Vulnerabilities	Low	8	3	5	0
Operational Performance	Low	11	5	4	2
Total		46	12	27	7

Green risk items within tolerance.
31 risks out with tolerance.

Key Priorities

The IG&S Accountability and Assurance Framework details key areas of action for the year. These have been identified as:-

- Improved Key Performance Measure across areas where limited or no measures exist.
- Continued review of procedures and alignment of the IG&S Accountability and Assurance Framework within policy content.
- Provision of role-based training for staff who have specific IG/Data Protection responsibilities.
- Implementation of Subject Access Requests improvements and single point of contact.
- Development and completeness in the Information Asset Register.
- Implementation of Records Management Plan.
- Preparation of Cyber Resilience Framework Action plan following the NISD audit.

2.3 Assessment

Look at each of the priority areas the following can be reported.

Key Performance Indicators
The status of KPIs for each category is detailed below:-

Category	KPI Measures Established	Frequency of Update
Leadership and Oversight	Yes	Annually
Policies & Procedures	Yes	Quarterly
Training and Awareness	Partial	Quarterly
Individual's rights	Partial	Monthly
Transparency	None	Quarterly
Records of processing and lawful basis	Partial	Quarterly
Contracts and data sharing	Partial	Monthly
Risks and DPIAs	Yes	Quarterly
Records Management and Security	None	Monthly
Breach Response and monitoring	Partial	Monthly

The work associated to the establishment of these measures/KPIs will be targeted for completion by 13/10/23. The mechanism to record and implement may take longer but will form part of the assessment.

Procedure and Policy review
All IG&S Policy documents have been reviewed within the year and are now submitted for publication. Further review of Policies is now required to ensure the revised IG&S Accountability and Assurance Framework arrangements are incorporated and there is consistency with legislation development and local procedure arrangements.

The 19 associated procedures are being reviewed and will be presented to the Policies and Procedures group for consideration.

Review the management and implement an improvement plan for Subject Access Requests (SAR)

The SAR Short Life Working Group (SLWG) has now completed its review of the existing approach and has implemented changes in line with a single point of contact. The process is in early adoption for SARs relating to Acute Services and will be implemented fully in the

coming months. Recording of performance across areas remains variable as highlighted in Appendix 1, Table 2 – Summary Performance Measures.

Planned improvement to Information Asset Register and associated Service Catalogue

Work continues to catalogue all information assets in use within NHS Fife, including those that have been mandated nationally. While rapid risk assessment was allowed during the initial period of the pandemic, the appropriate identification of Information Asset owners is necessary to support this work.

To date, there is a 70.3% completion rate on Apps submissions and a 72.8% completion for Systems with additional support being offered for the remaining areas.

The establishment of the register will also allow cataloguing of existing contractual arrangements and associated supplier management expectations.

Development of project in support of the implementation of Records Management Action Plan

As reported to Clinical Governance Committee in January 2023, the response to NHS Fife's Records Management Plan, has been received from the Keeper. While all 15 areas of the plan are being progressed, focus is being given to the two Amber areas of Business Classification and Audit trail.

Implementations have now taken place into early engagement services within both corporate and clinical areas. This allows the development of informed records management guidance to be developed to support the next phase of implementation.

The improvement project plan is estimated to take 2 years to complete.

NISD Action Plan Implementation

The draft NISD Audit Report (August 2023), reported a compliance level of 87% and increase from the previous year of 76%.

The report states NHS Fife is a high-performing Board, with well-defined security policies and procedures in place.

The current action plan focussed on the following areas identified within the report:-

- Actions to address the remaining 9 urgent recommendations
- Supplier Management
- Asset Management (associated with Information Asset Recording)
- Privileged Access Controls and Network Segregation
- Resilience and Disaster Recovery Testing

The final report expected week commencing 28 August 2023 and a review and action plan will be presented to the October 2023 Steering Group meeting.

Incident Reporting

During the period July 2022 to June 2023, 12 incidents were reported to the ICO and/or NISD Competent Authority. During that period 2 incidents were not reported within the

required 72-hour period. Further mechanisms are being developed to ensure there is every opportunity to report a potential breach within the 72-hour period.

At the current time 2 incidents remain active with the ICO and additional information is being provided to support the investigation of the potential breach.

2.3.1 Quality/ Patient Care

A culture that is supported in understanding its collective and individual responsibilities for Information Governance and Security is necessary to ensure services can consistently provide high levels of care and services and are not impacted by disruption, financial loss or reputational damage.

2.3.2 Workforce

Many of the activities identify will require NHS Fife to embrace the work and projects associated with improvements. The modelling of approach, consultation and impact to services will be consider via the IG&S Steering Groups, with appropriate escalation to EDG.

2.3.3 Financial

Some of the activities to mitigate risk and support compliance may incur additional costs.

2.3.4 Risk Assessment/Management

The risk management approach and review has concluded, and the ongoing reporting and mitigation actions forms a standard component of the IG&S Steering Group activities. The group and D&I teams continue to monitor existing and emerging risks.

Many of the actions listed and prioritised have a direct bearing on Corporate Risk 17 – Cyber Resilience. This risk has a current rating of High.

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

An impact assessment has not been considered in the creation of this report.

2.3.6 Climate Emergency & Sustainability Impact

No other impact considered.

2.3.7 Communication, involvement, engagement and consultation

- Report creation reflects the work undertaken by the IG&S Team, view of the Information Governance Steering Group and associated stakeholders.

2.3.8 Route to the Meeting

This paper is presented directly to the Clinical Governance Committee.

2.4 Recommendation

- **Assurance** – The Committee are asked to note the progress being made across the IG&S domains and take assurance from the governance, controls and measures in place.

Assurance Summary

The details of the report, KPIs, progress with the workplans and alignment to external and internal audit allows the following level of assurance to be provided:-

Level of Assurance:			
Substantial Assurance	Reasonable Assurance	Limited Assurance	No Assurance
			
	Current Level A reasonable level of assurance is provided to the Steering Group.		

3 List of appendices

Appendix 1: Information Governance and Security Operational Performance

Appendix 2: Information Governance and Security Accountability and Assurance Framework

Report Contact

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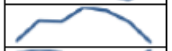
Appendix 1 – IG&S Operational Performance

	Information Governance & Security Performance Summary	Target	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Trend
Operational Performance	Cyber Security - Exposure Score*	25%	38	26	24	25	23	20	26	24	23	22	29	25	
	FOI's - Responses within target	85%	80.8%	90.8%	90.3%	97.6%	96.0%	90.5%	80.0%	83.1%	86.3%	93.8%	95.0%	89.9%	
	SARs Received (% responded to timeously)	100%	96.0%	100.0%	97.0%	67.0%	87.0%	84.0%	100.0%	100.0%	97.7%	98.0%	98.9%	99.0%	
	Information Governance Incidents	Avg 98	120	129	98	97	128	98	85	102	90	78	82	68	
	Incidents Reported to ICO or CA		1	1	0	0	2	1	1	3	2	1	0	0	
	Incidents Reported within 72 Hours		1	0	0	0	1	1	1	3	2	1	0	0	
	Follow up required by ICO		0	0	0	0	1 x TBC	0	0	1 x TBC	1 x TBC	1 x TBC	0	0	
	Annual Measures		2020	2021	2022										
	NISD Compliance Status		53%	69%	76%										
	NISD Risk Exposure		13%	8%	3%										
	NISD Controls Completed		53%	58%	64%										

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

Information Governance and Security Accountability and Assurance Framework

Produced in August 2023

Introduction

The purpose of the ***Information Governance and Security (IG&S) Accountability and Assurance Framework*** is to provide a unified view of the current controls, actions and activities being undertaken across NHS Fife, as we evidence our responsibilities for compliance.

The ***IG&S Accountability and Assurance Framework (IGSAAF)*** is presented to the Information Governance and Security Steering Group on a quarterly basis and is available to all governance committees where appropriate.

The ***IGSAFF*** comprises of the following sections:

I. Executive Summary

a. Report sections and summary of frequency of updates
b. Performance Measures Summary
c. Risk Summary
d. Key Milestones and changes within reporting period

II. Performance Assessment Reports

a. Leadership and Oversight
b. Policies and Procedures
c. Training and Awareness
d. Individuals Rights
e. Transparency
f. Records of processing on a lawful basis
g. Contracts and data sharing
h. Risks and DPIA
i. Records Management and Security
j. Breach Response and monitoring

Section II provides further detail on performance measures relating to existing controls, actions and activities being undertaken for improvement, consideration of existing or emerging risk and a statement of assurance for the IG&S Steering Group to consider.

The prioritisation of activities places greater emphasis on feedback received from external and internal audit, guidance provided by external expert bodies e.g. Information Commissioners Office (ICO), National Cyber Security Centre (NCSC) and National Service Scotland's Cyber Centre of Excellence (CCoE), Internal Audit, internal risk assessment and internal event and breach response themes.

The ***IGSAAF*** has been developed following consultation and feedback from the IG&S Steering Group and following the consideration of a mapping exercise between the **ICO Accountability Framework** and the **Scottish Public Sector Cyber Resilience Framework** (***SPSCRF***) of which the **Network Information Security Directive** (**NISD**) is used as the current audit mechanism by Scottish Government's Competent Authority. The NISD audit only considers 80% of the controls within the ***SPSCRF.*** *

Following review of the mapping exercise it was decided that the core elements identified in the ICO Accountability Framework and Scottish Public Sector Cyber Resilience Framework

** Reference Cyber Resilience Framework V1.2 Section 1 Item 5*

provided key topics to support the continued development of an effective privacy management programme.

The ICO Accountability Framework assess organisations maturity against 10 categories. Each category has several expectations, 77 in total, with a total of 338 controls that organisations are assessed against.

For NISD the domain account is 4, with 17 categories with 101 expectations and 430 controls. New controls are being introduced in the 2023 audit.

The NSID Framework is a component of the overarching Scottish Public Sector Cyber Resilience Framework. Many frameworks exist within the cyber security sector including Cyber Essentials, Cyber Essential Plus and ISO27001, however the SPSCR incorporates best practice and controls from all.

I. Executive Summary

At each meeting, the Steering Group is asked to consider performance targets, controls and improvement actions identified across each of the 10 areas. This section of the report provides a summary of these indicators, where data is available, along with previous performance and where possible, benchmarking.

a. Report sections and summary of frequency of updates

Summary of the Framework Categories: -

Leadership and Oversight	Requirement for clear and documented governance structure in support of the assurance and management of IG&S activities and risks, across all responsible areas of NHS Fife. Key Leadership roles established including, but not limited to, SIRO, Caldicott Guardian, Data Protection Officer/s, Information Security and Cyber Security Manager. Evidence of reporting and assurance
Policies & Procedures	Through a range of policies and procedures, that are reviewed and updated on a regular basis, we can demonstrate visibility to staff and the public of the processes required for data protection, information governance and security. These policies and procedures seek to remonstrate data protection by design and default and ensure strong compliance with security controls in support of SPSCRF.
Training and Awareness	Evidence a considered approach to staff training and awareness programme that is linked to staff members employment lifecycle and role. This includes support for specialised roles, the ability to monitor impact of activities and support awareness raising where risks or incidents require corrective action.
Individual's rights	Consistently inform individuals (staff, patients and patient's representatives) of their rights to access information and have suitable processes and resources to handle just requests in a timely manner. This includes processes to rectify inaccurate or incomplete records and erase or restrict access or processing where individuals request. Individuals are also given access to recognise and respond to individual's complaints about data protection.
Transparency	Transparency helps individuals to exercise their rights and gives people greater control. This is particularly important if the processing is complex or if it relates to a child. Being transparent about what we do with personal data will support data sharing with third parties.
Records of processing and lawful basis	It's a legal requirement to document our processing activities. The main activities in support of this work include Information Asset Registers, associated Data Protection Impact Assessments (DPIAs) and consideration of consent models. The processing of data is easier and less risky when such documents exist and are maintained.
Contracts and data sharing	Through contractual mechanisms and DPIA the legitimacy and requirement to share data is a key consideration. Data sharing agreements are established and maintained and support the development of guidance or procedures. Contracts are required with all processors and a record is kept and maintained.
Risks and DPIAs	We have and maintain ways of identifying and managing risks associated with Privacy and Security. DPIAs are one way to identify risks and high risks, relating to privacy, require reported to the ICO.
Records Management and Security	The implementation of NHS Fife's Records Management Plan is key in supporting the accountability principles and maintain the security of data we create, retain and destroy. How and who access this data is key to maintaining security and this is supported by Business Continuity and disaster recovery plans.
Breach Response and monitoring	The requirement to detect, investigate and record any breaches is fundamental to this category. Personal data breaches can have a range of adverse effects on individuals and to NHS Fife. The requirement to notify the ICO of personal data breaches is 72 hours and is a key measurement in this area.

The reporting frequency for each section and the current availability of measures is noted below: -

Table 1 - Category Relevance, Update Frequency and Measures

Category	Relevant to ICO Accountability Framework	Relevant to NISD/Cyber Resilience Framework	Frequency of Update	Measures Established
Leadership and Oversight	Relevant	Relevant	Annually	Yes
Policies & Procedures	Relevant	Relevant	Quarterly	Yes
Training and Awareness	Relevant	Relevant	Quarterly	Partial
Individual's rights	Relevant	Not Relevant	Monthly	Partial
Transparency	Relevant	Not Relevant	Quarterly	None
Records of processing and lawful basis	Relevant	Not Relevant	Quarterly	Partial
Contracts and data sharing	Relevant	Some Relevance	Monthly	Partial
Risks and DPIAs	Relevant	Relevant	Quarterly	Yes
Records Management and Security	Relevant	Relevant	Monthly	None
Breach Response and monitoring	Relevant	Relevant	Monthly	Partial

We are currently within the NISD Audit cycle. On completion of the NISD Audit and review of the report, associated actions will be included in the Accountability and Assurance Framework.

b. Performance Measures Summary

Table 2 - Summary Performance Measures

	Information Governance & Security Performance Summary	Target	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Operational Performance	Cyber Security - Exposure Score*	< 25	25	23	30	26	24	23	22	29	25	30	25	24	23	22	25
	FOI's - Responses within target	85%	97.6%	96.0%	90.5%	80.0%	83.1%	86.3%	93.8%	95.0%	89.9%	90.7%	90.1%	77.1%	85.0%	84.8%	
	SARs Received (% responded to timeously)	100%	67.0%	87.0%	84.0%	100.0%	100.0%	97.7%	98.0%	98.9%	99.0%	98.9%	97.4%	98.5% *	100% *	100% *	
	Information Governance Incidents	Avg 94	97	117	98	95	102	90	78	82	62	65	85	88	101	142	111
	Incidents Reported to ICO or CA		0	2	1	1	3	2	1	0	0	1	2	1	0	1	0
	Incidents Reported within 72 Hours		0	1	1	1	3	2	1	0	0	0	1			0	
	Follow up required by ICO		0	1	0	0	o	0	0	0	0	1	2			1	
	Mandatory Training Renewal **	80%						65%			36%				49%	50%	
	Annual Measures		**2020**	**2021**	**2022**	**2023**											
	NISD Compliance Status		53%	69%	76%	87%											
	NISD Risk Exposure		13%	8%	3%												
	NISD Controls Completed		53%	58%	64%												
	Public Sector Cyber Resileince Compliance					77%											

		NIS / GDPR Reportable	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Technical Incidents	1. Negligible Incidents	N	3826	4186	3675	3569	4251	3507	3077	3504	2636	3524	3394	3800			
	2. Minor Incidents	N	3				1			3	1	3		3			
	3. Moderate Incidents	Y										1					
	4. Major Incidents	Y															
	5. Extreme Incidents	Y															

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

** - Only partial information available from SAR teams

*** - Source EDG Training Compliance Report

c. Risk Summary – June 2023

The IG&S Steering Group has agreed to the use of the Board risk appetite description as part of its responsibilities for effective risk management. The following definitions are:-

a) **Low** - Regarding statutory functions, we have very little appetite for risk, loss, or uncertainty. We are prepared to accept low levels of risk, with a preference for ultrasafe delivery options, while recognising that these will likely have limited or no potential for innovative opportunities. (This would be demonstrated by a risk rating less than or equal to 6)

b) **Moderate** - Prepared to accept only modest levels of risk to achieve acceptable, but possibly unambitious outcomes and limited innovation. (This would be demonstrated by a risk rating that is more than 6 but less than 12)

c) **High** - Willing to consider and / or seek all delivery options (original / ambitious / innovative) and accept those with the highest likelihood of successful outcomes, in pursuit of objectives even when there are elevated levels of associated risk. (This would be demonstrated by a risk rating that is more than 12 but less than 20. A risk rating of 20 or 25 being unacceptable for all risks)

D&I will aim to apply the overarching definitions to the risks concerned with its operational responsibilities including IT/Cyber infrastructure.

The IG&S Steering Group has agreed to the following risk tolerance levels for the following categories of risk:-

Table 3 - Risk Category and Tolerance Levels

Risk Category	Tolerance Level
Data Breaches	LOW
Infrastructure	MODERATE
Access Controls	MODERATE
Information Assets	MODERATE
Supplier Management	MODERATE
Threats and Vulnerabilities	LOW
Operational Performance	LOW

The full detail and definitions can be found in the Digital and Information Risk Management Statement.

Summary Risk Position on 7 July 2023

Table 4 - Summary Risk Position – IG&S Only

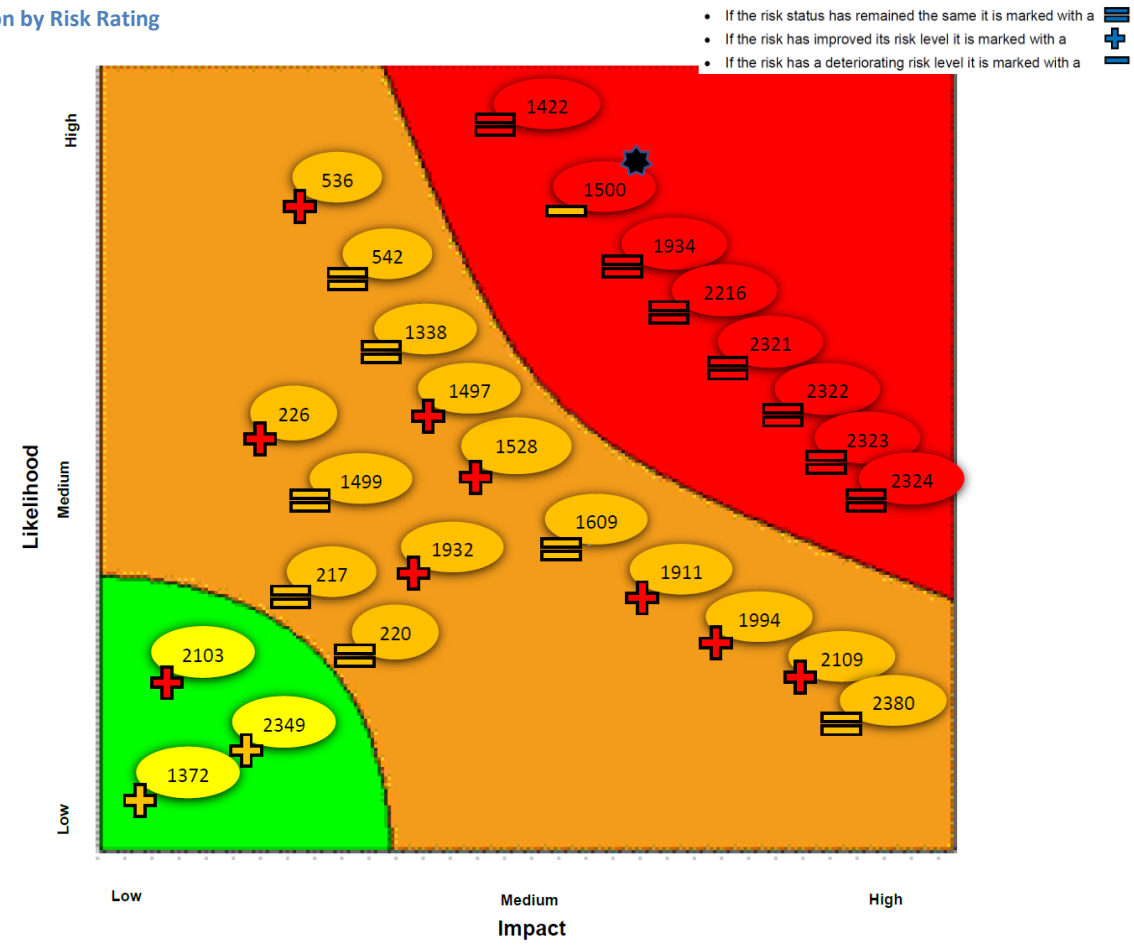
Risk Level	Initial Risk Level	Current Risk Level	Previous Period Risk Level (March 2023)
High Risk	18	**8**	**8**
Moderate Risk	8	**15**	**14**
Low/Very Low Risk	0	**3**	**3**
Total	26	**26**	**25**

Table 5 - Risk Summary by Category all D&I Risks

Categorisation	Tolerance	Total Risks	Current Risk Level Breakdown		
			High	Moderate	Low
Data Breaches	Low	11	1	10	0
Infrastructure	Moderate	5	1	2	2
Access Controls	Moderate	4	0	3	1
Information Assets	Moderate	6	2	3	1
Supplier Management	Moderate	1	0	0	1
Threats and Vulnerabilities	Low	8	3	5	0
Operational Performance	Low	11	5	4	2
Total		46	12	27	7

Green risk items within tolerance
July 2023 – 31 risks out with tolerance.

Figure 1 - Risk Visualisation by Risk Rating

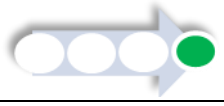
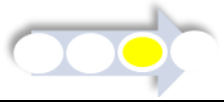
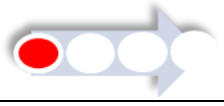


d. Key Milestones and changes within the reporting period

This report is presented as the baseline to the Information Governance and Security Steering Group and so no changes are reported.

Assurance Summary

The details of the report, KPIs, progress with the workplans and alignment to external and internal audit allows the following level of assurance to be provided:-

Level of Assurance:			
Substantial Assurance	**Reasonable Assurance**	**Limited Assurance**	**No Assurance**
			
	Current Level A reasonable level of assurance is provided to the Steering Group.		

Patient Experience and Feedback

PEaF Quarterly Report (Q1) for Clinical Governance Committee

April - June 2023

Published Month Year

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CONTENTS

Introduction

Introduction.docx

Measuring the Experience

Care Opinion highlights the 25 organisations across the UK, with the highest number of staff listening, learning, and making changes. NHS Fife is the top performing NHS Scotland Board.

NHS Fife's **Care Opinion** highlights for Q1 include:

- **355** stories, viewed **25,525** times in all:
  - April 82 stories
  - May 103 stories
  - June 170 stories

In Q1, Care Opinion moderators rated the stories as:

- Not critical 81% (290)
- Minimally critical 5% (18)
- Mildly critical 8% (30)
- Moderately critical 4% (15)
- Strongly critical 1% (2)

An important aspect of Care Opinion is the ability to feedback information to patients on changes which have been made.

Positive and Negative Themes

What was good?

What could be improved?

Compliments: Admin

Compliments.docx

Compliments	22/23 Q2	22/23 Q3	22/23 Q4	23/24 Q1	Total
Compliment	266	400	222	296	1184
Learning from Excellence	4	0	0	0	4
Comments and Feedback	4	8	0	3	15
Total	274	408	222	299	1203

Compliments	22/23 Q2	22/23 Q3	22/23 Q4	22/23 Q1	Total
Acute Services Division - Planned Care & Surgery	134	216	91	126	567
Acute Services Division - Emergency Care & Medicine	1	9	22	30	62
Acute Services Division - Women, Children and Clinical Services	29	6	11	23	69
Community Care Services	57	65	41	70	233
Primary and Preventative Care Services	14	25	27	22	88
Complex and Critical Care Services	16	15	6	9	46
Corporate Directorates	0	1	4	1	6
No value - Miscellaneous	29	27	25	15	96
Total	280	364	227	296	1167

Comments:

Emergency Care & Medicine **-** Just wanted to show my heart felt and sincere gratitude to the staff at the Victoria Hospital Kirkcaldy, especially in the Medical High Dependancy Unit. My dad was brought in very poorly after a long period suffering from Alzheimers disease, and an acute chest problem.

They took great care of him to make sure his and the family's wishes were met. They took great care to ensure dad did not suffer in his last moments, and his passing was as peaceful for him and my family as could have been wished for.

Thank you all so much.

Primary and Preventative Care Services – The Glenrothes School Nursing base were asked to support a Residential Service Listening Forum by sharing what we do as service and how residential staff can contact us and how their young people can contact our service. There was many people grateful to have an understanding of our current School Nursing provision for early intervention and prevention. The organiser specifically thank staff for support the event.

Planned Care & Surgery - I would like to express my gratitude for the treatment and genuine warmth and kindness shown to me on my recent admission

Every person I encountered from P/A reception, nurses, surgeon, anaesthetics PT, domestic to discharge made me feel enveloped in a security blanket of professionalism. I could see that it is a highly charged, fast paced, environment to work in. But not once did I encounter anything but genuine interest in my wellbeing. I even enjoyed the meals apart from the porridge- or maybe I had too much pain relief. Right from the operation I felt a massive difference in pain and instability in fact I was told off a few times for getting ahead of myself.

I know this unit will go on to make life more bearable for a great number of people.

Many, many thanks

Community Care Services *– We would like to express our heartfelt thanks to the wonderful, caring nurses on your team. These amazing nurses attended to our mother in the final days of her life. The care and attention she received from all of you were exemplary. You do one of the most difficult jobs imaginable with immense care and compassion. We can't thank you enough. God bless you all.*

Complaints:

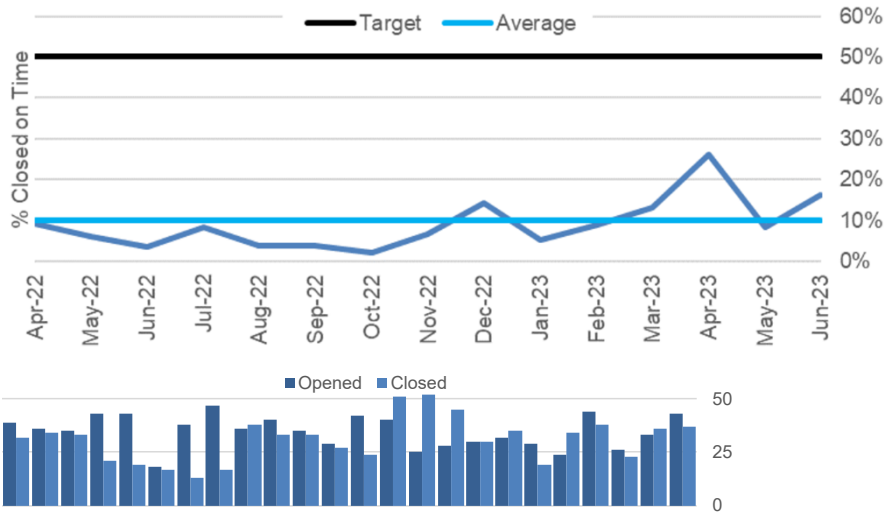
Complaints.docx

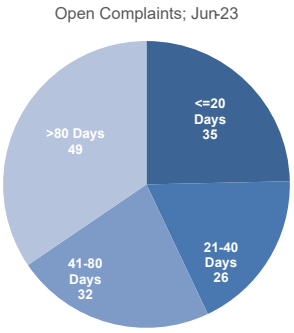
This table presents the total number of Enquiries, Concerns, Stage 1, and Stage 2 complaints received each quarter:

Records logged in Datix Complaints module – 01/07/2022 - 31/06/2023	22/23 Q2	22/23 Q3	22/23 Q4	23/24 Q1	Total
Stage 1 Complaint	151	122	133	151	557
Stage 2 Complaint	102	85	92	102	381
Concern	150	139	92	124	505
Enquiry	120	143	151	189	603
Total	523	489	468	566	2046

Stage 2 closed complaints and % closed within the 20-day standard timescale

	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 2023	May 23	Jun 23
Closed Complaints	33	33	27	24	51	52	45	30	35	19	34	38	23	36	37
% closed within timescales	**9.1**	**6.1**	**3.7**	**8.3**	**3.9**	**3.8**	**2.2**	**6.7**	**14.3**	**5.3**	**8.8**	**13.2**	**26.1**	**8.3**	**16.2**





Themes

The quarterly ranking of each theme is highlighted in brackets.

	22/23 Q2	22/23 Q3	22/23 Q4	23/24 Q1
1	Disagreement with treatment / care plan (63)	Disagreement with treatment / care plan (11)	Disagreement with treatment / care plan (49)	Disagreement with treatment / care plan (26)
2	Poor nursing care (35)	Co-ordination of clinical treatment (8)	Staff attitude (22)	Co-ordination of clinical treatment (11)
3	Face to face (34)	Staff attitude (5)	Co-ordination of clinical treatment (18)	Face to face (5)
4	Co-ordination of clinical treatment (26)	Poor nursing care (5)	Unacceptable time to wait for the appointment / admission (15)	Poor nursing care (5)
5	Staff attitude (25)	Face to face (4)	Face to face (13)	Staff attitude (4)

These complaint issues have been addressed at a local level, but organisational learning must take place to improve practice and to improve the patient experience. The establishment of the Organisational Learning Group will support this endeavour.

Locations receiving most complaints:

1. General Medicine (28)
2. Obstetrics & Paediatrics (23)
3. Mental Health (20)

Improving the Experience

Surveys, Focus Groups, Care Assurance Processes

Each quarter, this section will include feedback from patient / family surveys, complainant survey, patient and staff focus groups, and care assurance processes, including leadership walkarounds; 15 steps challenge; shadowing / observation; 'warm welcome / fond farewell' initiative; care experience improvement model.

'Welcome Poster' is an initiative to standardize Ward/Department information, outlining expected commitments and NHS Scotland Uniforms. Poster has recently been reviewed and updated.

Scottish Public Services Ombudsman

The SPSO is the final stage for complaints about public service organisations in Scotland and offers an independent view on whether the Board has reasonably responded to a complaint. A complainant has the right to contact the SPSO if they are unhappy with the response received from the Board.

The number of SPSO cases, decisions and outcome by quarter:

	Apr to Jun 2022	Jul to Sep 2022	Oct to Dec 2022	Jan to Mar 2023	2022/ 2023	Apr to Jun 2023	Jul to Sep 2023	Oct to Dec 2023	Jan to Mar 2024	2023/ 2024
New SPSO cases	3	13	4	5	25	8				8
SPSO decisions	6	4	1	3	14	5				5
SPSO cases fully upheld	1	1	0	1	3	1				1
SPSO cases partly upheld	3	2	0	0	5	0				0
SPSO cases not upheld	2	1	1	2	6	1				1
Cases not taken forward	6	1	1	0	8	3				0
New SPSO cases this quarter					**New SPSO decisions this quarter**					

This quarter, 5 new information requests have been received. These relate to the following services:

- Planned Care: 1
- Emergency Care: 2
- Community Care Services: 2
- Multi-Directorate: 3

NHS Scotland Model Complaints Handling Procedure

NHS Scotland Model Complaints Handling

Indicator One: Learning from complaints

A statement outlining changes or improvements to services or procedures as a result of consideration of complaints including matters arising under the duty of candour. This should be reported on quarterly to senior management and the appropriate sub-committees, and include:

- *The Patient Experience Team is working collaboratively with the Organisation Learning Group and Clinical Governance to align learning from complaints and adverse events. This will ensure learning is shared and implemented across the wider organisation, to improve the quality of services that enhance the safety of the care system for everyone.*

- *An SPSO recommended action plan highlighted a failure to use a straight lift following a suspected hip injury after a patient fall. They advise that relevant staff should be aware of the requirement for assessing potential fractures and safe manual handling for possible fractures, including using flat lift equipment. The Board have been asked to provide evidence that training needs have been reviewed for safe manual handling with reference to relevant national guidance. Lateral Lifters are being purchased for the organisation across the Acute Services Division, Health & Social Care Partnership, Mental Health and Manual Handling Training Rooms. Training will commence once the equipment is received.*

- *How learning from complaints is recorded within Services / Division will be explore and the use of the Action Module within Datix will be promoted.*

- *Within Datix there is now a function to connect Complaints to incidents and this will ensure learning from both are linked.*

Indicator Two: Complaint Process Experience

A statement to report the person making the complaint's experience in relation to the complaints service provided. NHS bodies should seek feedback from the person making the complaint of their experience of the process. Understandably, sometimes the person making the complaint will not wish to engage in such a process of feedback. However, a brief survey delivered in easy response formats, which take account of any reasonable adjustments, may elicit some response.

- *A new Patient Experience Feedback questionnaire has been developed on Microsoft Forms to capture the experience of the person making the complaint in relation to the complaints handling process provided. The questionnaire will be sent out 2 -3 weeks after the complaint response letter. This will allow us to obtain feedback each month by contacting complainants who have opted in. Since starting in January 2023, we have seen an improved response rate on average of 23%. The data will be analysed used to measure and make improvements to the Complaint handling process.*

Indicator Three: Staff Awareness and Training

Subject Title		No. of staff			Notes
		NHS	SWFC	VOL	
Good conversations (Gc) (3 day course)	Q2	7	6	2	Figures provided for NHS, Social work / Fife Council, Voluntary Sector –
	Q3	12	6	3	
	Q4	6	10	4	
	Q1	8	7	1	
Gc half- day intro course	Q2	3	7	2	
	Q3	8	7	5	
	Q4	1	17	4	
	Q1			4	
Gc Foundation Management		30			
Human Factors		-			NES offer a range of training and information resources on this topic – Learning page sites, presentations, Guidance, webinars and posters. We are unable to report on engagement in these resources.
Duty of Candour Training	Q2	170			
	Q3	166			
	Q4	196			
	Q1	121			

Indicator Four: The total number of complaints received

	Q2	Q3	Q4	Q1	Total
4a. Number of complaints received by the NHS Fife Board	253	207	225	261	**946**
4b. Number of complaints received by NHS Primary Care Service Contractors	198	115	92	98	**503**
4c. Total number of complaints received in the NHS Board area	**451**	**322**	**317**	**359**	**1449**

Records logged in Datix Complaints module – 01/07/2022-30/06/2023 - Admin	22/23 Q2	22/23 Q3	22/23 Q4	23/24 Q1	Total
Stage 1 Complaint	151	122	133	151	**557**
Stage 2 Complaint	102	85	92	102	**381**
Concern	150	139	92	124	**505**
Enquiry	120	143	151	189	**603**
Total	**523**	**489**	**468**	**566**	**2046**

NHS Fife Board - sub-groups of complaints received -

	Q2	Q3	Q4	Q1	Total
4d. General Practitioner	11	11	7	15	**44**
4e. Dental	3	1	1	2	**7**
4f. Ophthalmic	0	0	0	0	**0**
4g. Pharmacy	0	0	0	0	**0**
Total - Board managed Primary Care services	**14**	**12**	**8**	**17**	**51**

	Q2	Q3	Q4	Q1	Total
4h. General Practitioner	77	65	47	59	**248**
4i. Dental	3	0	6	9	**18**
4j. Ophthalmic	2	0	0	0	**2**
4k. Pharmacy	121	50	39	39	**249**
Total – Independent Contractors	**203**	**115**	**92**	**107**	**517**
4l. Combined total of Primary Care Service complaints	**217**	**127**	**100**	**124**	**568**

Indicator Five: Complaints closed at each stage

Number of complaints closed by the NHS Board *(do not include contractor data, withdrawn cases or cases where consent not received).*	**Number**				**As a % of all NHS Fife complaints closed (not contractors)**			
	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
5a. Stage One	136	123	131	144	51%	52%	59%	76%
5b. Stage two – non escalated	110	95	72	37	42%	41%	32%	20%
5c. Stage two - escalated	18	17	20	8	7%	7%	9%	4%
5d. Total complaints closed by NHS Board	**264**	**235**	**223**	**189**	**100%**	**100%**	**100%**	**100%**

Indicator Six: Complaints upheld, partially upheld, and not upheld -

Stage one complaints	**Number**				**As a % of all complaints closed by NHS Fife at stage one**			
	Q2	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**
6a. Number of complaints upheld at stage one	35	36	31	62	29%	35%	37%	43%
6b. Number of complaints not upheld at stage one	63	42	36	59	52%	41%	42%	41%
6c. Number of complaints partially upheld at stage one	23	24	18	24	19%	24%	21%	16%
6d. Total stage one complaints outcomes	**121**	**102**	**85**	**145**	**100%**	**100%**	**100%**	**100%**

Stage two complaints Non-escalated complaints	Number				As a % of all non-escalated complaints closed by NHS Fife at stage two			
	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
6e. Number of non-escalated complaints **upheld** at stage two	13	18	12	6	25.5%	30%	30%	16%
6f. Number of non-escalated complaints **not upheld** at stage two	25	23	14	18	49%	38%	35%	49%
6g. Number of non-escalated complaints **partially upheld** at stage two	13	19	14	13	25.5%	32%	35%	35%
6h. Total stage two, non-escalated complaints outcomes	**51**	**60**	**40**	**37**	**100%**	**100%**	**100%**	**100%**

Stage two escalated complaints Escalated complaints	Number				As a % of all escalated complaints closed by NHS Fife at stage two			
	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
6i. Number of escalated complaints **upheld** at stage two	2	1	1	1	14%	7%	6%	9%
6j. Number of escalated complaints **not upheld** at stage two	9	10	13	7	65%	67%	81%	64%
6k. Number of escalated complaints **partially upheld** at stage two	3	4	2	3	21%	26%	13%	27%
6l. Total stage two escalated complaints outcomes	**14**	**15**	**16**	**11**	**100%**	**100%**	**100%**	**100%**

Indicator Seven: Average times -

	Q2	Q3	Q4	Q1
7a. the average time in working days to respond to complaints at stage one	14.2	14.1	11.5	7.85
7b. the average time in working days to respond to complaints at stage two	93.8	98.7	127.7	38.73
7c. the average time in working days to respond to complaints after escalation	102.4	66.4	51	26

Indicator Eight: Complaints closed in full within the timescales -

	Number				As a % of complaints closed by NHS Fife at each stage			
	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
8a. Number of complaints closed at stage one within 5 working days.	83	60	65	63	93%	87%	88%	84%
8b. Number of non-escalated complaints closed at stage two within 20 working days	5	5	5	10	6%	7%	7%	13%
8c. Number of escalated complaints closed at stage two within 20 working days	1	4	4	2	1%	6%	5%	3%
8d. Total number of complaints closed within timescales	**89**	**69**	**74**	**75**	**100%**	**100%**	**100%**	**100%**

Indicator Nine: Number of cases where an extension is authorized-

	Number				As a % of complaints closed by NHS Fife at each stage			
	Q2	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**
9a. Number of complaints closed at stage one where extension was authorised	19	16	16	23	35%	27%	62%	68%
9b. Number of complaints closed at stage two where extension was authorised (this includes both escalated and non-escalated complaints)	36	44	10	11	65%	73%	38%	32%
9c. Total number of extensions authorised	**55**	**60**	**26**	**34**	**100%**	**100%**	**100%**	**100%**

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

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

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

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NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**8 September 2023**
Title:	**Care Opinion 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 gathered through Care Opinion, to describe the opportunities for learning and change when things do not go well, to encourage storytelling through the Care Opinion platform, to share feedback and to create and promote a culture where staff and services engage with feedback.

This is presented for:

- Assurance

This report relates to a:

- Local policy

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

- Person Centred

2 Report summary

2.1 Situation

Patient feedback is reported quarterly through the Clinical Governance Oversight Group. No quality indicators are identified in which patient feedback performance levels are measured.

This report will describe the quality of patient experience feedback gathered through Care Opinion and highlight changes and improvements implemented to enhance patient care and service delivery.

2.2 Background

Care Opinion was introduced to all Scottish Health Boards in 2011. It is a safe, easy, confidential, and supportive platform for the public and staff to use and exists to create learning and change in health services.

Care Opinion stories are widely read across Scotland by staff and services, researchers, educators, policymakers, civil servants, the third sector and, importantly, the public. The use of Care Opinion by the public and the number of staff listening, responding, and learning from stories has increased across all NHS Health Boards and, over the years, has become embedded in practice and culture.

Care Opinion is a powerful and invaluable tool, and each post offers real-time, honest feedback from patients, families, and carers. Responders have become more confident with receiving feedback, creating opportunities for open two-way conversations, and actively listening to find out what really matters, supporting learning and development to make a real difference, positively impacting person-centred change, improving care, and sharing good practices.

There is a well-established link between improved patient experience and positive staff well-being. It is vital to celebrate and share the good feedback and work as it positively impacts staff morale and is valuable in ensuring learning can be replicated across the organisation, further embedding the value of Care Opinion, and listening to the patient's voice.

2.3 Assessment

NHS Fife is currently rated one of the top three Health Boards for Care Opinion post in Scotland. There continues to be a focus on increasing the number of Services listed on NHS Fife's Care Opinion, cultivating more opportunities for the public to share feedback and for staff and Services to engage. Fife Health & Social Care Partnership (H&SCP) have also recently taken up a Care Opinion subscription and the Patient Experience Team offers support, sharing ways of working and celebrating patients' stories following their journey across services in NHS Fife and H&SCP.

The Patient Experience team are actively going out into service and ward areas promoting Care Opinion and gathering patient stories from those who may have never had their stories shared or heard publicly. This has received positive feedback, and post numbers are increasing.

The number of allocated places for responders in NHS Fife has increased from 300 to 500. Over the next year, more Services and staff at all levels will be encouraged to take on responder's rights, promote the use of Care Opinion, and respond directly to posts.

There will be a focus on staff training and linking with the Care Opinion Team to support this. Developing our approach to demonstrate how we learn from the feedback we receive and the improvements from this. Empowering and encouraging staff to act on feedback to influence change and practice, record the actions taken due to feedback, and close the learning loop.

Regular posts are shared via NHS Fife social media platforms to raise the profile, encourage the use of Care Opinion, and showcase examples of patient stories and change.

A new Care Opinion webpage for staff is also being created. This will provide information regarding training and education opportunities, available resources, and promotional materials, showcasing areas that engage well with Care Opinion posts, celebrating positive stories and sharing learning opportunities.

Planned Change

Respondents can add additional “change information” when they post a response by showing whether feedback leads to a change. There are three change options available.

What is the change information?

1. No change is planned.
2. We are planning a change.
3. We have made a change.

What happens to the change information added?

Adding the change information makes it easy for the Care Opinion website to show when feedback has led to a change and can be helpful in different ways.

1. This is shown on each story so everyone can see what has happened.
2. It is easy for responders / services to search for changes they have made.
3. Create reports of change across all or part of the organisation, which can be shared with staff, Boards, and regulators.
4. Easy to see which organisations are doing the most with patient and carer feedback.

What is change?

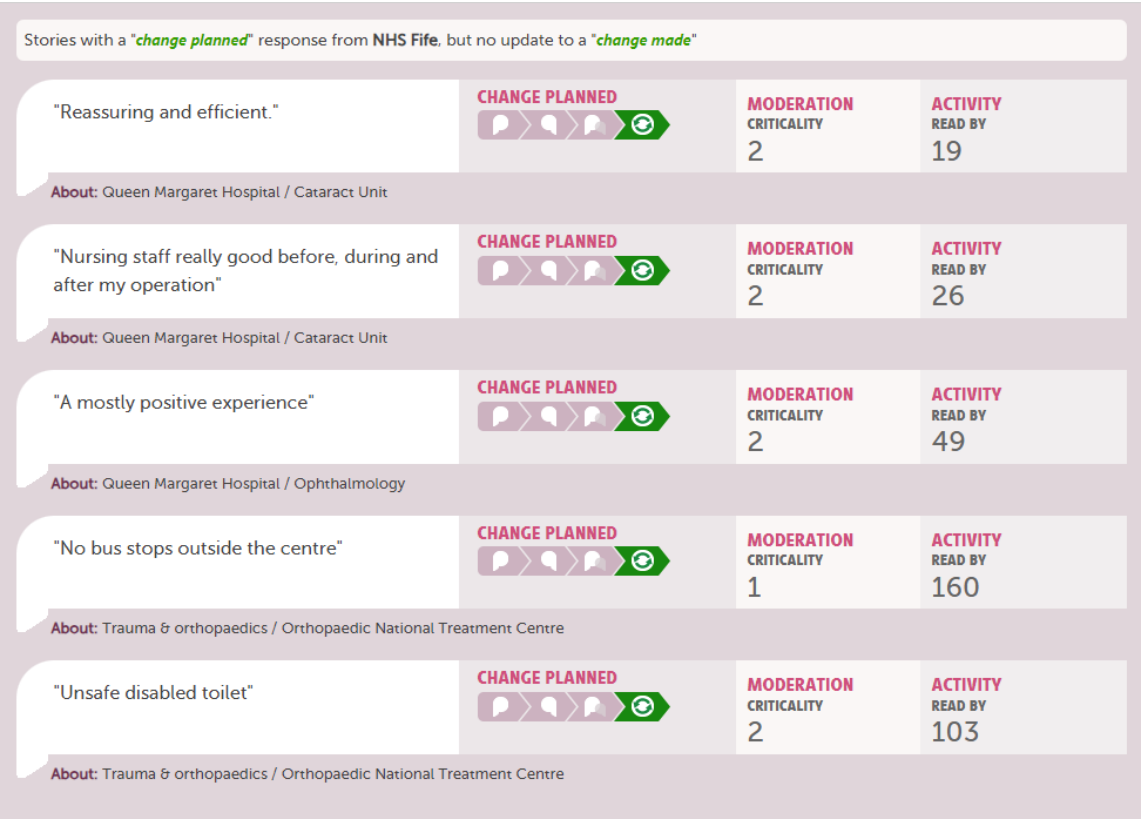
Change may mean different things, depending on the context and how online feedback is used to make improvements.

For example:

- For the service provider, change may be a different way of doing things, bringing feedback into staff meetings, a new policy, a new post, a comfortable chair for relatives, or clearer signage.

- For the commissioner, change may be a new way of involving people in commissioning, something new to add to performance monitoring, or a consultation on an issue of concern.
- For the local patient involvement body, a change might be a decision to pursue a specific local issue, to organise a public meeting, or to monitor local feedback on something.
- For a national or regional policy team, a change might be a change to policy, new guidance for health services, or a new approach to policy making in a specific area.
- For those providing professional education and training, a change might be a decision to bring patient feedback into their courses, or to give students a new way to reflect on patient experience.

The top 5 – latest Care Opinion stories with a planned change



Top 5 – Planned Change - Most recent post with a change planned

Nursing staff really good before, during and after my operation

About: Queen Margaret Hospital / Cataract Unit

Posted by Jayden (as a service user), 2 months ago

Long wait time for cataract operation, no one's fault but a letter or a text from the hospital regarding waiting times would've been appreciated.

Nursing staff really good before, during and after my operation. A cup of tea or any drink after the procedure would have been welcomed.

Was really worried day 2 post-op as my vision was really hazy, phoned the cataract unit who told me this was normal.

Follow up appointments were vague. I was told I was listed for my 2nd eye op but not told I would be seen in outpatients before this.

These are just minor gripes/suggestions and I would recommend the Queen Margaret cataract unit

Responses

Response from Stacey Arnott, Senior Charge Nurse, Cataract Unit, Queen Margaret Hospital, NHS Fife last month

Posted by Jayden (as a service user), 2 months ago

Dear Jayden

Thank you for taking the time to feedback on your recent experience within the cataract unit. It it lovey to hear that the nursing care was very good throughout your visit.

I appreciate your feedback regarding a drink following your surgery and we will look at this to see what changes are required.

We always advise patients at their clinic appointment and on the day of theatre that they will not be followed up in the hospital setting but at their own optometrist who will then feedback into the hospital this prevents patients having to travel unnecessarily into the hospital setting.

I wish you well in your recovery.

Top 5 – Planned Change - Greatest number of times read

No bus stops outside the centre

About: Trauma & orthopaedics / Orthopaedic National Treatment Centre

Posted by Lynseylyns1 (as a relative), 2 months ago

My mum had an appointment at the treatment centre today. She has walking difficulties but is otherwise independent. As she doesn't drive, she had to get a bus to the centre. However, there are no bus stops outside the centre and she therefore had to walk quite a distance to reach the centre which was both painful and exhausting for her. This comes as a surprise, bearing in mind the type of centre this is, and I am sure there are many patients in a similar situation as her.

Responses

Response from Neil McCormick, Director of Property & Asset Management, Estates & Facilities, NHS Fife 2 months ago

Dear Lynseylyns1

I am sorry that your Mum had a painful and exhausting experience visiting the National Treatment Centre.

The NTC was designed a number of years ago and the planning process included looking at public transport links. I will review the documentation which will have included consultation with the bus companies who have specific requirements about the placement of additional stops.
I will also look into the potential for clearer directions for the shortest and easiest way to get from the bus stops to the NTC. Unfortunately some of the normal access routes from the hospital have been closed off during the pandemic and we are going to open these back up in the summer once we have made necessary changes to the road layouts to ensure pedestrian safety.

I hope that this is helpful

How feedback can make a difference

Am I Invisible?

About: General practices in Fife

Posted by Sunset Lover (as the patient), last month

After the death of my partner last year and having trouble sleeping and really coming to terms with it all, I finally reached out to my GP Surgery in March.

I managed to get a telephone appointment for that afternoon with a nurse, who sympathised with me and gave me a prescription for Diazepam. The nurse also told me that they couldn't book me an appointment with the bereavement counsellor for that month as the appointments had all been booked up. They then tried for April, only to tell me that the diary wasn't open yet. But not to worry, as I was on their radar now.

3 months on and still nothing from the surgery regarding an appointment. I feel that it was hard enough for me to reach out once, and I wasn't prepared to do it again.

So at the end of June a formal letter of complaint was sent 1st class post to the surgery.

Nearly 3 weeks on and still not a dickie bird from the surgery.

My trust in NHS Fife has not been at a high level for the past 2 years, and now it is at rock bottom.

Responses

Response from Siobhan McIlroy, Head Patient Experience, Corporate Services, NHS Fife last month

Dear Sunset Lover

My name is Siobhan McIlroy and I am the Head of Patient Experience. NHS Fife welcomes all feedback, so thank you for taking the time to post on Care Opinion.

Firstly I want to offer my condolences on the loss of your partner. This must be a very difficult and sad time for you.

I am sorry that you have not had a good experience with your GP practice and received the support that you have needed. I would like to discuss this with your further. If you could email me your GP Practice details, and your name and date of birth. You can email me at Siobhan.mcilroy@nhs.scot.

Thank you again for sharing your story, best wishes and take care. Hopefully I will hear from you soon, Siobhan.

Update posted by Sunset Lover (the patient) last month

Thank you Siobhan.

I have emailed you the details requested. I don't feel so invisible now.

Learning from feedback

Post-op symptoms

About: Queen Margaret Hospital / Day Surgery

Posted by AprilOp (as the patient), 4 months ago

The operation went well under general anaesthetic and I was discharged after being able to pass urine.

However, once I was home the pain level was really severe, including continual bleeding and I was totally incontinent, neither of which I was prepared for.

The literature I was given stated that the post-op symptoms would be mild, and they certainly were not.

Responses

Response from Siobhan McIlroy, Head Patient Experience, Corporate Services, NHS Fife 4 months ago

Dear AprilOp

My name is Siobhan McIlroy and I am the Head of Patient Experience. NHS Fife welcomes all feedback, so thank you for taking the time to post on Care Opinion.

I am sorry to hear that your post operative symptoms were severe and not what you expected. This mush have been shocking and very frightening for you.

If you send me your name, date of birth and let me know what operation you had I can try to get someone from the service to discuss your symptoms with you. My email address is siobhan.mcilroy@nhs.scot.

I hope you are recovering well, take care and best wishes, Siobhan.

Response from Jacqueline Stecka, Senior Charge Nurse, Urology DTC, NHS Fife 3 months ago

Dear AprilOp

I want to firstly thank you for agreeing to speak with me directly to ascertain the post operative symptoms you experienced following your iTIND procedure. I am very sorry that it was not how you expected it to be and appreciate you giving your permission to provide feedback on the outcomes following our discussion.

It is also appreciated that you were happy for me to discuss this with the Consultant Urologist who undertook your procedure, he was also very grateful for the feedback and how it will enable us to facilitate service improvements and ensure patient-centred care can be achieved as we embrace this new procedure into the Urology service.

The issues we identified and the planned solutions are as follows:

Patient information - in addition to the patient seeing a video during the consultation process we will add in an Patient Information Leaflet (PIL) to take home. There will also be a post-operative leaflet which will advise what to expect after your procedure.

Medication - on discussion with the Consultant there will be additional post-operative medication provided, this will aid in reducing pain/discomfort which may be experienced in the days following procedure. There will also be the addition of a pre-medication - this will be provided on the morning of procedure when you come into hospital.

Post operative check - we discussed that you thought it may be beneficial for staff to contact patients 3-4 days after procedure to check on progress and to identify if patient is experiencing any issues - this is still under discussion but we will ensure meantime that patients have a point of contact should they experience any issues prior to post operative appointment which occurs 1 week after.

If there is anything else you wish to discuss further, please do not hesitate to contact me or the Urology team.

Thank you and best wishes

Jackie

Update posted by AprilOp (the patient) 3 months ago

Thank you for following up and I hope it will be beneficial for others in future

2.3.1 Quality/ Patient Care

Analysing data will lay the foundation for quality improvement work, and the Patient Experience Team, alongside Services and the Organisational Learning Group, will review themes, trends and lessons learned from feedback, complaints, and adverse events, which can be triangulated with activity and staffing resources.

2.3.2 Workforce

The Patient Experience Team establishment has been reviewed, examining workload and workforce planning. With the current workforce focusing on reducing the workload generated through the Complaints Handling Procedure, gathering Patient Experience feedback is challenging.

The team consists of 1.0 WTE Band 7 Patient Experience Team Leader, 3.6 WTE Band 6 Patient Experience Officers, 1.8 WTE Band 4 Patient Experience Support Officers, 2.0 WTE Band 4 Patient Experience Administrators, and 2.07 WTE Band 3 Patient Experience Administrators.

An additional 0.26 WTE Bank Patient Experience Support Officer joined the Patient Experience Team to gather feedback through Lived Experiences, Participation and Engagement and Care Opinion. Visiting in-patient areas and promoting the use of Care Opinion with staff, patients, families, and carers and gathering stories from patients who otherwise would not be able to share or have their stories heard.

2.3.3 Financial

N/A

2.3.4 Risk Assessment/Management

Listening to patients and learning from feedback is vital in reducing reputational risk. Stories with planned changes not followed up by responders to advise whether change has been implanted or not. The Patient Experience Team is linking in with Care

2.3.5 Equality and Diversity, including health inequalities

People can expect to experience integrated care and support services that are underpinned by a Human Rights Based Approach, in which:

- People’s rights are respected, protected and fulfilled.
- Providers of care clearly inform people of their rights and entitlements.
- People are supported to be fully involved in decisions that affect them.
- Providers of care and support respect, protect and fulfil people‘s rights and are accountable for doing this.
- People do not experience discrimination in any form.
- People are clear about how they can seek redress if they believe their rights are infringed or denied.

2.3.6 Other impact

N/A

2.3.7 Communication, involvement, engagement, and consultation

Care Opinion feedback is shared at Clinical Governance and at the Executive Directors Group.

2.3.8 Route to the Meeting

Executive update from the Patient Experience Team.

2.4 Recommendation

The Committee is asked to note the report and take **assurance** that feedback is sought and welcomed from patients, families and carers to influence and shape change person-centred care and Services.

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Annual Review of stories told about NHS Scotland Services in 2022-2023

Report Contact
Author: Siobhan McIlroy
Head of Patient Experience
Email: Siobhan.mcilroy@nhs.scot

Care Opinion

What's your story?

Annual Review

of stories told about NHS Scotland Services in 2022-2023

Branching out and putting down roots

More stories, more staff listening, more learning and change

Table of contents

Introduction

Fraser Gilmore, Executive Director and Head of Scotland

The theme for our 2022/23 annual review of **"Branching out and putting down roots"** is an apt one, based on all of the brilliant engagement we have seen across Scotland. Like a growing tree that takes up space, reaches to the sky and with roots permeating the earth, we have seen the use of Care Opinion by the public and staff increase across NHS Boards, and become embedded in practice and culture.

Feedback is a gift and as such, we are grateful to the patients, family members, guardians, carers and other member of the public who shared the **6,455 stories** we received in 2022/23. All of these story authors wanted to thank staff and services when things went well and offer opportunities for learning and change for when things did not go so well. This **37% increase** in stories from 2021/22 really shows the work that staff and services have put in to promoting storytelling on Care Opinion, as well as developing a continued trust in the platform.

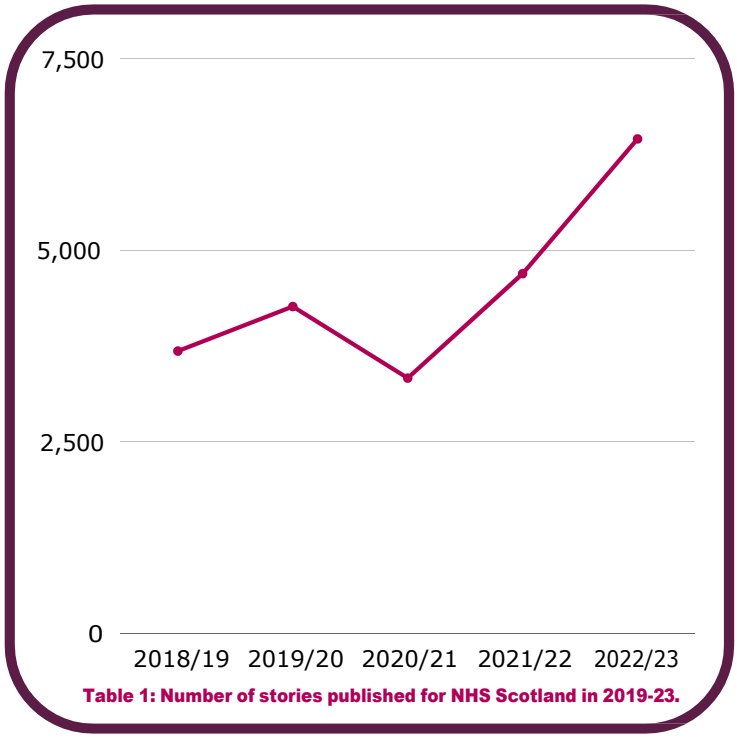


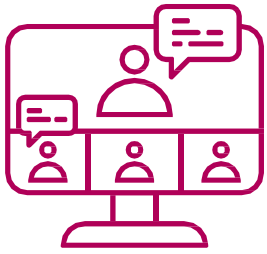
Table 1: Number of stories published for NHS Scotland in 2019-23.

We have also seen a growth in the number of **staff listening**, responding and learning from stories shared by the public, which has now risen by **25%** to **over 3,460**. This, along with Health Boards increasing the number and variety of services listed on Care Opinion, has cultivated more opportunities for the public to share feedback and for staff and services to engage.

We are delighted to see that Care Opinion stories are widely read across Scotland, not only by staff and services, but researchers, educators, policy makers, civil servants, the third sector and, importantly the public. All of these people have a place in helping make our healthcare services better for everyone. In 2022/23 we saw an **increase in the numbers of stories read and this rose by around 6% to 955,826**.

At Care Opinion we have also been growing and developing. Throughout the year, we have continued to offer and improve training as part of our online programme and created bespoke sessions for staff and services.

We attended and hosted many events and two conferences, highlighting the great work of Healthcare services across the UK, supported and promoted new research on online feedback and engaged teams with our ever growing menu of guides and materials. We also never stop developing the platform itself, constantly striving to make Care Opinion more safe and easy for the public and staff to use with a consistent aim to create and improve features based on the needs of all users.



In November 2022, we were delighted to hit the milestone of **more than 30,000 stories shared about NHS Scotland services.** To celebrate this milestone National Clinical Director, Jason Leitch shared the following:

> *"The experience of patients, families and carers is crucial to the staff of the health and care service. Care Opinion has unlocked these experiences and brought them to the light to allow celebration and improvement. It has been the most important person-centred change in the last few years."*

As we travel **through 2023/24**, we are delighted that we have **already surpassed 35,000 stories** on Care Opinion. Each of which is gift from a member of the public and an opportunity to listen, learn and improve.

It's all about what we learn from each story, so I thought I would end with a quote from a family member and someone who is a nurse themselves, who shared a beautiful story about the passing of their father:

> *"We go along in life on wards, ER and outpatients, doing our jobs and sometimes we need to stop and think when chaos and stress are all around us, when we feel we achieve nothing and what is the point of it all! That so many families like mine watch you and think 'I am grateful you are here, I am grateful for the care you give to your patients and families every day'. We matter because you show us how much you care."*

CEO Overview of this year

James Munro, CEO

At Care Opinion we love a good metaphor, especially when it expands our understanding. Healthcare language often seems to suggest the NHS is a vehicle: driving improvement, monitoring dashboards, delivering care packages. But this is a limited and limiting view of what care means to people. Instead, our metaphor for this report is one of organic growth and interdependence, and of slow but steady maturing.

Care Opinion exists to create learning and change in health services, and our approach relies on the idea that the stories people share inform and enrich the everyday thinking of thousands of staff proving hundreds of different services. Sharing stories widely, and easily, is at the heart of our approach.

So it is extremely encouraging that in Scotland, Care Opinion has now been adopted by all the territorial health boards and a growing number of health and social care partnerships too. At the same time, interest in using the platform to support professional education and development is growing, as evidenced by the strong Scottish attendance at our 2023 education conference. And alongside this, connections with Scotland's academic and policy communities are growing too. We hope our policy webinar in October 2023 will nurture this interest.

As online feedback becomes widespread and accepted across the system we hope that it, in turn, can foster a culture of openness to learning and growth. A speaker at our spring conference noted that Care Opinion changes culture in a way which is "soft, organic and relaxed". As we continue to put down roots in the Scottish healthcare landscape, and take our place in the wider ecosystem of people working to make care the best it can be, that feels like a sustaining mantra for the year ahead.

Some of our most read stories

When a member of the public shares their story on Care Opinion, we make sure that it is sent to the service(s) that their story is about, so they can learn from the feedback they have received and respond. But this isn't where the readership ends. Other staff, Politicians, Civil servants, Researchers, Educators and, of course the public also read stories too. Below are some of the most popular stories read in 2022/23.

Ward 2 Hairmyres Hospital

"Fantastic care from all staff at Hairmyres Hospital - Medical Admissions Unit, Radiology, Minor Injuries and Ward 2. A very special mention to Charge Nurse Gina on Ward 2 who went above and beyond to ensure my mum was able to access the right care [...]. I cannot thank [...] enough for their person centred care, demonstrating the values of the NHS."

771 views

739 views

"Stobhill GP Out of Hours Centre, excellent service"

"I was seen within 10 minutes of arrival by a very pleasant nurse and then by a very efficient and capable young doctor (possibly called Issy) who took my history and examined my chest, then correctly diagnosed a chest infection secondary to Covid and provided me with a full course of Amoxicillin."

"Perinatal experience"

"This was my second pregnancy and I was cared for by the excellent team of midwives in NHS Grampian, particularly Sophie, who was my named midwife, Hannah, who was the student midwife looking after me, and Ian, the midwife from midwife led Aberdeen maternity unit."

880 views

Keeping the conversation going...

Care Opinion is all about safe and transparent conversations between Authors and Staff / Services. An Author shares their story, whether positive or critical and services can respond showing how they are taking the feedback on board and learning from it.

But it doesn't always end there! Authors sometimes respond back to give further information, or in some cases to thank staff for their responses. These responses from authors really show the impact that a good reply from staff and services can have.

We know that a positive story can have an amazing impact on staff morale, but a response from an author commenting on a great response, can go even further. Here is just a small sample of what some of these authors said:

"Thank you for taking the time to respond, I am delighted that any comment written by the public is being directed to the appropriate department. My thanks to you also as The Lead Nurse, very well run unit."

"Claire, as an ex NHS nurse, I really was blown away by this nurse led endoscopy unit. So friendly, professional, caring and empathetic.

I do hope you pass on my comments because each and every member of staff deserves praise and recognition for the work they do."

"Every one of the staff we met were empathetic, caring and reassuring. My mother says the care went above and beyond.

Please do pass on our sincere gratitude to all concerned."

"Thank you all for your responses. It was really a worrying time for me, however, being able to get the healthcare intervention on time for my husband was just extraordinary.

My husband is continuing to recover and has expressed his gratitude to the NHS services."

“Of course I wish I had never had my accident in the first place, but every cloud has a silver lining and seeing professional medical teams delivering a first class service with empathy and compassion is in fact a "reward" in itself.”

“The staff nurse was also very lovely; but it is hard and unfair I think of me to single people out as every person there was smiling, kind and engaged with the patient in a very impressive way.

Really impressed and thankful as the experience was scary. Many thanks to you all again.”

“The care continues now on Ward 17. My mum is making good progress and the team are working diligently to get to the bottom of her health concerns. Thank you to everyone of you. I feel safe in the knowledge that my mum is in the best hands.”

“I appreciate you passing my comments on to the radiology staff involved. All wards and departments were all very important links in the chain to my treatment and care and I want to send some positive feedback in these challenging times.”

“It a pleasure to be able to give feedback as a channel for giving personal thanks as well as perhaps providing positive information for other patients and relatives facing the prospect of surgery.”

“Thanks to Kevin for acknowledgement and reply to my story. It was a pleasure for me to have an opportunity to perhaps reassure other patients that their well-being is not limited to physical considerations only by those “at the helm” as it were

I should add that my continuing treatment in dialysis reveals similar examples of kindness and thoughtfulness daily

Many thanks for the opportunity to express my gratitude to those concerned.”

Supporting the practice of Realistic Medicine across Scotland

As a heart doctor working in NHS Forth Valley I was familiar with feedback from patients shared as stories on the Care Opinion platform. Last year, when I became a National Clinical Advisor for Realistic Medicine, I was interested to explore how we can learn from such stories, as part of supporting the practice of Realistic Medicine across Scotland. Since person centred care and shared decision-making are central to the practice of Realistic Medicine it's been fascinating to take a deep dive into Care Opinion to see if, and when, these approaches are taking place. We've been listening to patients and looking at patterns and trends in what they say to understand if they feel they are involved in and informed about their care. I am pleased to say, through Care Opinion, we're hearing more and more from people and families and carers about what really matters to them.

Realistic Medicine is also concerned with reducing harm and waste in health and care services, tackling unwarranted variation, and continuing innovation and quality improvement across health and social care. It's clear that feedback from service users is very valuable in developing services according to these principles of care, and it's heartening to see service providers using feedback to make improvements.

I know when we first started using Care Opinion in my clinical team there was a lot of anxiety about what it might mean for us, as service providers. Despite careful moderation ensuring the focus is on the service rather than the individual, we were worried about "negative" stories and how we'd deal with the concerns which emerged. I do remember feeling disappointed by the story about my service entitled "information vacuum" which described the impact a lack of appropriate information had had on a patient. Though it was a hard read I was able to put myself in the patient's position, better understand their experience of their journey with us and recognise that we could (and should) do better. Reviewing our service, it was clearly designed more around staff than patients.

Following this feedback we took the chance to redesign elements with input from this service user. Soon we were all feeling much better about the service, and I felt better about my work too, as I had not only helped that individual but had improved things for many other future patients. Now more than 30,000 stories have been told across Scotland, for the most part, positive. I've seen that as they became more familiar with the platform, Care Opinion responders become more confident with feedback and using it to support service development, as we did. In this way, Care Opinion has become an additional tool in delivering complete patient care, since patients receive timely responses to their concerns and what emerges is more of a *conversation* which seems to work well for staff and service users alike! There is a well-established link between improved patient experience and positive staff wellbeing and I now see staff feeling more closely connected to their service users through the stories told on Care Opinion. Perhaps it's helping us to re-connect with our purpose as care givers.

Last year, the Realistic Medicine team published our Vision for Value Based Health and Care. Using Realistic Medicine principles, we are seeking to provide better value care for people, specifically care which provides outcomes which really matter to them, like my patient who found themselves in an **information vacuum**. Better value health and care is also concerned with providing sustainable, environmentally-responsible care, mindful of the available resources, and is concerned with sustainability of our health and care system as a whole.

We know that up to a fifth of the resource used in our health and care system fails to deliver meaningful outcomes for people. That's bad for patients and hard for those of us working in health and care too. Through the practice of Realistic Medicine, and informed by the stories of our service users, I believe we can develop a Culture of Stewardship around our precious resources while delivering better outcomes for patients, the healthcare system and the environment. This is the essence of Value Based Health and Care I'm excited to continue working with Care Opinion and hearing what our patients think about that!

Article was written and created by Catherine Lebinjoh, National Clinical Lead for Realistic Medicine and Kirsty Elliott, VBH&C Policy Officer.

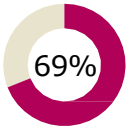
VALUE BASED HEALTH & CARE

Three Health Boards share their 2022/23 Care Opinion Journey

This year we asked 3 Health Boards to share their Care Opinion journey over 2022/23 with us. We asked about their experience of using the platform over the year, to tell us about their work to promote feedback, how they were using Care Opinion stories for learning and change, and how these stories have impacted on staff culture. With so many wonderful things that boards are doing to utilise Care Opinion across Scotland, we also wanted to hear if there was anything else they wanted to highlight. Here is what they had to share:

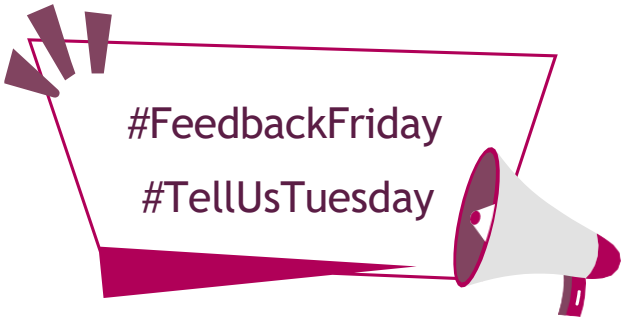
NHS Greater Glasgow and Clyde

Listening to our patients, their families and carers, and hearing about their experience of care is extremely important to **NHS Greater Glasgow and Clyde**. Care Opinion provides us with the opportunity to gather real-time feedback and open a two way dialogue. Person centred care can only be delivered by listening to patients and carers and finding out what matters to them. The feedback we receive helps us capture what matters to our patients and their families, identify themes for improvement, as well as celebrating what works well and providing the opportunity to acknowledge the great care provided by our staff.



During 2022/23, we received 1,542 stories - our highest ever with a 69% increase from the previous year. We ended on a high in March 2023, with a record number of patients and carers sharing their story (232).

We continue to raise awareness of Care Opinion among staff, patients, carers and their families as one of the main mechanisms for people to share their experiences about the care that is received and how we deliver our services. We increasingly used social media to raise the profile of Care Opinion, sharing people's stories during a number of awareness days, such as International Nurses Day, Midwives Day and Carers Week, alongside more regular promotion with our #FeedbackFriday and #TellUsTuesday campaigns.



On a weekly basis we include examples of positive feedback via our Chief Executive's Brief and include regular articles in our staff newsletter. We have also developed a new Care Opinion webpage for staff.

Going forward we plan to develop our approach to demonstrating how we learn from the feedback we received and the improvements flowing from this. This includes empowering and encouraging staff to act on feedback to influence change and practice, record the actions taken as a result of feedback and close the loop on Care Opinion. Thus demonstrating to those sharing their experiences and the wider public how feedback has made a difference.

Nicole McInally
Project Manager,
Patient Experience and Public Involvement Team (PEPI)

NHS Fife

It has been another busy year for **NHS Fife**, and we continue to face challenges across many of our healthcare systems. Care Opinion has been vital in ensuring we receive valuable feedback from patients and families. It is wonderful that people take the time to share their stories, and we thank them and value their honesty and feedback. Sharing positive feedback with staff lifts morale, knowing the care they provide is appreciated and helps to make a difference. Sharing the patient's story and their gratitude with the team is lovely.

We continue to appreciate patient feedback as a powerful tool. Through Care Opinion, we hope our patients and families feel they are being listened to and their feedback is being acted upon. We all want to deliver person-centered, quality, safe care, and the vital information we get from Care Opinion allows staff the opportunity to learn, develop and implement change, along with sharing good practices. Staff are really engaged in promoting the use of Care Opinion and responding to feedback, with many reaching out to patients when their experience could have gone better and offering an opportunity to discuss concerns further directly with the service or the Patient Experience Team.

We continue to see an increase in people sharing their stories on Care Opinion, which is fantastic, and this year, our colleagues in Fife Health and Social Care Partnership have joined. We are also actively going out into the ward areas to gather patient stories from patients who may have never had their stories shared or heard publicly. We are already receiving great feedback, and our story numbers are increasing.

Table 2: Word Cloud showing the most-used "what was good?" tags for stories told in NHS Fife between 2022/23.

Over the next year, we plan to encourage more services to promote the use of Care Opinion and to support all levels of staff to respond directly to posts. We want to raise awareness of the Care Opinion Dashboard, focus on staff training, and work with the Care Opinion Team to support us with this. We are all really excited to see how things continue to develop and to continue sharing and acting upon the feedback we receive, learning from what went well and what could have gone better.

Siobhan McIlroy
Head of Patient Experience

NHS Tayside

During 2022/23, NHS Tayside made several significant strides towards embedding Care Opinion firmly within our culture. This was seen not only in the 132% increase in stories compared with 2021/22, but also in the 81% overall positivity and leap in responder numbers, which continues to grow thanks to the continued expansion of our service tree.

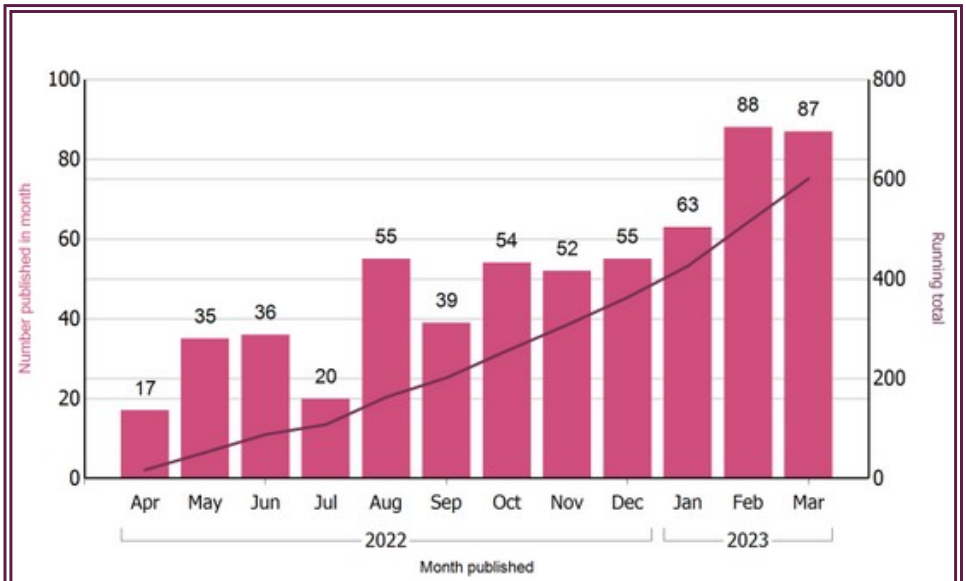


Table 3: Number of stories published every month for NHS Tayside in 2022/23

Notably, the fact that new services choose to promote Care Opinion from Day 1 demonstrates the shift in our culture, where Care Opinion is now just part of what we do.

Tayside's most viewed story during 2022/23 contained a British Sign Language video, produced by our Corporate Equalities Translation & Interpretation Team, who have been working to develop ways to help translate stories and responses in order to make Care Opinion more accessible, diverse and equitable for all its users. We're also ensuring non-clinical services are acknowledged for the important parts they play in patient journeys, with Spiritual Care and Bereavement, Domestic, Portering and Catering services - and more - featuring in our stories.

We're seeing how the transition out of Covid is starting to take effect, with stories about the transformation of our Vaccination Services, and how much patients appreciate a gradual return to normality, while continuing the enthusiastic appreciation for the work our staff members do.

With Perth & Kinross and Angus Health and Social Care Partnerships having recently taken up Care Opinion subscriptions, NHS Tayside has played an active part in the roll-out and transition of services from the Health Board subscription to theirs, but also in sharing ways of working, meeting regularly and celebrating the interlinked stories we receive which demonstrate the positive and rounded health service we provide to the patients of Tayside.

NHS Tayside appreciates and learns from the critical Care Opinion stories we receive, utilising the valued information for change, learning and development. We also recognise the importance of sharing the good work celebrated in stories, so that this valuable learning can be replicated across our organisation, further embedding the value of Care Opinion and listening to the patient voice.

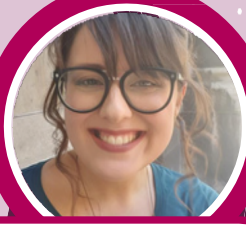
NHS Tayside

Victoria Sullivan
NHS Tayside Care Opinion Lead

Your Care Opinion Scotland team

Mhairi Smith, Moderator

Ali Patrick, Senior Moderation Officer



Krisztina Patocs, Business Administration and Support Officer

Lisa Dendy, Engagement and Support Officer

Fraser Gilmore, Executive Director & Head of Scotland

Danielle McEwan, Engagement and Support Officer

At Care Opinion, we work hard towards our mission every day, which is all about creating a safe and supportive space where people can share their honest feedback. We believe that every story has the power to make a real difference, so we make sure that each one finds its way to the right destination, where it can truly have an impact and bring about positive change. We're also committed to fostering transparency by ensuring that everyone has access to information on how services actively listen and adapt based on feedback.

This year, as part of our commitment to continuous improvement, we reached out to all our team members in Scotland to gather their valuable insights. We asked them the following question **"What have you learned from the stories on Care Opinion about NHS Scotland services in 2022/23 as shared by the public and/or staff?"** and here are their responses:

"When reflecting on the stories shared on Care Opinion about NHS Scotland services in 2022/23, I have learned so much on a personal level. These stories have shown me the incredible impact that healthcare professionals can have on people's lives, how genuine care and compassion can make a world of difference. They have taught me about the resilience and strength of individuals facing health challenges and the power of their voices in shaping the quality of care. These stories remind me of the human connection that lies at the heart of healthcare and this inspires me to continue advocating for patient-centred approaches."

Krisztina Patocs, Business Administration and Support Officer

"From my experiences over the last year, I have learned that there are lots of amazing services provided to patients in very specific situations, as well as those services we are used to seeing on Care Opinion. As promotion and awareness of Care Opinion has spread throughout organisations, I have seen some incredible feedback about new social care and health care initiatives, including maternity, paediatrics, long term condition management and mental health care. It is clear that staff are looking at feedback and exploring ways to improve the journeys of those who need it the most in different departments. I have also noticed an increase in awareness of sharing feedback from relatives, carers and friends of patients and service users, and these stories have allowed more people to be advocated for and have their voices heard. This is wonderful to see."

Lisa Dendy, Engagement and Support Officer

"Looking back over the past year and reflecting on the many stories that come to us through moderation, I've continued to learn about the am azing work and innovation taking place within services, as well as hearing about the issues facing both healthcare providers and the users of healthcare services in what are very challenging times. There is amazing resilien ce in both services and the wider public in rising to those challenges. Wha t has really struck me is how far the acknowledgement and empathy goes both ways in healthcare, with patients and service users consistently voicing their support for staff and their understanding of the challenges faced in healthcare today."

Ali Patrick, Senior Moderation Officer

"This is my first year with Care Opinion. As a moderator I have the privilege of reading a high volume of stories each week. It has been really impressive to discover the wide range of services which are offered across Scotland. In particular how these services are managed so well in particularly rural communities. Scotland has a unique geography which must make things challenging for both healthcare workers and patients alike but they make it work, and work to a high standard. I can only say well done to all the staff involved, under such challenging times they are continuing to deliver a personal and valuable service."

Mhairi Smith, Moderator

"From all of the stories that I have had the privilege of reading this past year, I've seen some great examples of the creative and innovative ways that staff are engaging with patients and service users. There has been a clear shift, for me as a reader, in the conversations that are happening and it's always lovely to see staff showing pride in both them and their teams, and echoing this through their responses. It's clear to me through reading these stories that staff and services continue to work hard and it's heartwarming to read the interactions between them and authors.

It's also reassuring to witness the thoughtful ways in which staff are encouraging story authors to get involved in changing practice, especially when things haven't quite gone to plan. This reinforces the importance of simply having a chat, we're all human after all!"

Danielle McEwan, Engagement and Support Officer

Journey of Growth

2023

In November 2022, we reached the milestone of 30,000 stories shared by the public about NHS Scotland Services .

6,455 stories told — **955,826** stories read

96% response rate

2022

In April 2022, the Scottish Government renewed the Care Opinion subscription for all health boards until March 2026.

40% increase in number of stories told from the previous year.

4,696 stories told — **904,205** stories read

95% response rate

2021

19% increase in number of staff listening during the challenging time of the Covid-19 pandemic.

3,333 stories told — **615,039** stories read

96% response rate

2020

In 2019/20, there was an increase of 10% in the number of stories posted by the public, which was an almost 140% increase from the past 5 years.

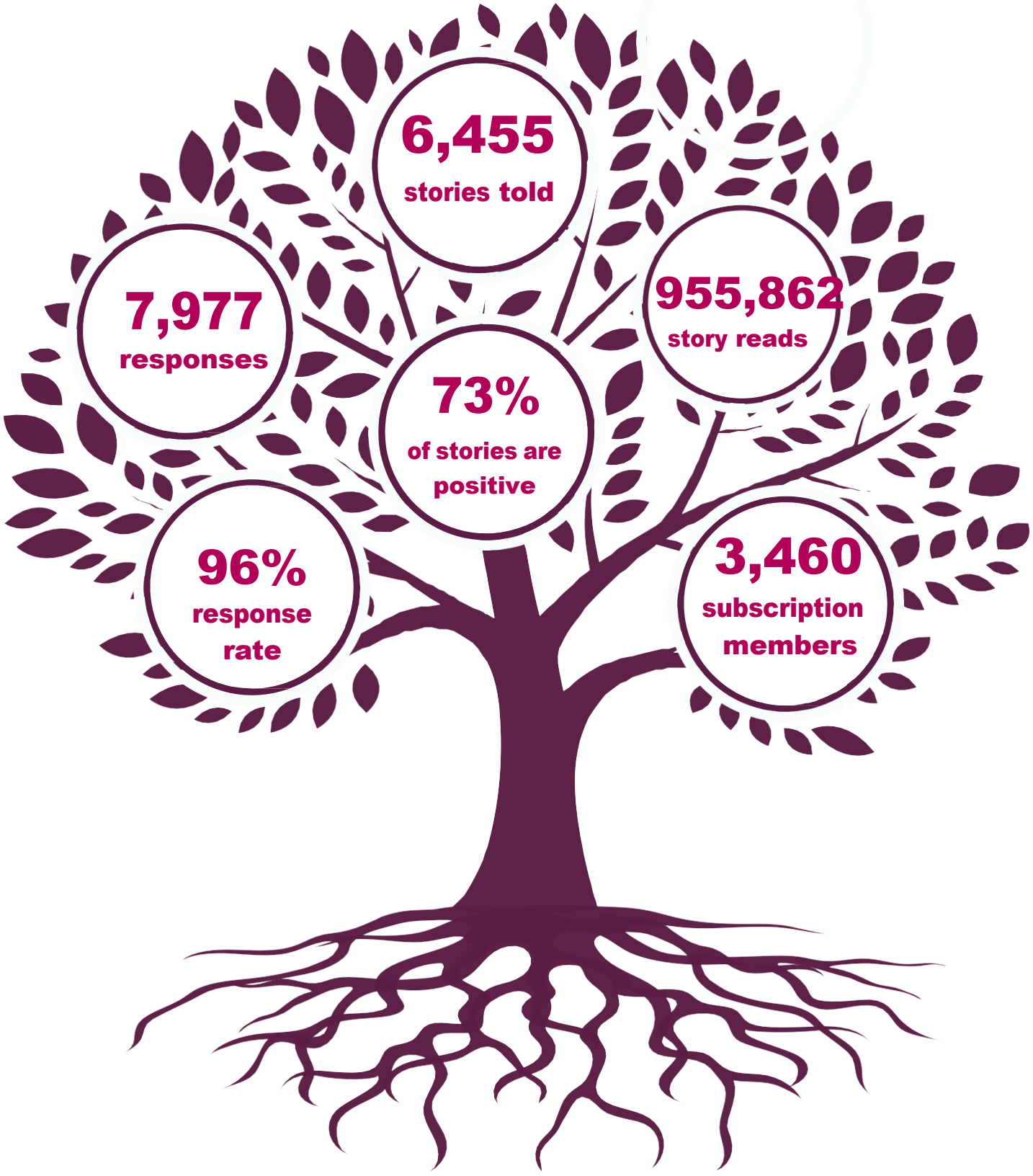
4,267 stories told — **649,166** stories read

97% response rate

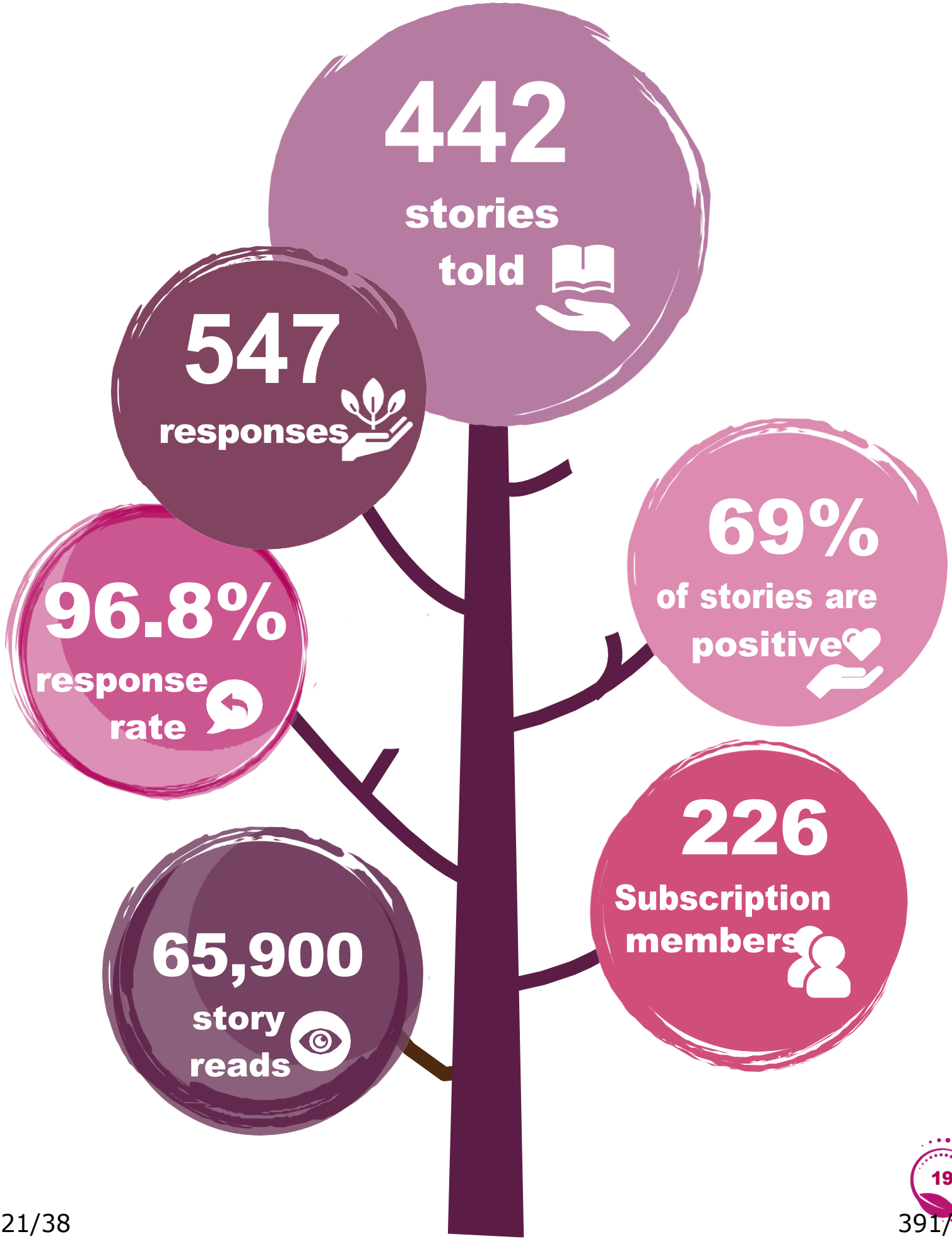
2019

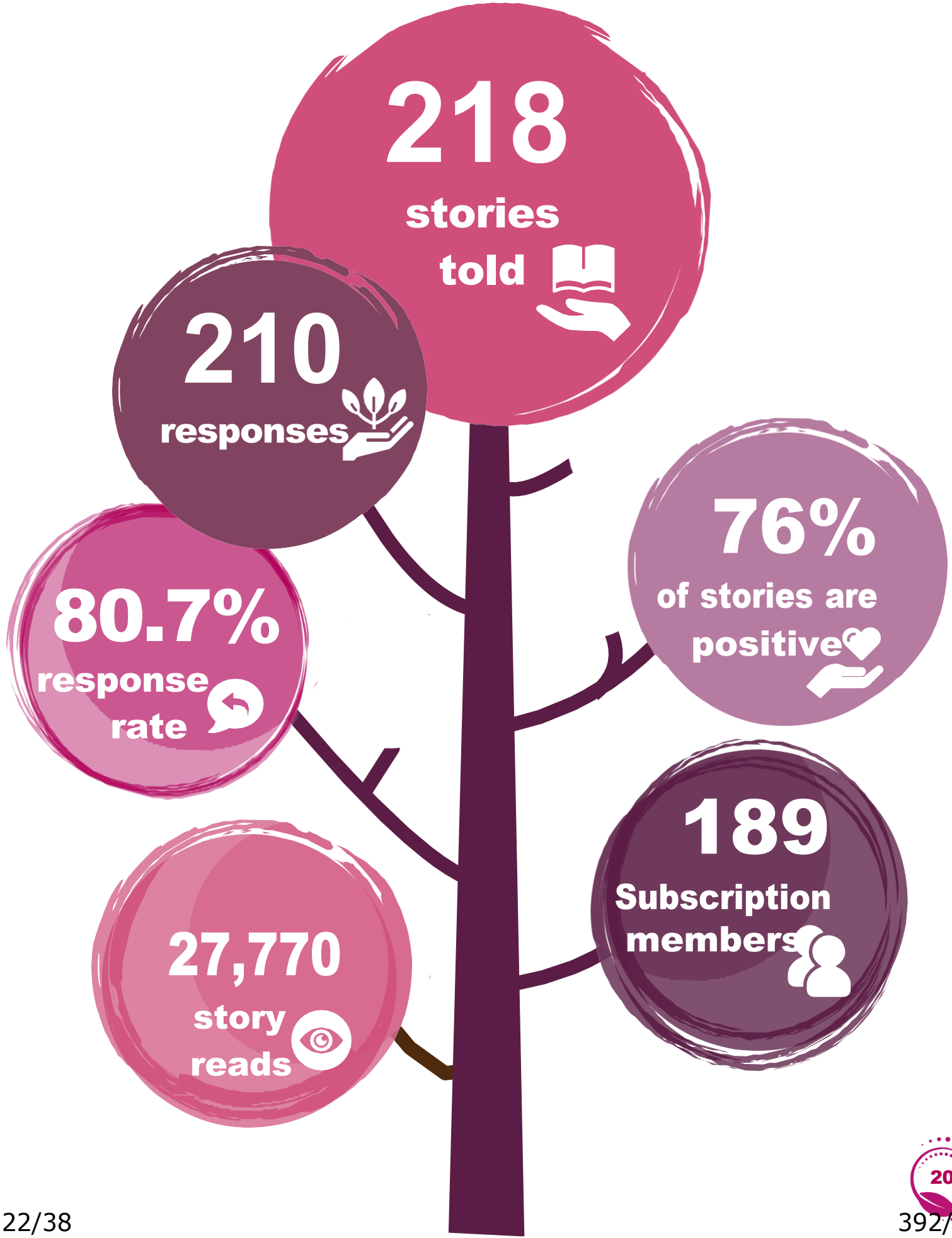
Activity across NHS Scotland services in 22/23

The below infographic outlines activity on Care Opinion about NHS Scotland services during 2022/23.

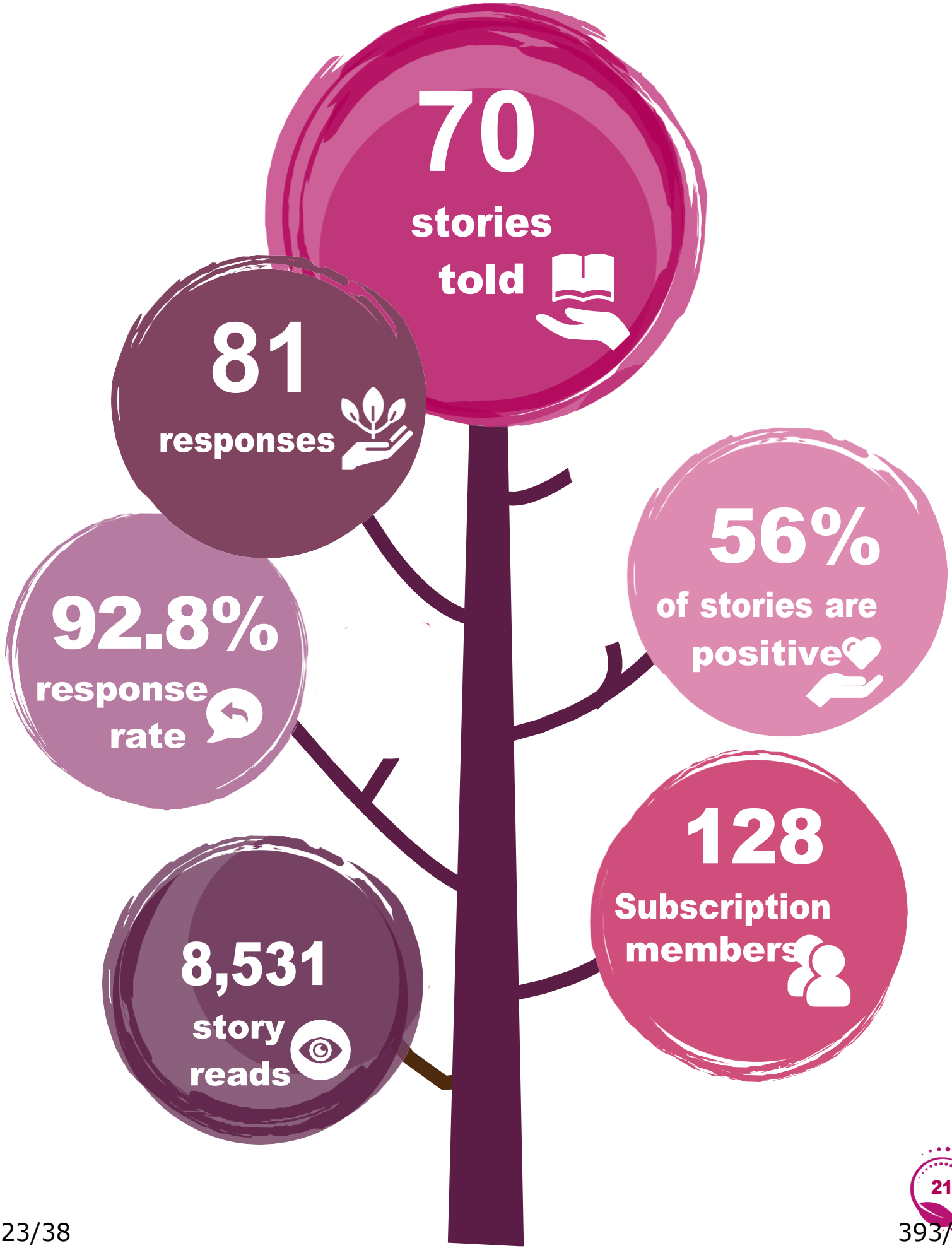


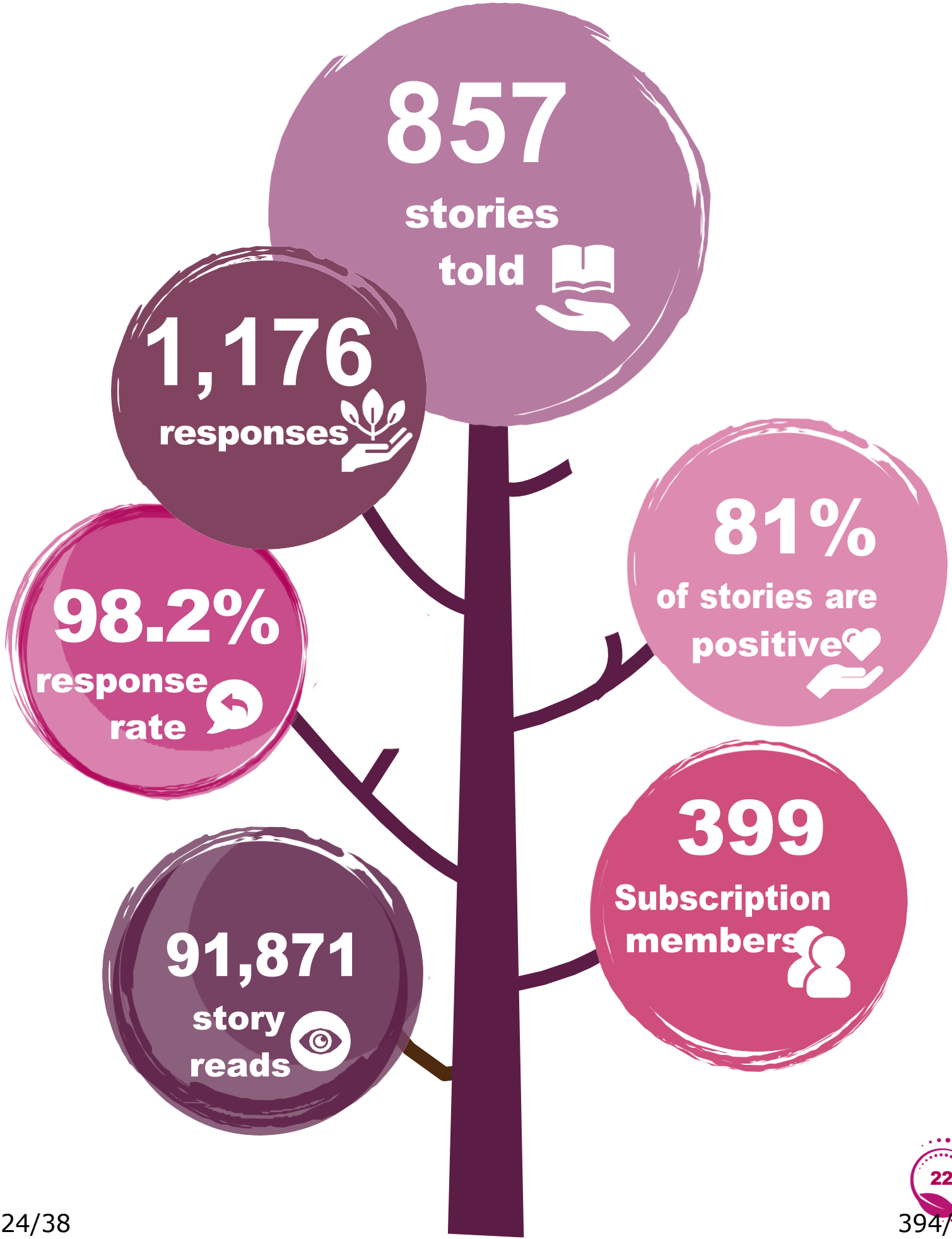
The following pages have infographics outlining activity on Care Opinion for each Health Board during 2022/23.

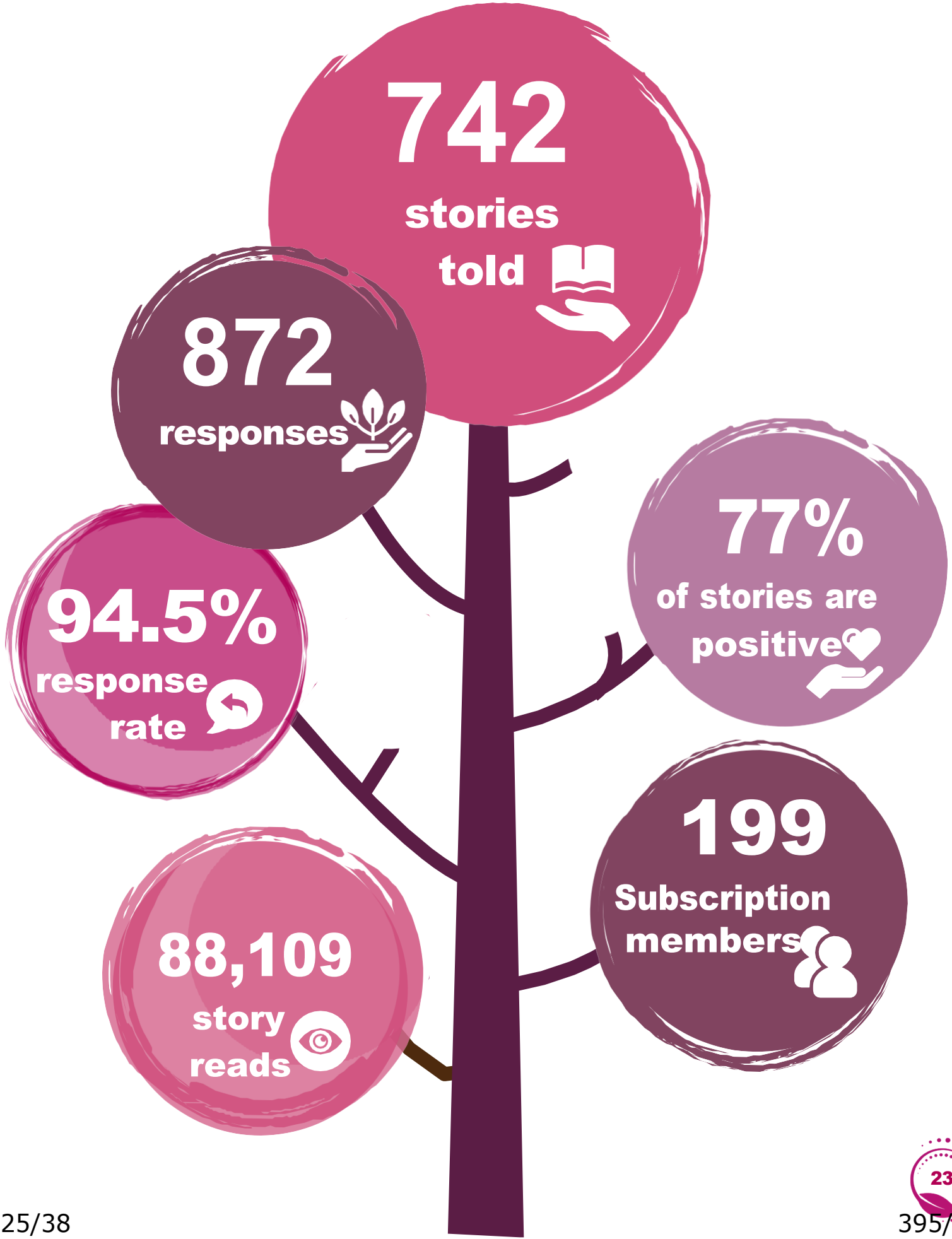

442
stories
told
547
responses
96.8%
response
rate
69%
of stories are
positive
226
Subscription
members
65,900
story
reads


218
stories told
210
responses
80.7%
response rate
76%
of stories are positive
189
Subscription members
27,770
story reads

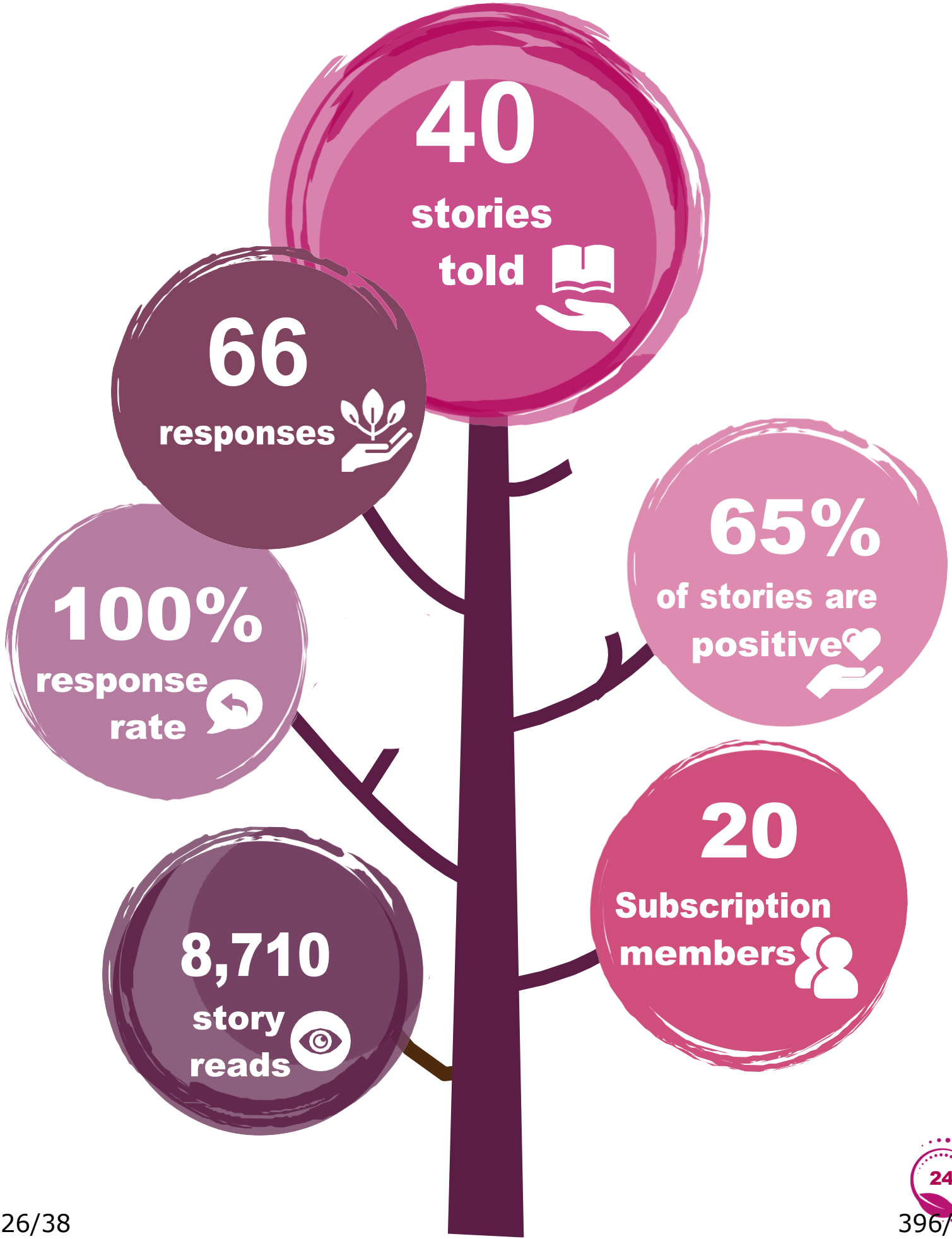
NHS Dumfries and Galloway



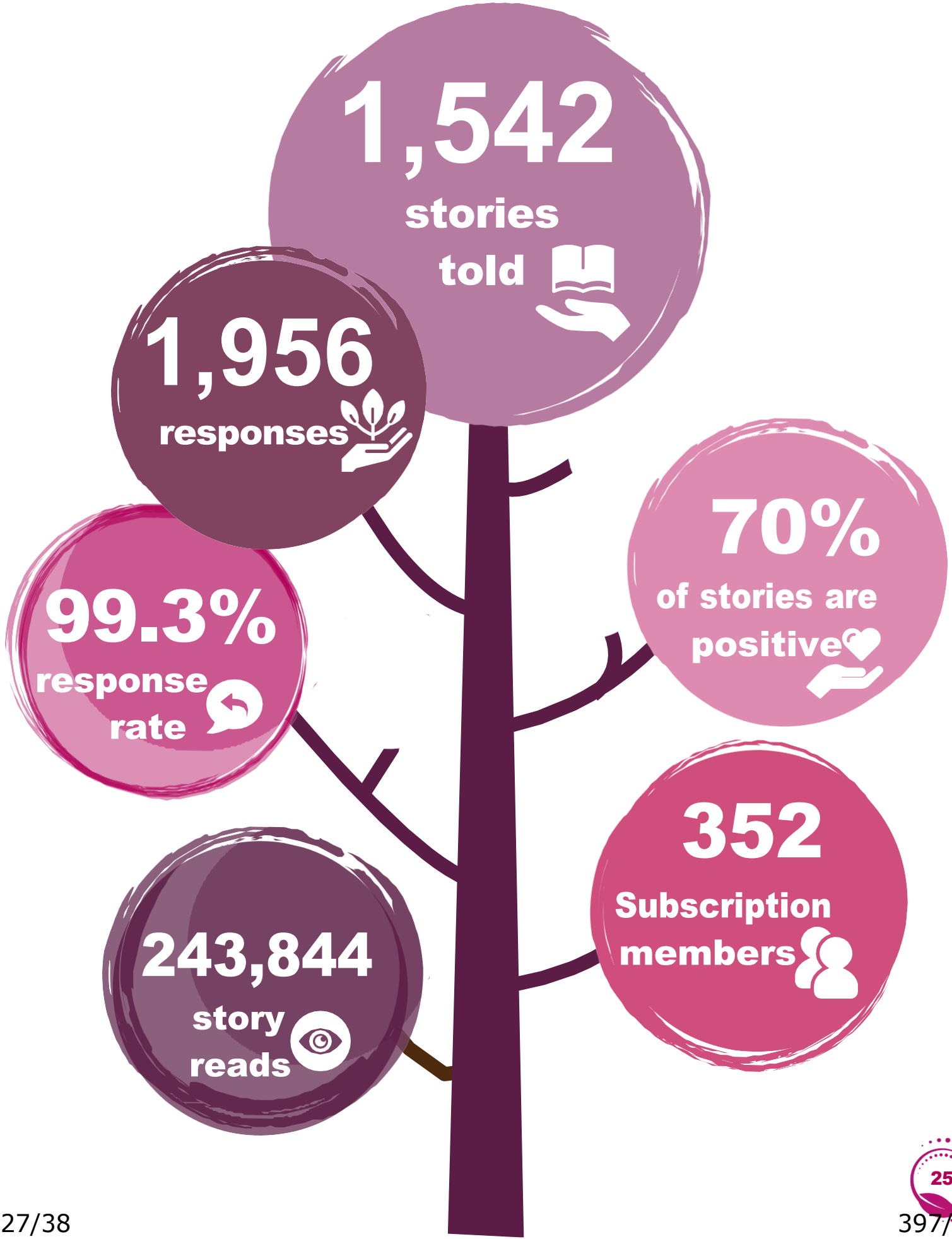

857
stories
told
1,176
responses
98.2%
response
rate
81%
of stories are
positive
399
Subscription
members
91,871
story
reads

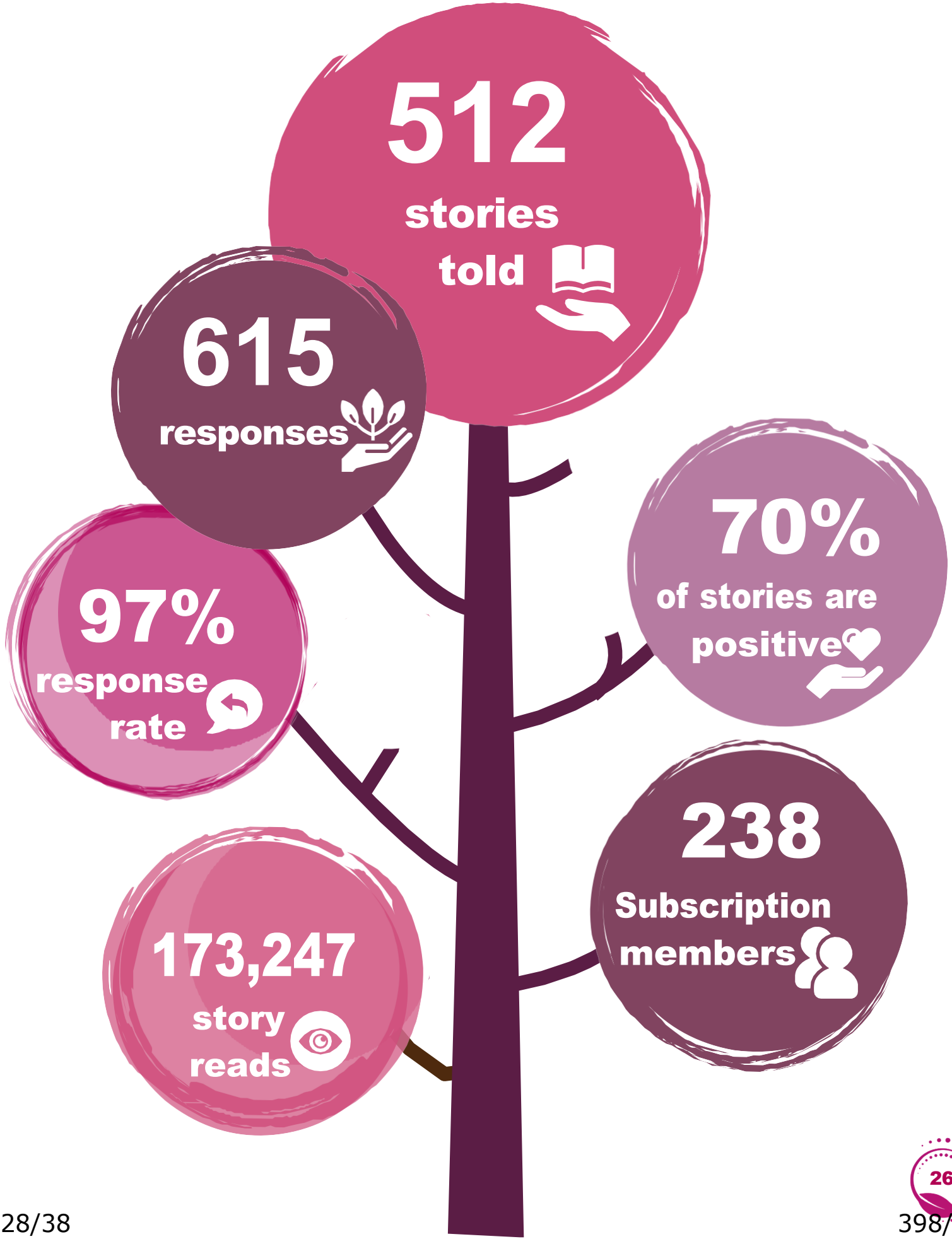

742
stories
told
872
responses
94.5%
response
rate
77%
of stories are
positive
88,109
story
reads
199
Subscription
members

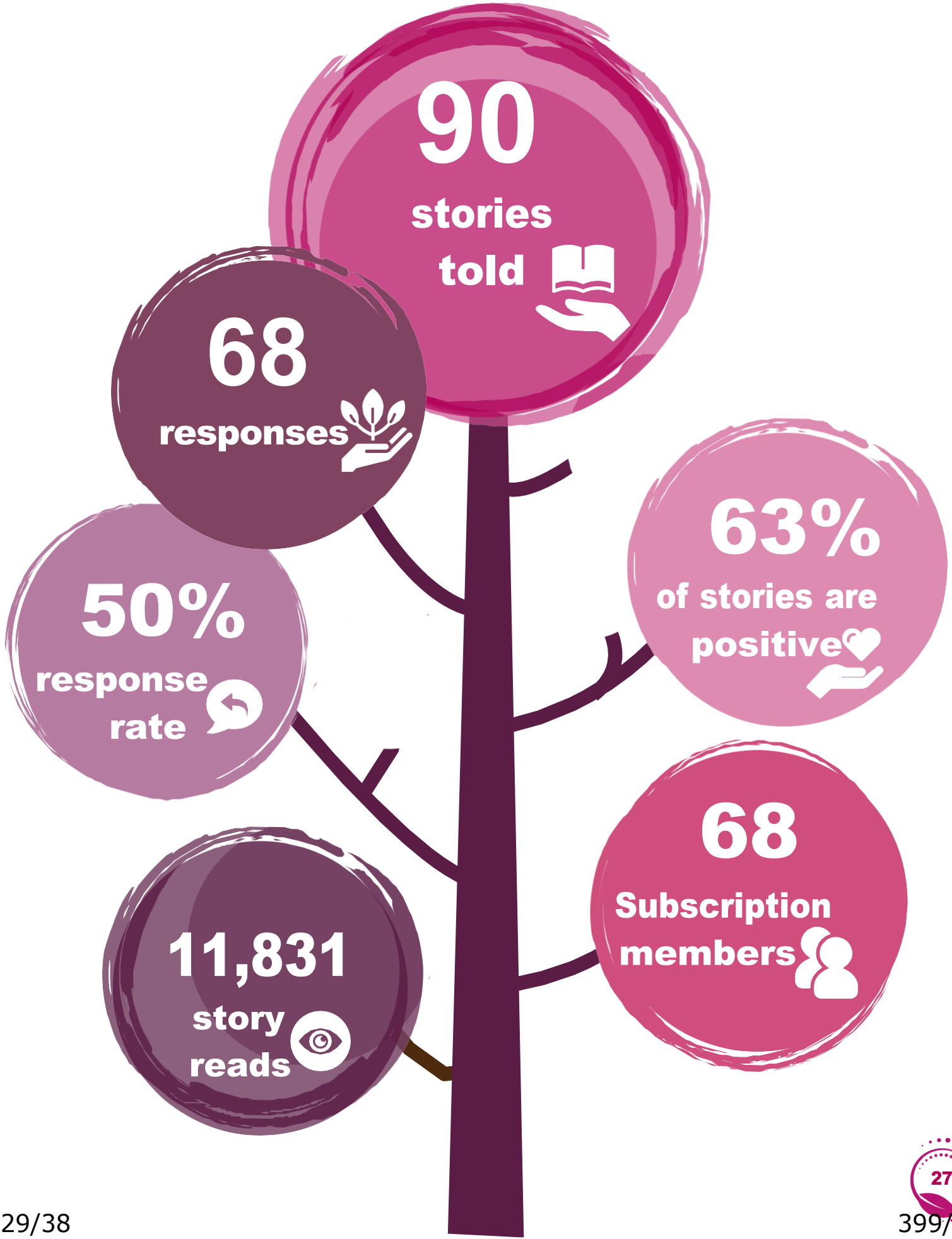
Golden Jubilee National Hospital

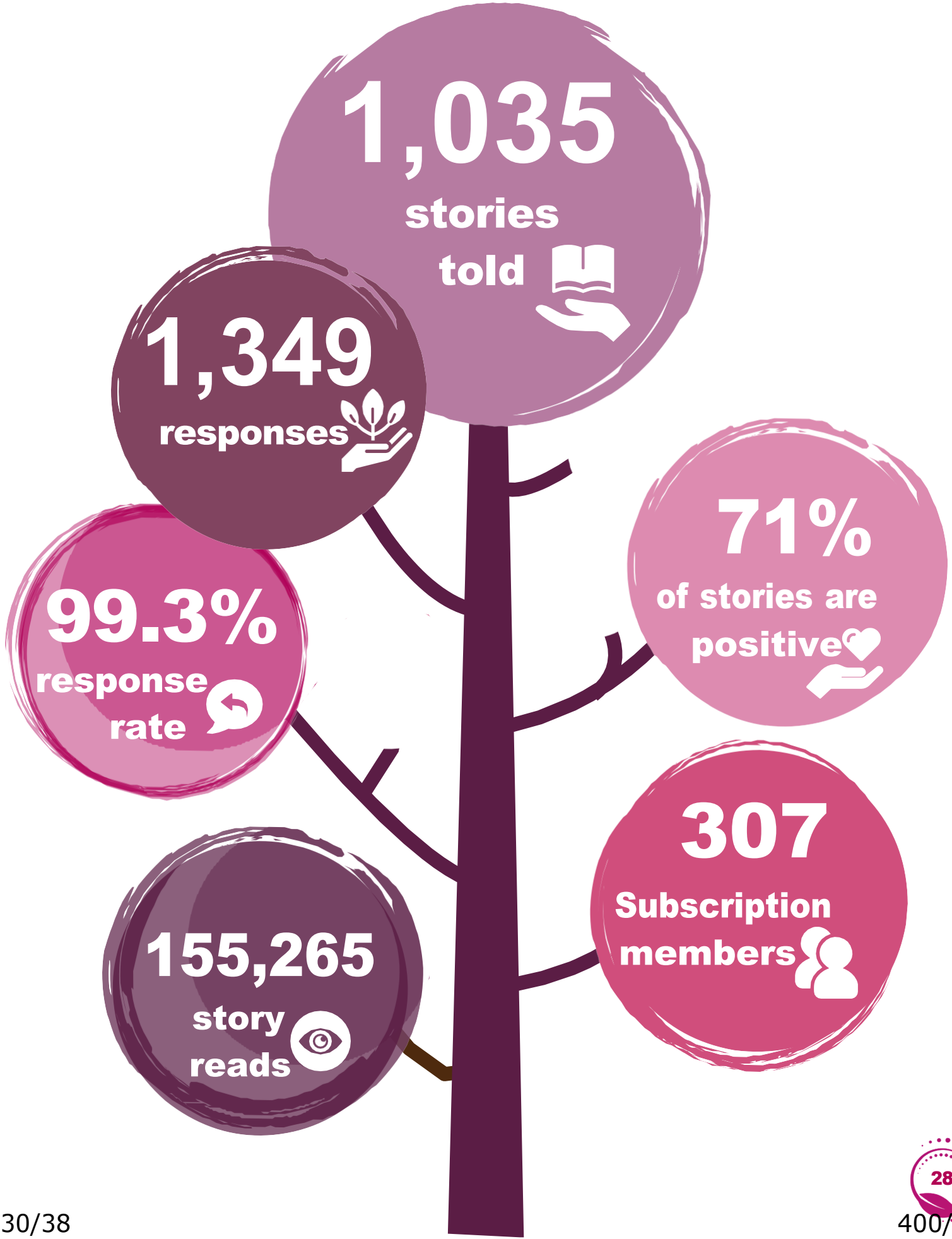


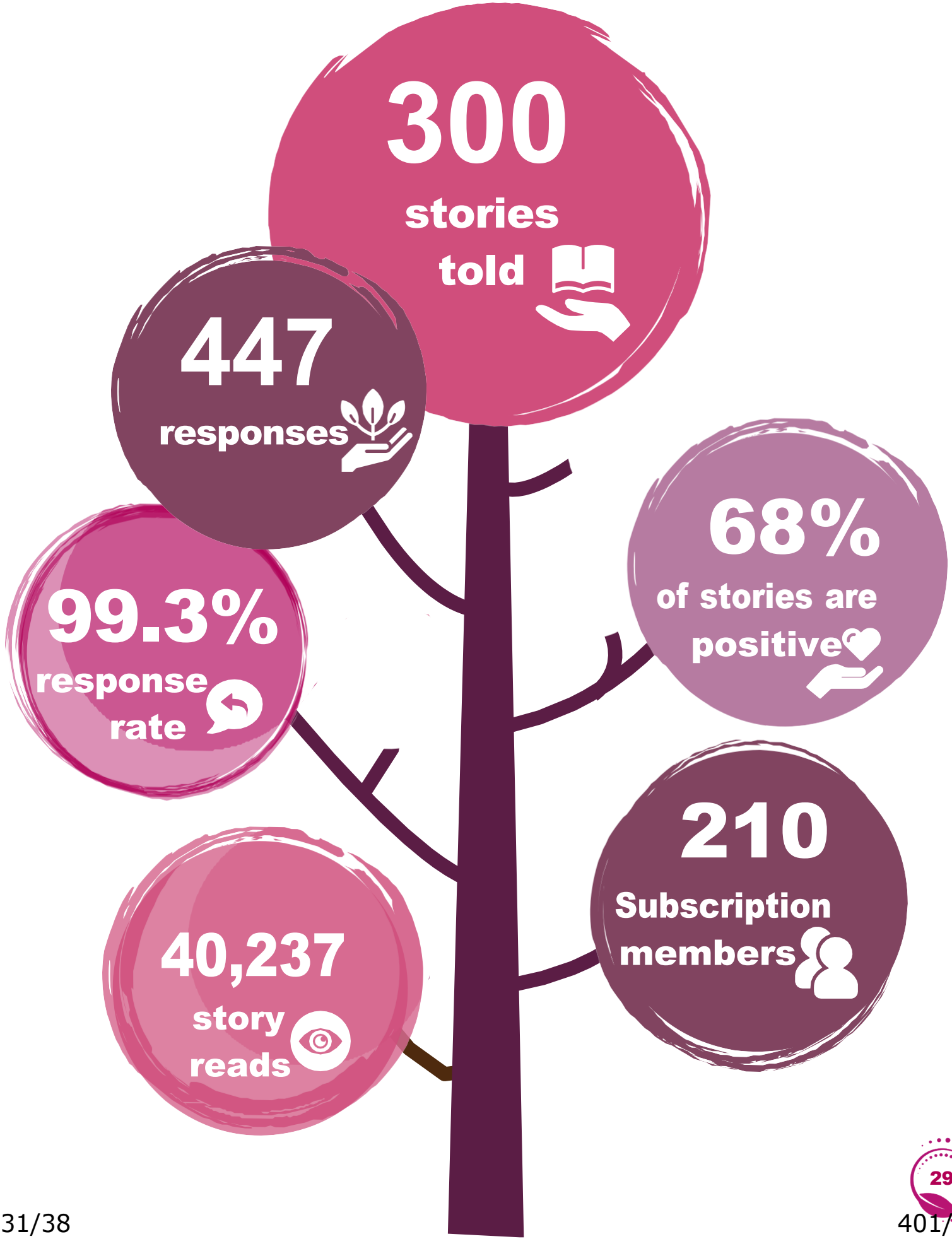
NHS Greater Glasgow and Clyde

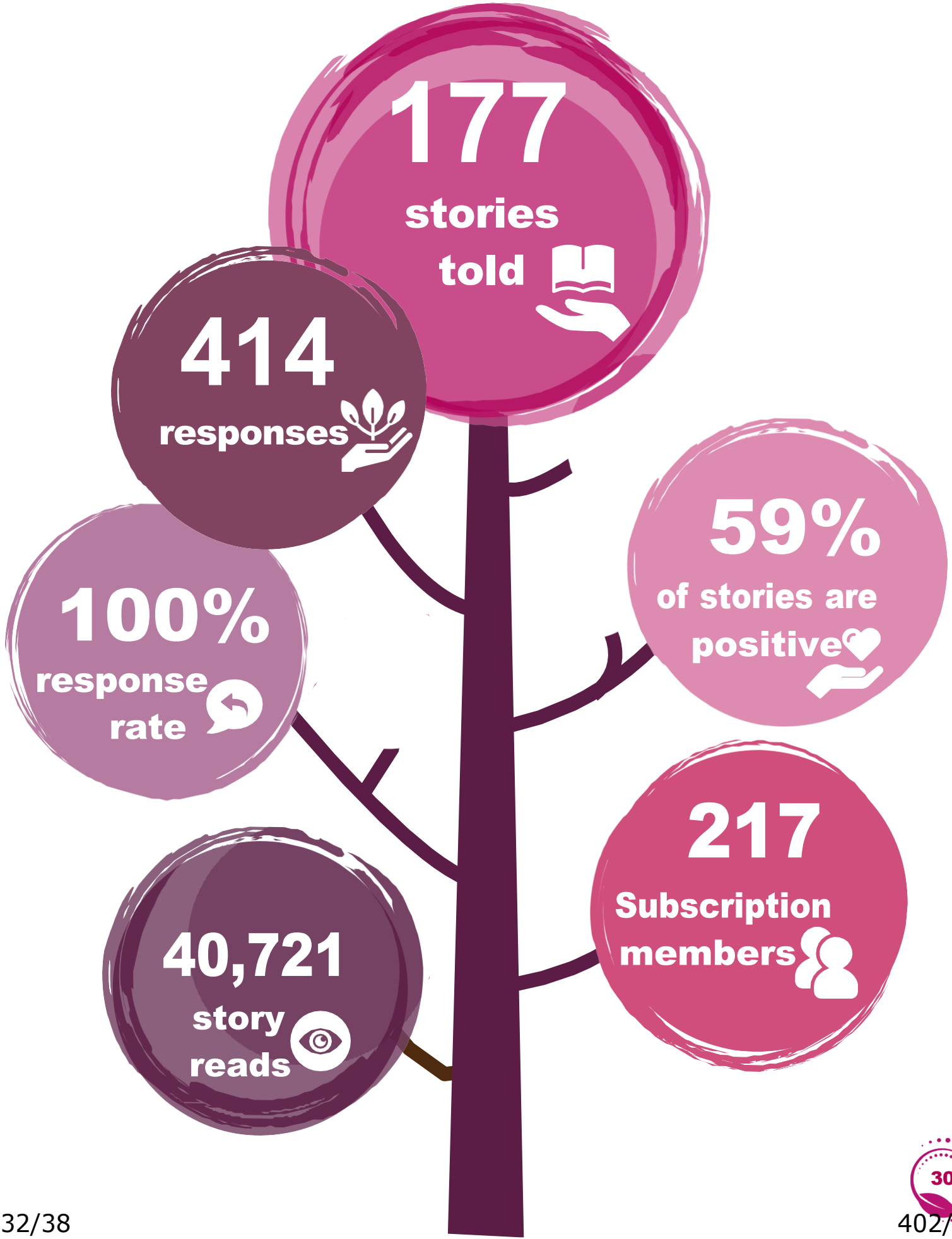


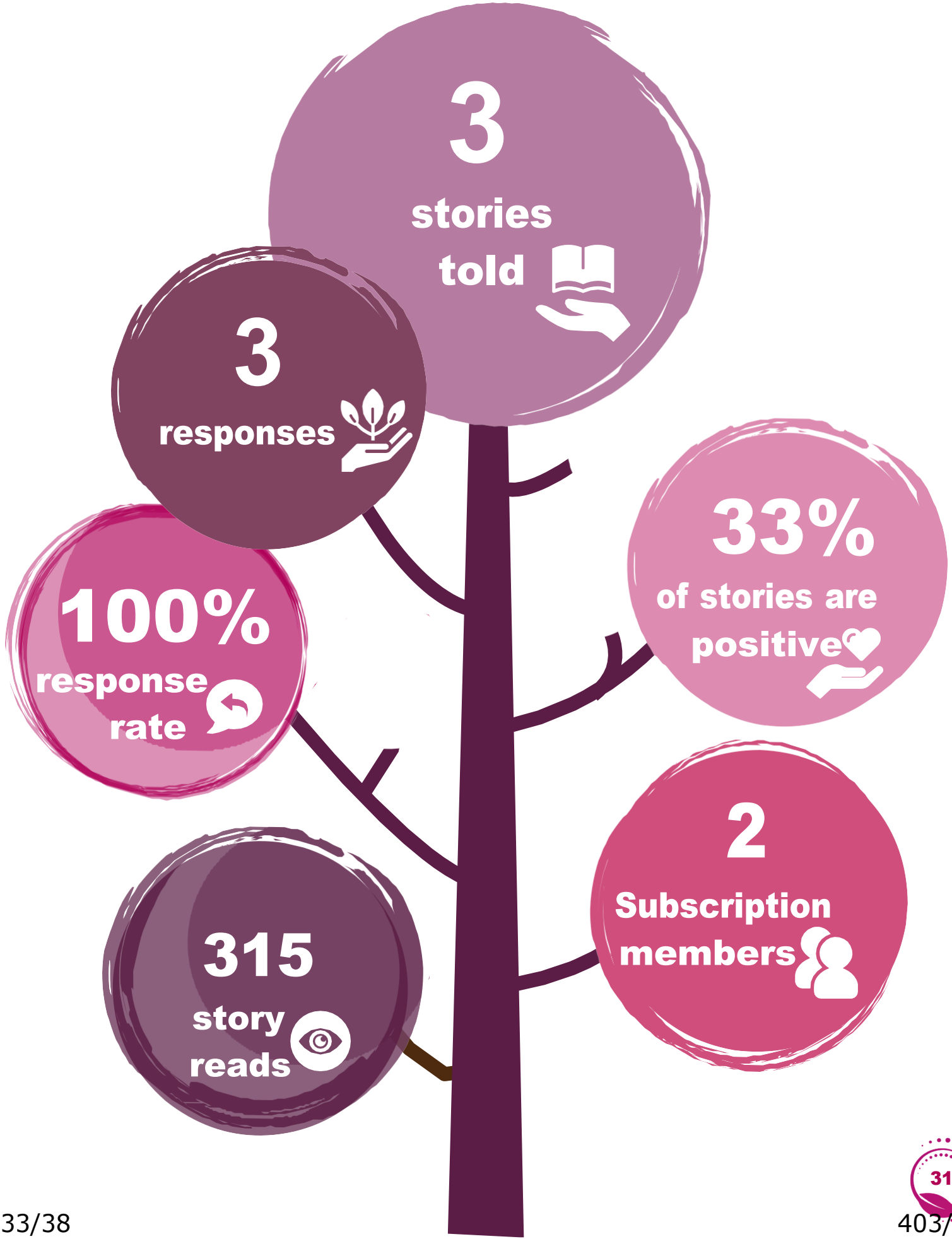

512
stories
told
615
responses
97%
response
rate
70%
of stories are
positive
238
Subscription
members
173,247
story
reads


90
stories
told
68
responses
63%
of stories are
positive
50%
response
rate
68
Subscription
members
11,831
story
reads

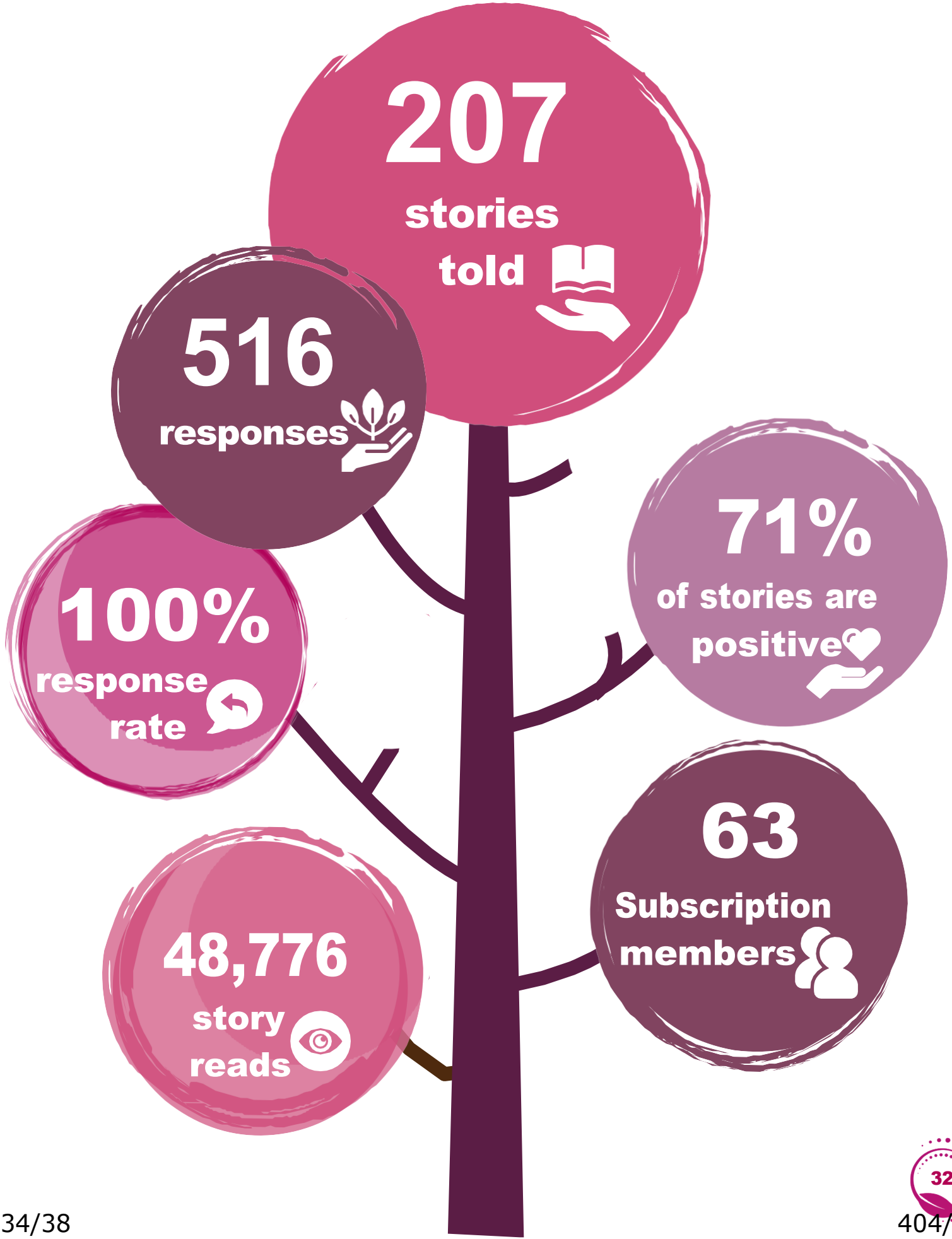

1,035
stories
told
1,349
responses
71%
of stories are
positive
99.3%
response
rate
307
Subscription
members
155,265
story
reads

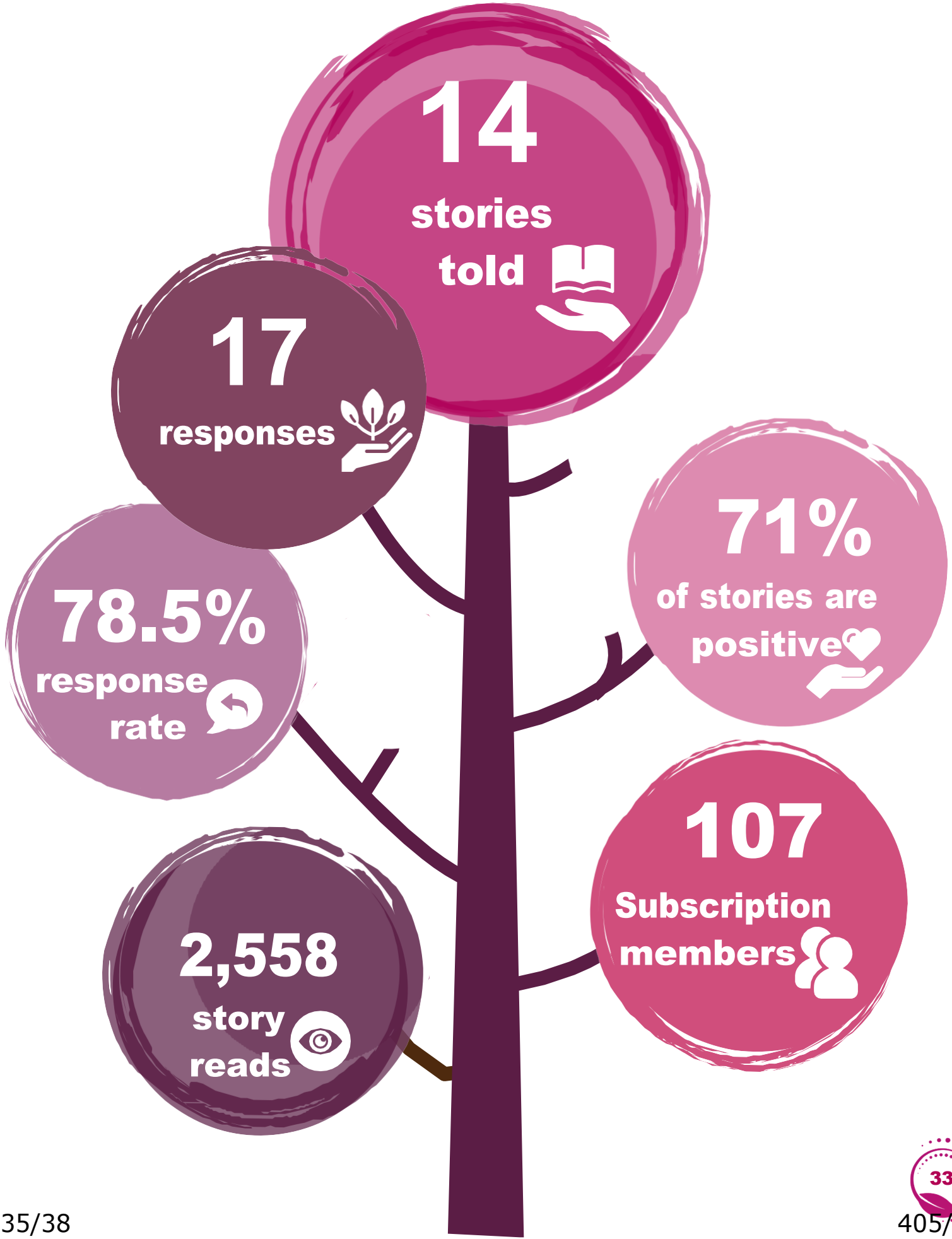

300
stories
told
447
responses
68%
of stories are
positive
99.3%
response
rate
210
Subscription
members
40,237
story
reads

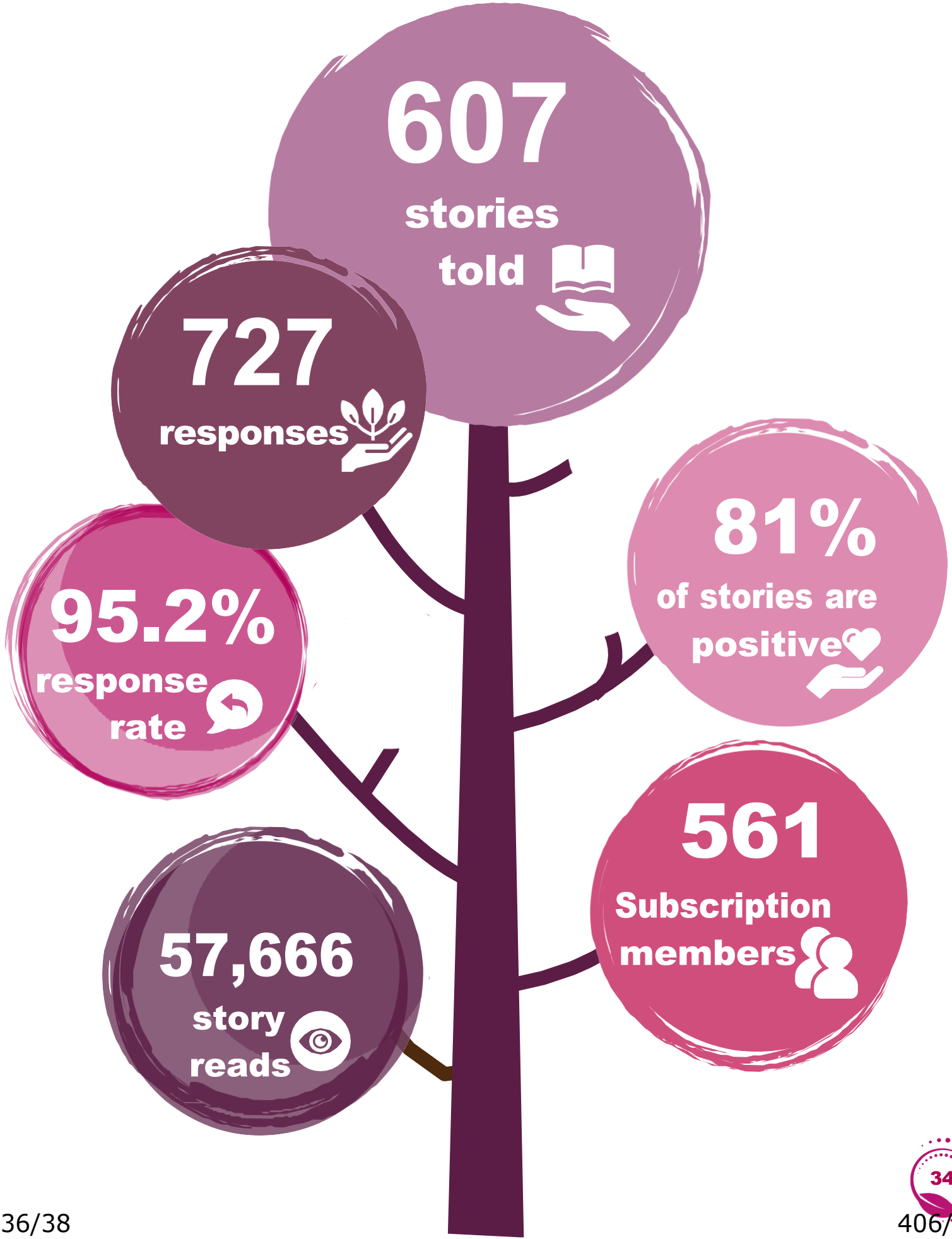

177
stories told
414
responses
59%
of stories are positive
100%
response rate
217
Subscription members
40,721
story reads


3
stories told
3
responses
100%
response rate
33%
of stories are positive
315
story reads
2
Subscription members

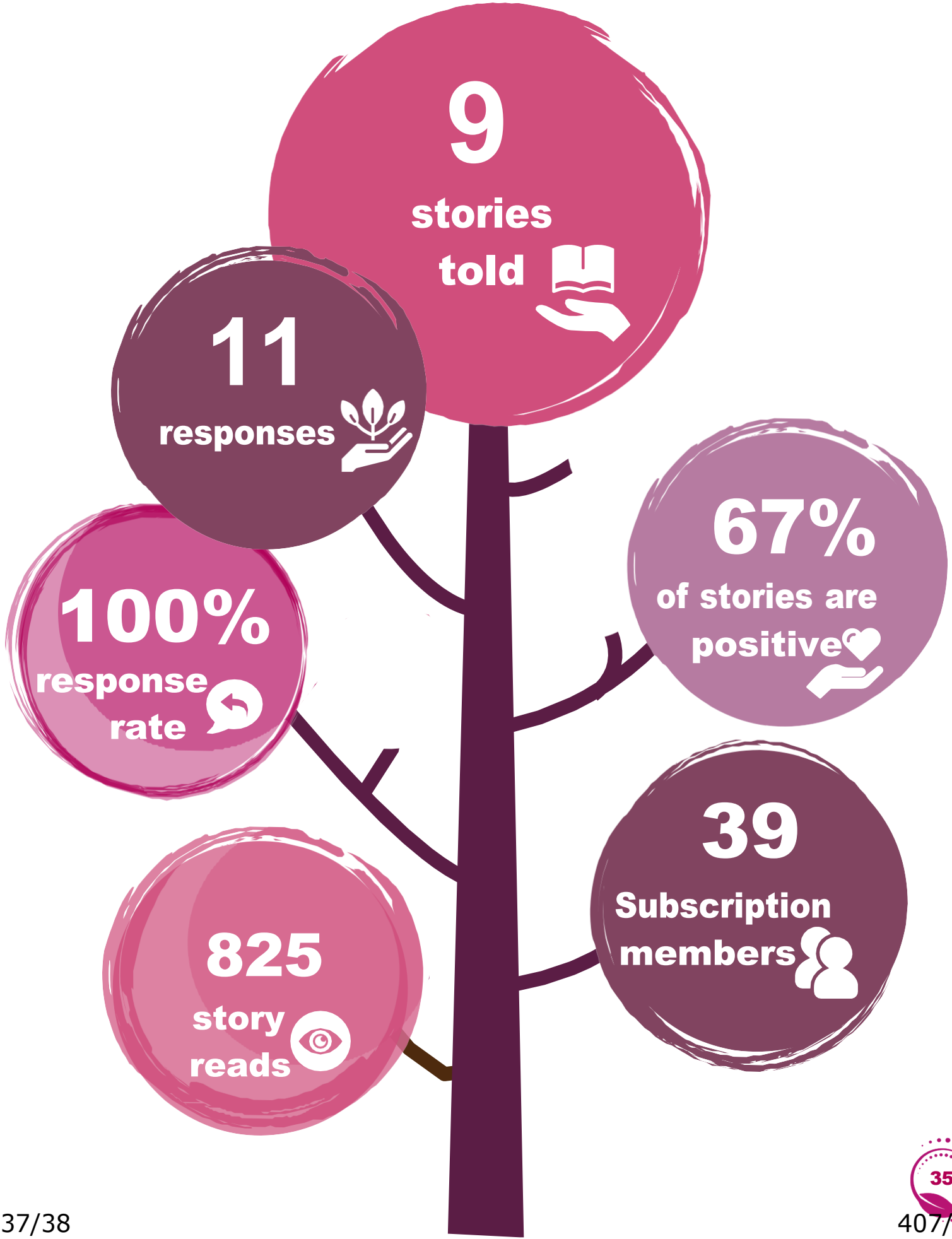
Scottish Ambulance Service




14
stories
told
17
responses
71%
of stories are
positive
78.5%
response
rate
107
Subscription
members
2,558
story
reads


607
stories told
727
responses
95.2%
response rate
81%
of stories are positive
561
Subscription members
57,666
story reads

NHS Western Isles



Contact us

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Care Opinion Scotland: 01786 583 661

@CareOpinionScot

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**8 September 2023**
Title:	**Allied Health Professions' Assurance Frameworks**
Responsible Executive:	**Janette Keenan, Executive Director of Nursing**
Report Author:	**Amanda Wong, Director of Allied Health Professions**

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Legal requirement
- 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 Allied Health Professions Senior Leadership Team recognised the importance of having more robust processes around professional assurance and governance.

Alongside this the team were keen to provide more direction and vision for learning and development, as well as research, knowledge, and innovation. The group has therefore developed three key strategic frameworks in relation to these areas, and this paper is being brought to provide the Clinical Governance Committee with assurance and awareness of these new documents.

2.2 Background

For the purpose of this report, Allied Health Professions is an umbrella term that covers 10 professions: Arts Therapists (Art, Music & Drama), Dietitians, Occupational Therapists, Orthotists, Orthoptists, Physiotherapists, Podiatrists, Prosthetists, Radiographers (Diagnostic and Therapeutic) and Speech & Language Therapists.

Any AHP wishing to practise their profession in the UK must be registered with the Health & Care Professions Council (HCPC) and this registration allows AHPs to practise and needs to be renewed every 2 years. This is to assure the public, patients, employers and other healthcare professionals that registered AHP's are up-to-date and are practising to the appropriate regulatory and professional standards.

However, it was recognised that a more robust assurance was required that included a wider range of measures, including supervision, TURAS(Objectives and PDP) etc. Alongside this two other priority areas were agreed as Learning & Development and Research, Innovation, & Knowledge; both linking strongly in the overarching Professional Assurance and Governance work.

2.3 Assessment

AHP registration is a two yearly process, and in the past we have checked the re-registration of staff on a two yearly basis (not all professions re-register with the HCPC at the same time given the number of professions the regulator oversees); however, it has been recognised that this is not adequate with the changes to the payment structure for fees, and therefore we required to review and tighten up this process.

This provided the AHP Senior Leadership Team an opportunity to provide a framework for all staff which would be a repository for all the information required by any individual or manager; and also a clear template for what was required to report and the timescales around this. You will find this all in the document in Appendix 1.

In developing this framework, we identified two areas that linked very closely with this; Learning & Development, and Research, Innovation & Knowledge. The AHP SLT took this opportunity to commission two separate pieces of work through already established AHP groups to develop strategic frameworks around these. Appendix 2 is the AHP Learning and Development providing a clear vision and direction for the overarching themes across all the professions, which will allow them to then focus on profession specific work. There will be a clear delivery plan that will sit alongside this document. Appendix 3 is the Research Innovation and Knowledge Strategic Framework, and this provides clear vision, direction and expectations for everyone around this area. The group is working on the development of a career escalator to sit alongside this document that will support staff to better understand the different levels within different job roles.

These three documents provide an improved vision and direction for all AHP services and professions across Fife, as well as more robust assurance and governance processes to underpin them. Overall, this will provide improvements for the organisation, staff and most importantly to ensure patient and public safety.

2.3.1 Quality / Patient Care

Regular supervision, appraisal and PDP setting ensures that registered AHP's are up-to-date and are practising to the appropriate regulatory and professional standards. The re-registration process also provides an opportunity to provide further evidence, by using the formal appraisal and PDP structures and Continuing Professional Development Portfolio documentation to support the professional declaration.

The Learning and Development Framework provides direction and information based around the four pillars of practice and the NES career framework, this aids staff at all levels to continually develop and career plan and links with the TURAS processes mentioned above.

2.3.2 Workforce

This continues to be challenging for all those working in the health and care services. However, supervision, appraisal and PDP activities were continued throughout to ensure staff could provide adequate evidence to allow re-registration to take place. These documents support all of this underpinning work.

2.3.3 Financial

NA

2.3.4 Risk Assessment / Management

NA

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

NA

2.3.6 Climate Emergency & Sustainability Impact

NA

2.3.7 Communication, involvement, engagement and consultation

AHP SLT has communicated with a range of AHP group, including AHPCAF, APH L&D Group and the AHP RIK Group. With groups undertaking commissioned work as well as providing feedback. All of these groups have a wide range of representation across the professions and from teams across the organisation.

2.3.8 Route to the Meeting

EDG

2.4 Recommendation

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

3 List of appendices

The following appendices are included with this report:

- Appendix No. 1: AHP Professional Assurance and Governance Framework
- Appendix No. 2: AHP Learning and Development Framework 2023-2026
- Appendix No. 3: AHP Research, Innovation and Knowledge Strategic Framework 2023-2026

Report Contact
Amanda Wong
Director of AHPs
Email amanda.wong@nhs.scot

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

NHS Fife

ALLIED HEALTH PROFESSIONS

PROFESSIONAL ASSURANCE & GOVERNANCE FRAMEWORK

PROFESSION: ALL

1. Introduction

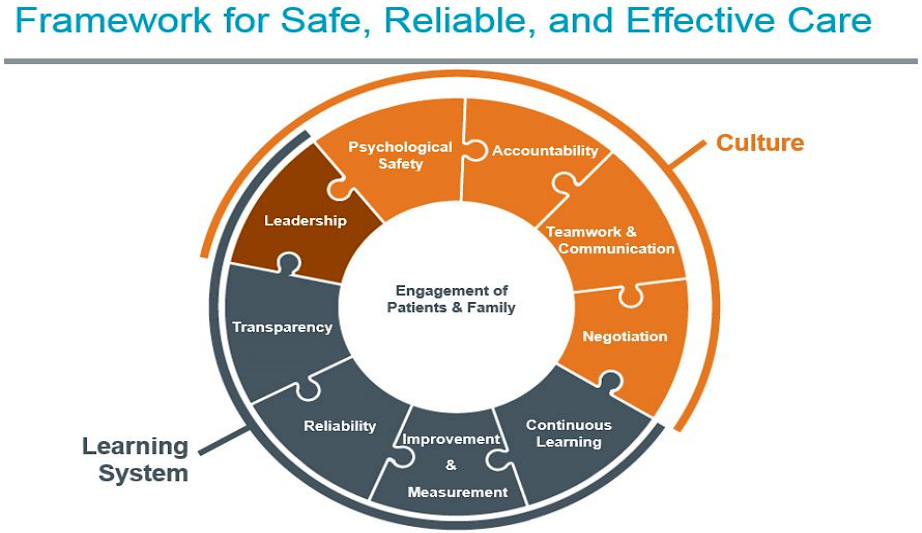
The Allied Health Professions (AHPs) are a diverse group of healthcare professionals who undertake diagnostic, technical, and therapeutic interventions. In NHS Fife the term AHPs covers 12 professional groups: Arts Therapy (Art, Drama, Music), Dietetics, Occupational Therapy, Orthoptics, Orthotics, Physiotherapy, Podiatry, Radiography (Diagnostic, Therapeutic) and Speech & Language Therapy.

The NHS Fife AHPs Professional Assurance & Governance Framework is a comprehensive set of guidance and standards designed to ensure the professional development and accountability of all AHP staff across our system.
This framework outlines the professional standards and expectations for all AHP staff, including registered practitioners, non-registered practitioners, and students. The goal of the framework is to ensure consistency in the provision of high quality, person-centred care, and interventions, by all AHP staff, in line with the values and objectives of NHS Fife. This is all underpinned by the Model for Good Governance, NHS Education Scotland 4 Pillars of Practice, the Principles of Excellence in Care, and the IHI Framework of Safe, Reliable, and Effective Care.

2. Professional Standards and Expectations

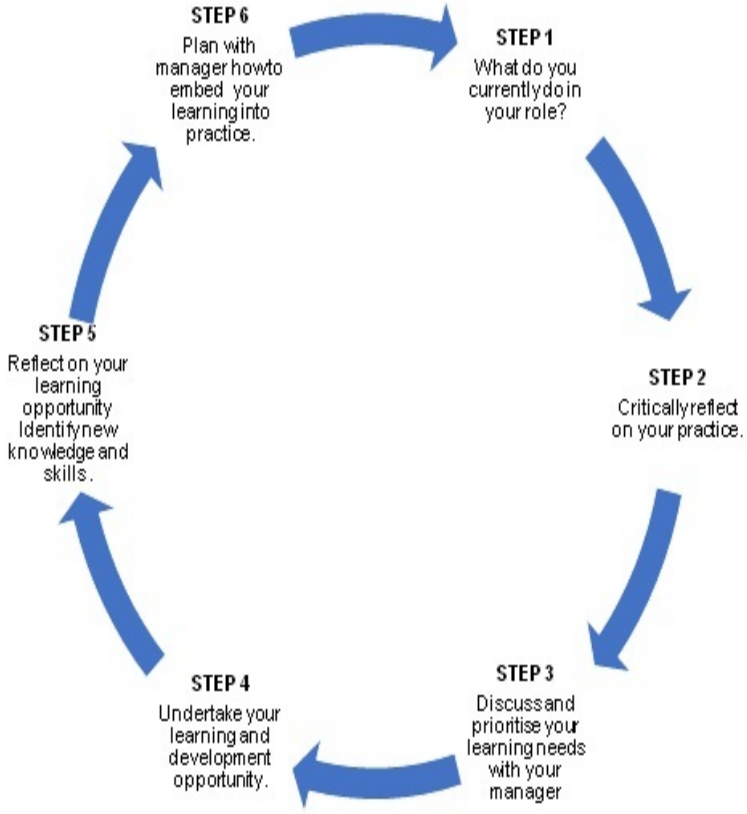
Professional standards and expectations are critical components in ensuring the quality and reliability of our services. They set the benchmark for professional behaviour, and technical competency, providing a framework for the delivery of consistent, high-quality services to communities. In this document, we outline the professional standards and expectations that guide our practice, including ethical principles, technical proficiency, and a commitment to continuous improvement. This document serves as a reference, as well as a reminder to our teams of the principles and values that drive our work.

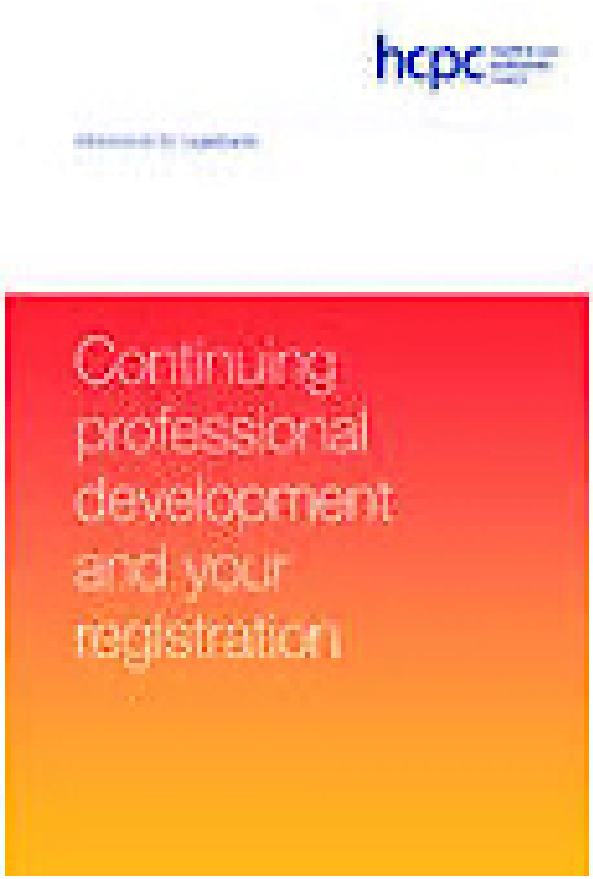
Excellence in Care, SG



3. Professional Development and Continuing Education

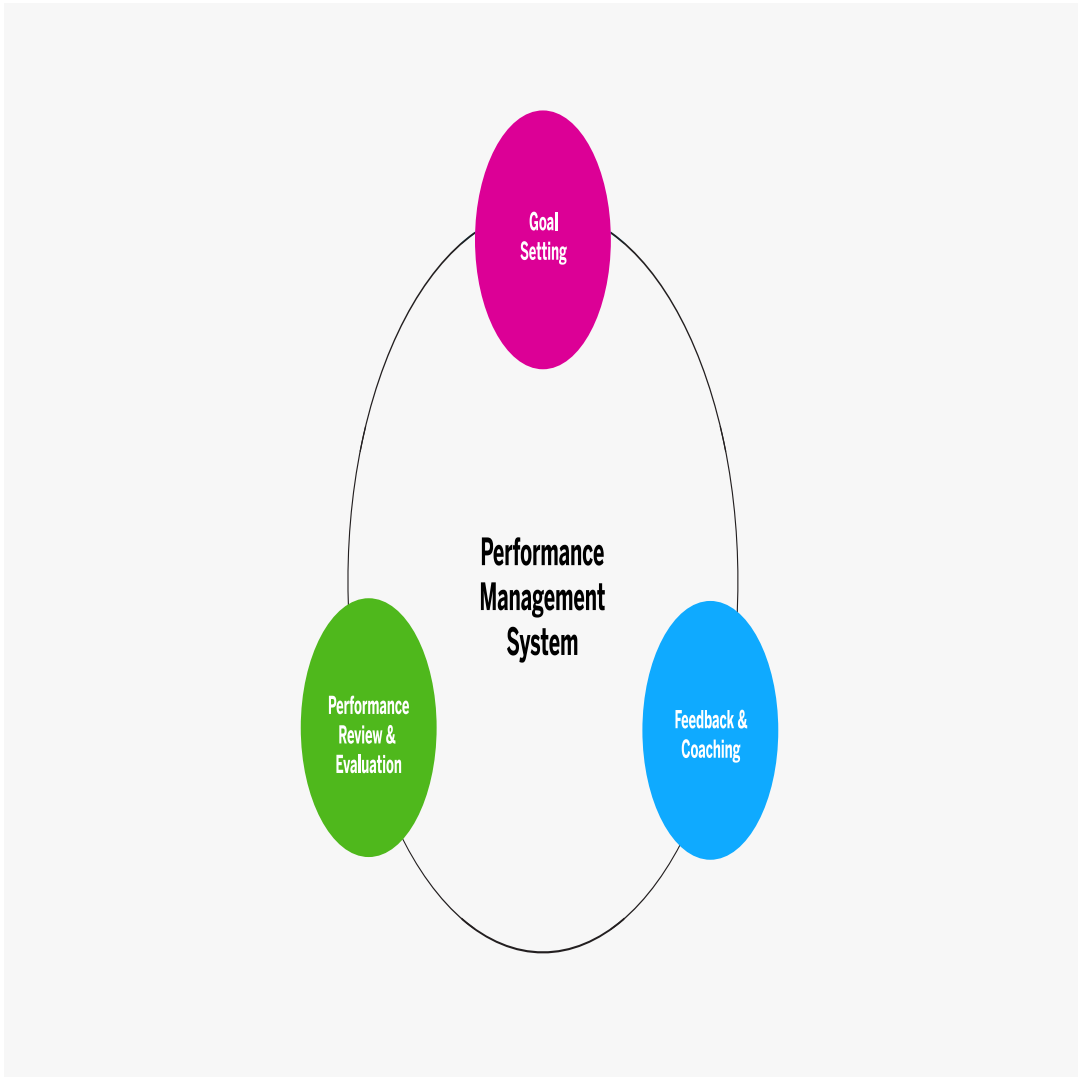
Professional development and continuing education are crucial in maintaining and enhancing the competencies and skills of all staff. The staff will use the evidence base available to support their interventions including the latest advancements, technologies and best practices, as this is essential in delivering effective and high quality services to our communities. In this document, we emphasise the importance of ongoing learning and professional growth of our team members. We outline the programmes and initiatives we have in place to support professional development and continuing education, and our commitment to providing the resources and opportunities necessary for our teams to deliver the best for their patients/clients, supported by the right person, with the right skills at the right time.

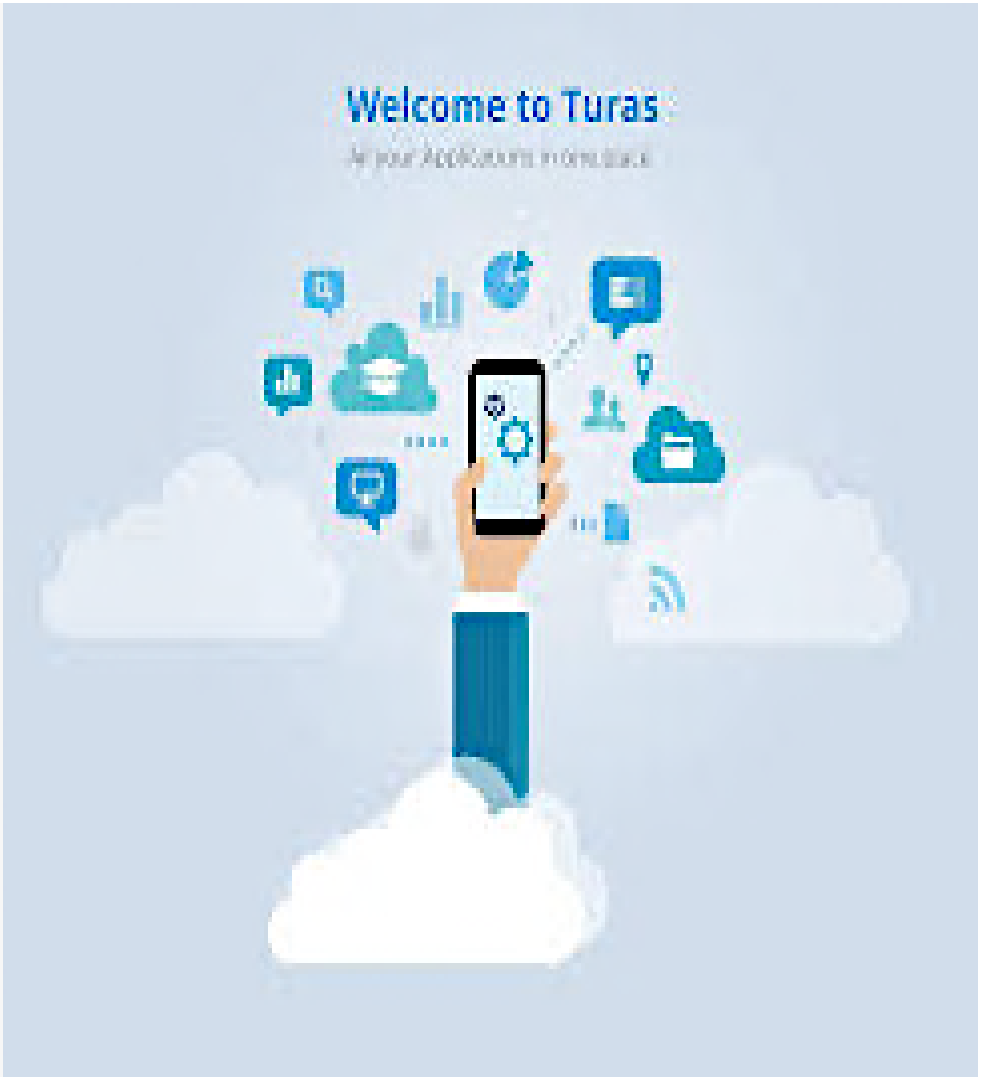




4. Performance Management and Evaluation

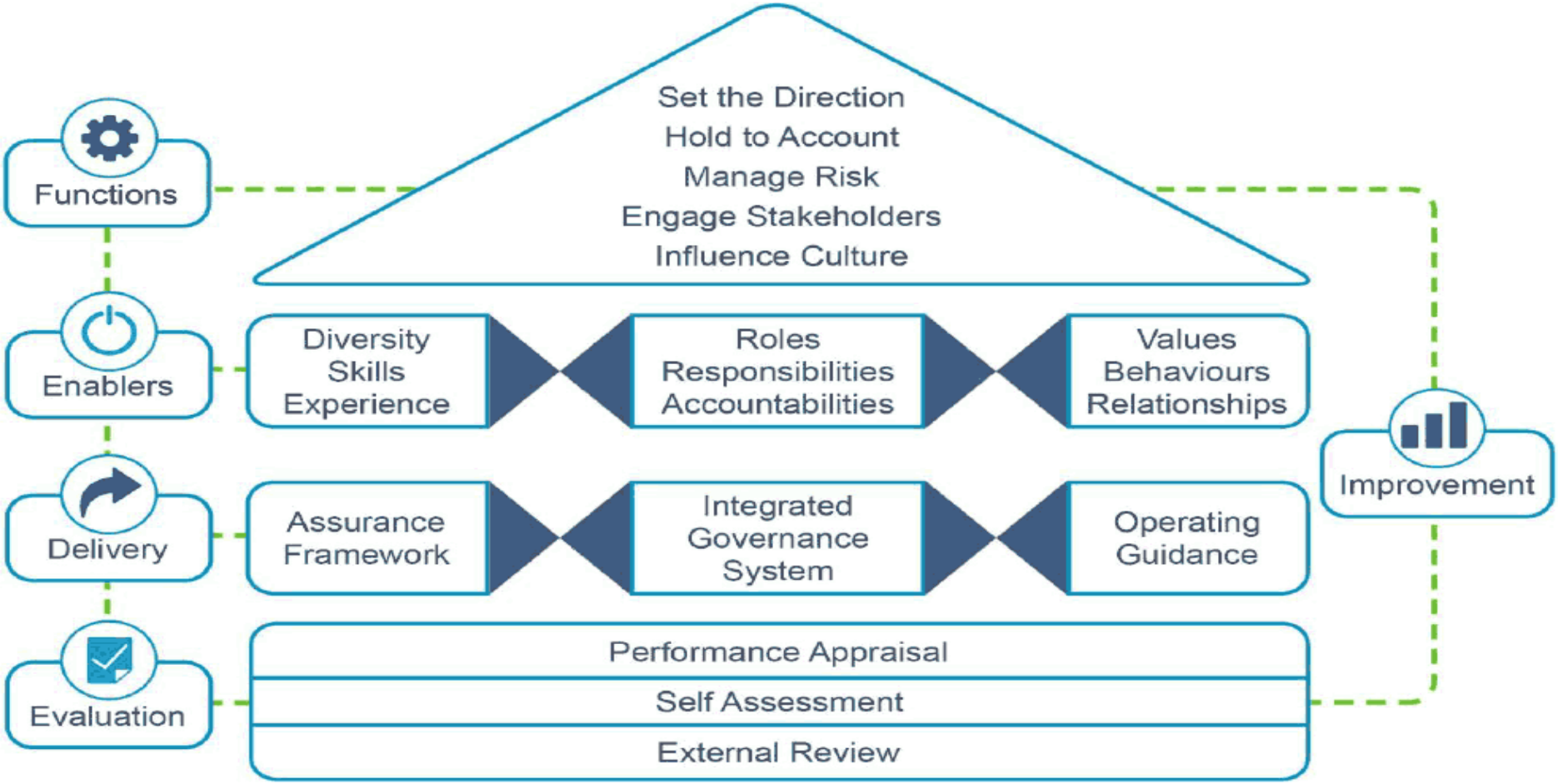
Performance management and evaluation are integral parts of ensuring high-quality care and services across the AHP's. They provide a framework for ongoing assessment of individual, team and service performance, and support continuous improvement in the delivery of care. In this document, we outline our approach to this for all AHP's. We emphasise the importance of regular performance feedback, appraisal, and professional development opportunities, and outline the process and tools we use to ensure that our team members are meeting our standards and expectation.





5. Governance and Oversight

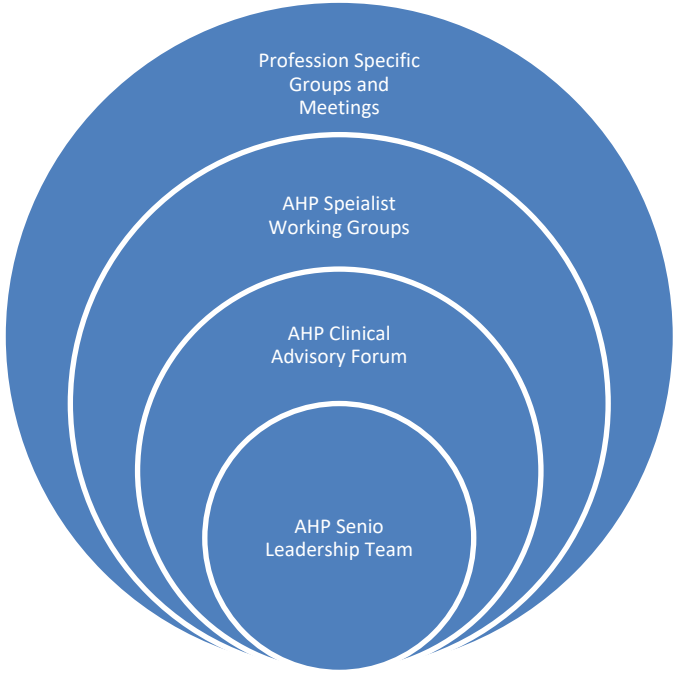
Governance and oversight are required to ensure appropriate accountability, transparency and the quality of care AHP's deliver. They provide a framework for the management of resources and decision-making and ensure that services are delivered in a manner consistent with ethical and professional standards. In this document, we provide the governance and oversight structure that guides all AHPs. We discuss the roles and responsibilities of individuals and regulatory and professional bodies, the processes and policies that ensure compliance with regulatory requirements and our commitment to transparency and accountability in the delivery of services. This document serves as a reminder to our teams of the importance of upholding the highest standards of governance and oversight in the provision of all our services.



The Blueprint for Good Governance, Scottish Government 2022

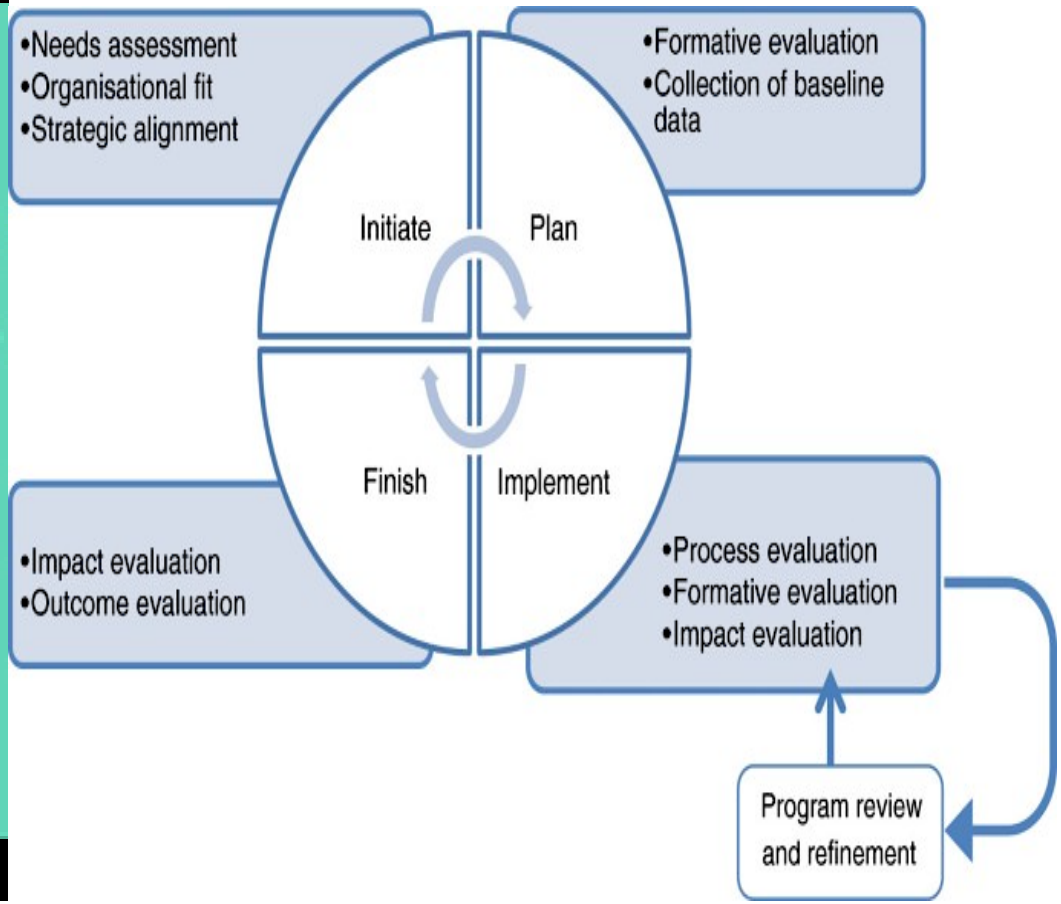
6. Reporting and Communication

Reporting and communication enable the exchange of information and feedback between different stakeholders, support informed decision-making, and promotes transparency and accountability in the provision of services. This document will outline our approach to reporting and communication; we will discuss the various channels and methods we use to communicate, and emphasise the importance of timely, accurate and relevant reporting.



7. Implementation and Review

Implementation and review are important steps to ensure services are delivered effectively and according to the established standards and expectations. They provide a mechanism to monitor the implementation of any changes and ensure that practices are consistent with our established policies and procedures. This document will outline the processes we have in place for the implementation and review of our services to provide assurance to the organisation. We encourage regular review and evaluation to ensure that our services are meeting the needs of our communities, and that we are continuously improving our practices where appropriate.



BMC Public Health 2014

8. References and Resources

- **Blueprint for Good Government, 2nd Edition, Scottish Government, November 2022: Blueprint for Good Governance**

Professional Bodies

- **British Association for Music Therapy:** BAMT Guide to Professional Practice & Code of conduct
- **British Association of Art Therapists:** https://baat.org/about/code-of-ethics/
- **British Association of Dramatherapists:** Code of Practice
- **British Association of Prosthetists and Orthotists:** Ethical Code Standards of Practice
- **British and Irish Orthoptic Society**: BIOS Standards and Guidance
- **British Dietetic Association:** Code of Professional Conduct
- **Chartered Society of Physiotherapy: Code of Professional Values and Behaviours 2019**
- **Royal College of Occupational Therapy: professional-standards-occupational-therapy-practice-conduct-and-ethics&data**
- **Royal College of Podiatry:** RCoP podiatric-practice/ professional-resources-area/standards
- **Royal College of Speech and Language Therapists**: RCSLT Guidance Standards
- **Society of Radiographers: SoR Code of Professional Conduct**

Health and Care Professions Council Documents

- **Health and Care Professions Council Standards of Conduct Performance and Ethics:** Standards of conduct, performance and ethics

Health and Care Professions Council Standards of Proficiency (By Profession)

- Arts therapists
- Chiropodists / podiatrists
- Dietitians
- Occupational therapists
- Orthoptists
- Physiotherapists
- Prosthetists / orthotists
- Radiographers
- Speech and language therapists

APPENDIX 1

Annual Stocktake

PRIMARY DRIVER 1:	**SECONDARY DRIVERS:**
Practitioners are equipped, supervised and supported according to regulatory requirements	Each registered practitioner meets professional regulatory HCPC requirements Staff with the right skills and values are recruited in line with HR requirements Staff undertake mandatory training and continuing professional development activities Staff are managerially supervised and formally appraised Staffing levels are informed by local & National Workforce and Workload Planning tools underpinned by the Common Staffing Methodology There is an underpinning agreement with relevant Higher Education Institution to govern student placements Continuing 'fitness to practice' requirements are fully met

No.	STEPS TO SECONDARY DRIVERS	INDICATORS	EXAMPLES OF EVIDENCE	UPDATE / PROGRESS	STATUS
1.1	Practitioners work to HCPC Standards of conduct, performance and ethics	All Fitness to Practice referrals are made through the Director of AHPs to ensure that they are fully aware of all referrals	Director of AHP's 6 monthly HCPC reports		
1.2	An up-to-date record is held of each practitioner's registration details, including re-registration	HCPC Registration data (websites)	Directorate / Department database reviewed 6 monthly on dates which are in keeping with direct debit payment schedules for each profession		
1.3	A senior AHP (appropriate to the specific profession) is involved in the recruitment of all AHPs as appropriate	Recruitment policy/process	Recruitment monitoring data		

1.4	Professional values and attitudes are explicitly assessed as part of the interview process (values based interviews)	Recruitment policy/process/training	Recruitment monitoring data		

No.	STEPS TO SECONDARY DRIVERS	INDICATORS	EXAMPLES OF EVIDENCE	UPDATE / PROGRESS	Status
1.5	Each practitioner holds their own training record and understands their responsibility, along with their manager, for meeting mandatory training requirements	Personal Development Planning and review (PDR) statistics	Individual learning and development records CPD Portfolios		
			Mandatory training records TURAS PDP reviews data		
1.6	Performance appraisal is undertaken by operational line managers. A senior AHP must be involved in the appraisal meeting if the line manager is not employed as a Registered AHP.	Performance appraisal records			
1.7	Practitioners have access to professional supervision (as part of regular supervision or as a separate arrangement where the normal supervisor is not of the same Profession)	Method and capacity to provide and monitor uptake of professional supervision	Supervision contract agreements in place		

1.8	Inter-agency / cross-professional formal education and development is monitored through governance arrangements		Through Public Protection Committees		

No.	STEPS TO SECONDARY DRIVERS	INDICATORS	EXAMPLES OF EVIDENCE	UPDATE / PROGRESS	Status
1.9	Implementation of NES, HCPC and Profession specific quality standards	Practice Education Lead(PEL) reporting; NES performance management reports: Profession specific annual reports			
1.10	AHP Staffing levels are informed by utilising available local and national aids and where available workforce and workload planning tools. Where tools are not available; participate in the development and trialling of any tools.	Tools are run as a minimum on an annual basis with reports prepared for Staff Governance Committee, Executive Directors Group and NHS Fife Board			
		Tools are used in redesign projects Escalation processes in place to manage staffing levels			

PRIMARY DRIVER 2:	SECONDARY DRIVERS:
Dispersed professional leadership focuses on outcomes and promotes a culture of interagency parity and respect	A team culture of collaboration is the norm through cross-professional/agency formal education and development Staff have the interpersonal skills and leadership ability to engage constructively in multi-agency partnership to achieve outcomes The unique contribution and accountability of professional roles in integrated care settings is clear Staff understand and have easy access to guidance on their professional accountability in multiagency teams where role blurring is expected Staff have access to formal supervision to discuss professional practice

No.	STEPS TO SECONDARY DRIVERS	INDICATORS	EXAMPLES OF EVIDENCE	UPDATE / PROGRESS	Status
2.1	Senior practitioners have access to leadership development in partnership working and leading across organisational boundaries	AHP profession specific leadership and professional reporting structure	% staff undertaking multi-agency leadership development programmes reported through the professional reporting structure to the Director of AHPs		
2.2	Senior practitioners have professional support and training in order to be able to engage constructively in multi-agency partnership, supervision of nurses, midwives & AHPs	Compliance with multi-agency leadership development programmes and other learning opportunities. Senior Leadership Team: monthly meetings			
2.3	Protocols are in place to support and advise practitioners on delegation of clinical and non-clinical activities within the NHS and in multi-agency settings	Compliance with protocols on role clarity Compliance with protocols on delegation principles in multiagency settings Compliance with protocols on professional accountability and reporting processes			

2.4	An appropriate senior AHP Professional Lead agrees staffing levels/skill mix with operational managers informed by local and national tools	Common Staffing Method Local and national Tools where available	Annual or more frequent use of tools with outputs used for discussions around staffing levels, skill mix etc		

No.	STEPS TO SECONDARY DRIVERS	INDICATORS	EXAMPLES OF EVIDENCE	UPDATE / PROGRESS	Status
2.4 cont	An appropriate senior AHP Professional Lead agrees staffing levels/skill mix with operational managers informed by local and national tools (as previous page)	Patient record audits (outcome data)			
		Patient feedback data			
		Staff feedback data			
		Staff absence data			
		Staffing establishments and levels			
2.5	An explicit decision-making process underpins which professional is most appropriate to provide specific aspects of care based on	Compliance with protocols on delegation principles in multiagency settings			

	assessed need and person-centred outcomes.				
2.6	An independent and objective senior AHP sits on disciplinary panels where professional conduct /competence is an issue	Compliance with policy on Employee Conduct			

No.	STEPS TO SECONDARY DRIVERS	INDICATORS	EXAMPLES OF EVIDENCE	UPDATE / PROGRESS	Status
2.7	A system is in place to enable all staff to raise a concern if they are asked to undertake a task for which they do not feel competent	Compliance with protocols on professional accountability and reporting processes			

PRIMARY DRIVER 3:	SECONDARY DRIVERS:
There is clear accountability for standards and professionalism at each level to the NHS Fife Board and Scottish Government	Senior professional leaders are engaged in all decisions affecting AHPs An escalation process is in place to raise issues of concern Vacancy levels, reasons for absence and temporary staffing-use are monitored A process measurement is used to demonstrate/improve caring behaviours A summary of learning and improvement from quality measures such as indicators, complaints and critical incident investigations are made available There is a system in place for operational and professional managers to jointly review data

No	STEPS TO SECONDARY DRIVERS	INDICATORS	EXAMPLES OF EVIDENCE	UPDATE / PROGRESS	Status
3.1	There is a formal system for involving a senior AHP in professional issues involving AHPs e.g. HR issues, the workforce and	HR Policies Recruitment Policy and Procedures			

	clinical governance implications of service design/redesign				
3.2	The senior AHP reviews workforce data with operational managers e.g. actual against proposed skill mix, vacancies, absence rates	Workforce data e.g. skill mix reviews, staff vacancies, temporary staffing use (agency and bank)			
		Core mandatory quarterly attendance statistics, capability, disciplinary and grievance data			

No.	STEPS TO SECONDARY DRIVERS	INDICATORS	EXAMPLES OF EVIDENCE	UPDATE / PROGRESS	Status
3.3	A measure is used to demonstrate / improve professional behaviours	Care Opinion			
3.4	Summaries of learning and improvement from quality measures (such as quality indicators, complaints and critical incident investigations) are used for organisational learning and are embedded within governance structures	Risk management reports			
		Critical incident review reports SAERs			
		Learning summaries from SAERs			
		Escalation reports and outcomes			
3.5	A recognised and well-publicised escalation process is in place to ensure AHPs are	Escalation reports and outcomes			

	able to bring concerns to the attention of senior managers and that they receive feedback				

No.	STEPS TO SECONDARY DRIVERS	INDICATORS	EXAMPLES OF EVIDENCE	UPDATE / PROGRESS	Status
3.6	PIN Guidelines and Policies underpin practice	Core mandatory quarterly attendance statistics, capability, disciplinary and grievance data			

PRIMARY DRIVER 4:	**SECONDARY DRIVERS:**
NHS Fife Board has a clear understanding about the quality of the AHP services	There is a direct reporting link from each level through the Director of AHP's to the Executive Director of Nursing The Director of AHP's and the Executive Director of Nursing is aware of areas of concern and seeks further assurance and improvement The AHP Senior Leadership Team supports the Executive Director of Nursing and models effective professional leadership Retrospective and 'real time' performance data is reviewed at NHS Board level There is a reporting and escalation mechanism in place for professional assurance to the CNO/CAHPO acting on behalf of the named government minister

No.	STEPS TO SECONDARY DRIVERS	INDICATORS	EXAMPLES OF EVIDENCE	UPDATE / PROGRESS	Status
4.1	There is a formal system for reporting to the Director of AHPs on professional issues involving AHPs	Complaints, compliments and critical incident statistics and reports (including reports of near misses)			
		Staffing and skill mix review reports			
		Records of referrals to HCPC and outcome of investigations and hearings			

		Pre and Post Registration Education Placement Audit reports			
		Patient feedback data Staff feedback data			

No.	STEPS TO SECONDARY DRIVERS	INDICATORS	EXAMPLES OF EVIDENCE	UPDATE / PROGRESS	Status
4.1 cont	As previous page There is a formal system for reporting to the Director of AHPs on professional issues involving AHPs	Risk management data (e.g. DATIX reports)			
		Specific Scottish Patient Safety Programme indicators			
4.2	A quality report is made to the NHS Fife Board via relevant governance structures which triangulates indicators of workforce and professionalism with relevant aspects of scrutiny and review reports and demonstrates evidence of the learning and continuous improvement arising from these.	Independent scrutiny reports, action plans and progress reports			
		NHS Fife Integrated Performance Report			
		NHS Fife Quality Report			
		Ombudsman reports			
		Healthcare Improvement Scotland inspection reports and audits			
4.3	There is a reporting and escalation mechanism in place for professional assurance to the CAHPO acting on behalf of				

	the named government minister				

COMPLETED BY:	HoS SIGN OFF:	DoAHPs SIGN OFF:
DATE:	DATE:	DATE:

APPENDIX 2

APPENDIX 3 PAF Descriptors

HCPC (Quarterly)

% compliance
Total number of HCPC Registered staff divided by the total no of registered staff.
Target compliance 100%

PDP (Quarterly)

% compliance
Total number of staff with an identified PDP (TURAS) divided by total number of staff (registered and non-registered HCSW).
Target compliance 80% allows for new starts and staff absence.

Objectives (Quarterly)

% compliance
Total number of staff with active objectives (TURAS) divided by total number of staff (registered and non-registered HCSW).

Supervision- 2 figures

% compliance **(annual)**
Total number of staff who have a supervision agreement in place divided by total number of staff, registered and non-registered.
Target compliance 80% allows for new starts and staff absence.

% compliance **(x2/year)**

number of staff who have received as a minimum x2 supervision in the previous 6 months divided by total number of staff; registered & non-registered.
Target compliance 80% allows for new starts and staff absence.

Vacancy Rate (Quarterly)

% vacancy factor. The number of unfilled posts divided by total number of posts; registered and non -registered staff calculated on the day of data collection.

Absence Rate (Quarterly)

% absence; The number of staff absent / off sick divided by total number of staff; registered and non -registered staff on the day of data collection. This does not include staff on maternity leave, study leave.

AHP Learning and development Framework

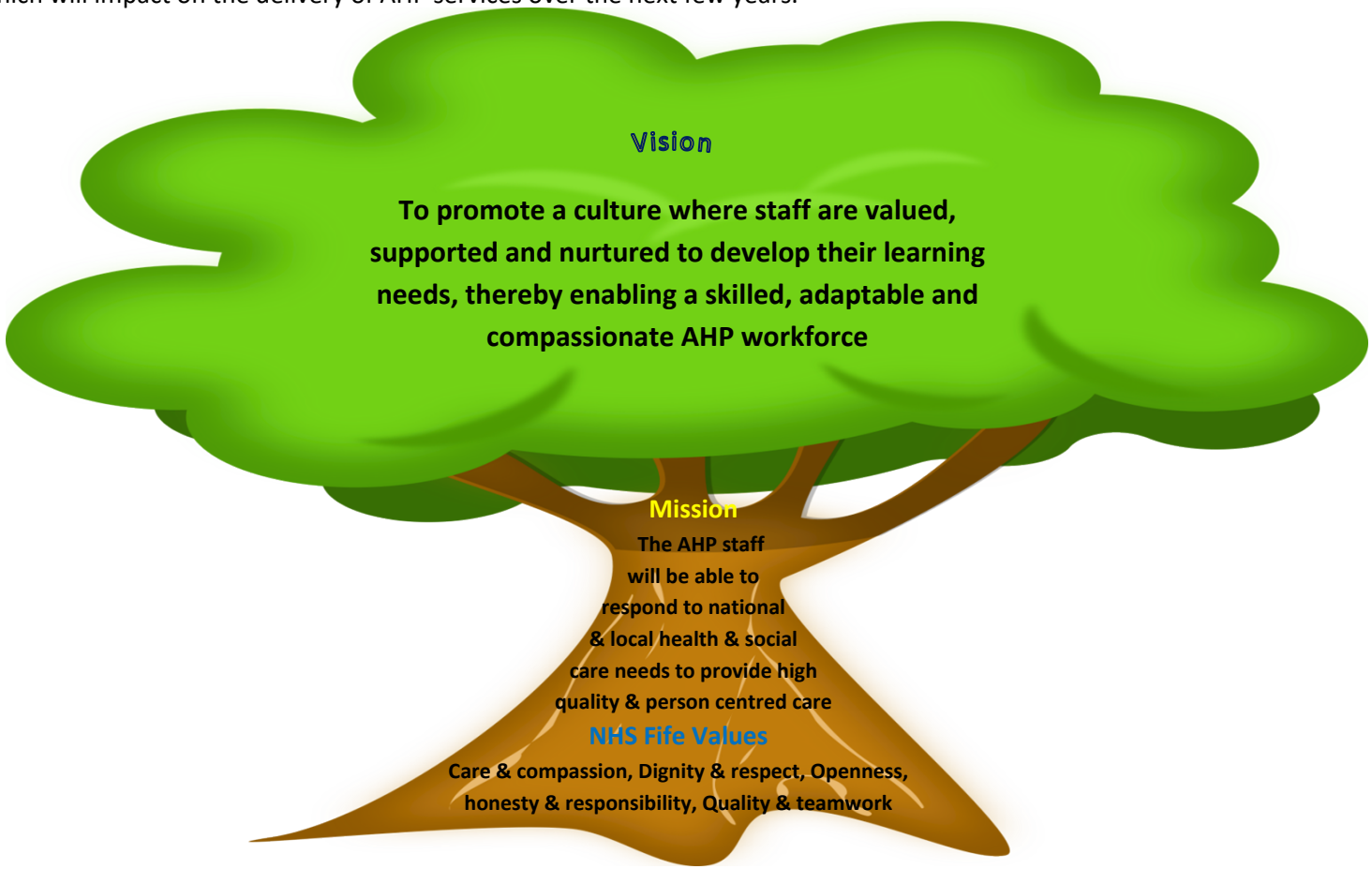
2023 - 2026

Table of Content

Introduction

The National Health Service (NHS) in Scotland has faced significant challenges over the past few years due to the increase in demand for health care services. This has been driven by a variety of factors including environmental, technological, demographical, sociological and financial. (1, 2, 3) It was recognised in 2012 that 'Scotland's AHPs are already working at the leading edge of a paradigmatic shift in the public sector towards enablement and personalisation, promoting an asset-based approach, self-management, resilience and independent living and preventing over-reliance on hospitals and professional intervention' (4). In view of this there is a need for Allied Health Professions (AHPs) to adapt and change (5,6) by rethinking how they engage and support the needs of contemporary healthcare service users.

These societal and healthcare changes are reflected in a range of different external and internal environmental drivers, opportunities and challenges, which will impact on the delivery of AHP services over the next few years.



Why We Need a Learning Development Framework

A culture of supported life-long learning supports the health and well-being of staff, improves their resilience, enables them to remain engaged and competent and allows them to adapt their skills to meet the changing health and care needs of the population.

AHPs, as a group of health professions who have a role at all stages of the life cycle, are ideally placed to be at the forefront of informing and shaping both current services and new models of care.

We need to ensure that all AHPs and AHP Health Care Support Workers (HCSW) staff are supported and have confidence to develop not just in their current jobs, but also new and emerging roles.

Effective learning and development are therefore essential to ensure all AHP staff feel valued, invested in and confident of the job they are doing and in developing and delivering services that meet the needs of our population.

This learning and development framework is underpinned by the NHS Education for Scotland (NES) four pillars of practice and is future focussed, ensuring best use of resources and is aligned to national and local policy drivers. The pillars of practice model describes how different jobs require a different mix of skills and knowledge. All levels of the career framework (2 -8) work across all four pillars.

This learning and development framework has two themes:-

- **The Four Pillars of Practice**
- **Future Focus**

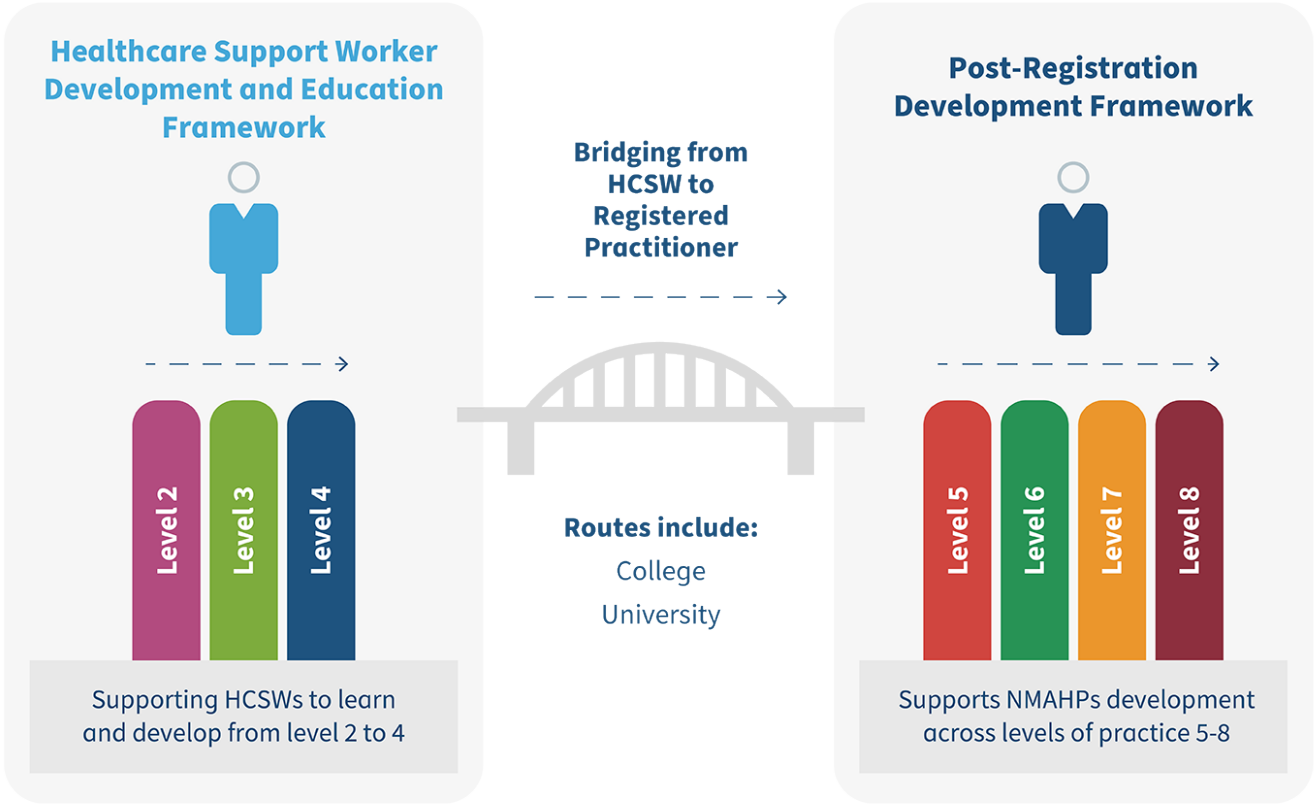
These 2 themes are essential for effective learning and development. For each theme we have described why it is important and how it can be achieved within our AHP services.

The AHP Learning and Development Group have ensured that the framework is applicable to registered AHPs and AHP HCSWs working at every level within NHS Fife.

AHPs Maximising Potential and Impact at Every Level of Practice

The NES Nursing, Midwifery and Allied Health Professions (NMAHP) Development Framework (2021) (previously the career framework) is an overarching resource comprising of two 'bridged' components: the HCSW Learning Framework and the Post-Registration Development Framework.

These development frameworks outline the expectations of roles at practice levels 2 - 8. They also incorporate the 4 pillars of practice. **The levels outlined in these frameworks do not equate to the agenda for change bandings.**

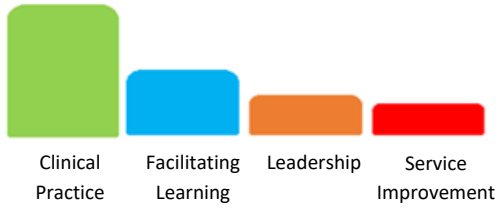


Theme 1 – The Four Pillars of Practice

The ‘pillars of practice’ model describes how different jobs require a different mix of skills and knowledge. All levels of the framework (2 - 8) work across the four pillars.

The pillars for HCSW (Levels 2 - 4) are:-.

It is acknowledged that some AHP HCSW are employed at band 5, however they equate to a level 4 within the development framework as they are not registered with HCPC.

HCSW pillars by level	
Level 2  	At level 2, clinical skills remain the strongest pillar of practice in your role; but it is equally important to recognise the role you play in supporting others to learn, for example students on placement or new member of the team.
Level 3  	It is the underpinning knowledge and skills which determine the level, not the list of skills people may have. The expectation at Level 3 is to use those clinical skills actively across the other three pillars and to have the underpinning knowledge and skills to take more responsibility and work safely in more complex situations.
Level 4  	At Level 4 you will be required to use your clinical skills to a higher level and to take greater responsibility within your role by accepting more delegated tasks from registered practitioners. You will need to demonstrate your knowledge and skills at Level 8 on the Scottish Credit and Qualifications Framework (SCQF), for example by studying for a Diploma in Higher Education or Professional Development Award.

The 4 pillars for registered staff (levels 5 – 8) are:

The emphasis on each pillar will be different depending on the staff member's level of the development framework and the type of role. For example, at level 5 most aspects of the AHPs' role will fit into the clinical pillar, however at level 8 the emphasis may be more on the evidence, research and development pillar.

The Clinical pillar also contains core content that can be expanded and contextualised for different roles including specialist clinical roles.

The knowledge, skills and behaviours described in the Facilitating Learning, Leadership and Evidence, Research and Development pillars are common to all AHP professions and specialities.

The leadership pillar is threaded through all levels of AHP roles as all AHPs and HCSWs are expected to be able to demonstrate leadership through individual behaviours, clinical delivery and service development. There are a number of leadership models which can be utilised either individually or as a combination. It can incorporate management skills and responsibilities and reflects current leadership development strategy depending on the level the AHP is working at. For levels 2 – 4, leadership can be demonstrated for example by leading patient groups, delegating to colleagues and involvement in service improvement.

All AHPs should lead on learning and development whether for their own Continuing Professional Development (CPD), a profession or department. A culture of learning and development throughout all AHPs within NHS Fife will ensure that this is incorporated into all AHP roles. AHPs at all levels will be aware that developing knowledge and experience is a core responsibility of their work activities.

Regular learning and development opportunities are vital to ensure all AHPs and HCSWs are fit to practice/be employed: the healthcare environments we work in are ever changing, with services frequently undergoing some form of development or improvement in response to changing service user/carer needs, or in response to new research evidence or improvements to care that lead to changes in clinical practice. Effective leadership at all levels will ensure this.

The Facilitation of Learning pillar includes the support of AHP's practice-based learning. AHPs in their role as practice educators contribute to the development and education of pre and post registration AHP students by providing practice-based learning. This contributes to ensuring that we have a future AHP workforce which is equipped to support and contribute to quality, safe and effective practice. Levels 2 – 8 can be actively involved in practice-based learning with defined responsibilities.

Theme 2 – Future Focus

Why is this important?

To ensure that AHPs and AHP HCSWs have the skills and experience to provide adaptable current and new services, learning and development must consider current and future healthcare provision. This includes ensuring AHPs, AHP HCSWs and also students have an understanding of both national and local policy, current impact and delivery and how to influence these in the future.

To achieve this:

1. **AHP roles and services will be responsive and adaptable to organisational development and priorities and service user's changing needs**

   AHPs at all levels will be knowledgeable of current policy drivers and demographics of people accessing health care. This will enable them to understand the changing health service and develop their services accordingly. Planning of learning and development will consider how health care delivery is changing to ensure AHPs continue to meet service user's needs. AHPs will have an understanding of how to influence future policy and strategy to ensure the health and social care is fit for purpose.

2. **AHPs will be supported and have confidence to develop new and emerging roles to meet people's needs**
   AHPs will have the expertise to lead innovation through access to appropriate learning and development activities. They will have the opportunity to develop their skills to capitalise on evidence-based practice, quality improvement, research, new technology and ways of working.

3. **A sustainable, expert AHP workforce will be in place.**
   Planning of learning and development activities should consider the needs of the service users who will access health care in the future. Continued relevant learning and development will ensure a skilled AHP workforce which is fit for practice and the future.

Action Plan to Achieve Themes

To achieve the two themes:

Key Statements	• Planning and participating in learning and development within each pillar of practice ensures individual's learning focuses on the different aspects of their role. AHPs and AHP HCSWs should practise across all four pillars and develop each pillar as their current or future role requires • Ensure AHPs and AHP HCSWs have the skills and expertise to provide adaptable services and future healthcare provision.							
	Action	Outcome measures	Responsibility	Start date	Status Red 0 – 50%	Amber 50 – 99%	Green 100%	Completion
1	The four pillars of practice are used as a basis of discussion in PDP & R, Turas appraisal and supervision. AHPs will take ownership of their own learning and development and are supported to do so.[1,2]	• Completion of a gap analysis of the pillars of practice across all AHP professions and development of an action plan to address any gaps • All AHP staff can identify the 4 pillars of practice • Evidenced within PDPs	AHP PELs in conjunction with AHP Learning and Development Oversight Group (AHPLDOG) AHP Senior Leadership Team					
2	All AHP staff will have access to Learning and Development opportunities across the four pillars of practice[1,]	• Completion of a gap analysis of the pillars of practice across all AHP professions and development of an action plan to address any gaps • AHP stories will be captured to demonstrate CPD undertaken across the four pillars • All learning and development activities are coded against 1 or more pillars of practice						

	Action	Outcome measures	Responsibility	Start date	Status			Completion
					Red 0 – 50%	Amber 50 – 99%	Green 100%	
3	All AHP staff are enabled to have active and regular engagement in learning and this will be supported by PDP & R[1,2]	• A survey to all AHPs to explore compliance with PDP & R • Annual audit of supported learning activities by each profession by each pillar of practice	AHP PELs in conjunction with AHP Learning and Development Oversight Group (AHPLDOG					
4	Learning and development is planned and organised to meet specific needs identified in workforce plans[1,2]	• Each AHP profession has a workforce plan reviewed annually • Evidence of the pillars of practice will be visible in AHP workforce plans • Learning and development is embedded in profession specific workforce plans	AHP Senior Leadership Team					
5	Value and importance of learning and development is embedded into practice and reflected in profession specific plans[1,2]	• Evidenced within work plans	AHP Senior Leadership Team					
6	AHPs will be supported and have confidence to develop new and emerging roles to meet service user's needs [2]	• Evidenced within PDPs • Impact of new roles developed. • AHP stories will be captured to demonstrate CPD undertaken within new emerging roles • Number of new roles developed	AHP Senior Leadership Team and Team leads					

[1]Pillars of Practice

[2]Future Focus

Resources

AHP Learning site on Turas Allied health professions (AHP) learning site | Turas | Learn (nhs.scot).

AHP NES portfolio – available to download via your Turas account

Effective Practitioner (NES) Effective Practitioner (scot.nhs.uk)

Flying Start (NES) Flying Start NHS® | Turas | Learn

HCPC standards for CPD Continuing professional development (CPD) | (hcpc-uk.org)

NES NMAHP Development Framework https://www.nmahpdevelopmentframework.nes.scot.nhs.uk

AHP support and supervision modules/sessions (NES) Allied health professions (AHP) supervision education sessions | Turas | Learn (nhs.scot)

Leading to Change (previously Project Lift) Home - Leading to Change

Transforming Roles Transforming NMAHP roles | NHS Education for Scotland

HCSW Learning Framework Healthcare Support Workers (HCSWs) | NHS Education for Scotland

Support Worker Central https://learn.nes.nhs.scot/34351/support-worker-central

Scottish Government AHP Education and Workforce Review: Recommendations Allied Health Professions - education and workforce policy review: recommendations - gov.scot (www.gov.scot)

NHS Fife Population, Health and Well Being Strategy - Population health and wellbeing strategy | NHS Fife

NES Practice Educator Framework – available in 2024.

Members of the AHP Learning & Development Oversight Group (AHPLDOG)

Name	Title
Margaret Braid	AHP Practice Education Lead (Chair)
Moira Dunsire	Podiatry Clinical Service Manager
Lyndsay Forbes	Mobility and technology manager
Gayle Fraser	OT Children and Young People's Health Care Support Worker
Karen Gray	Therapies Services Manager
Alyson Hutchison	AHP Practice Education Lead
Elspeth Ryan	Clinical Lead Dietitian
Gemma Wilson	Operational Lead Speech & Language Therapy
Laura Wilson	Advanced Orthoptist

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[1] Scottish Government (2016) A national Clinical Strategy for Scotland [online] [viewed February 2023] Available from https//www/gov.scot/Resource/0049/00494114.pdf

[2] Leiceter, G, (2016) *Transformative Innovation:* A Guide to Practice and Policy, Axminster: Triarchy Press.

[3] NHS Confederation (2020) *NHS Reset Reforming Health and Care Post COVID-19.* NHS Confederation Briefing [online] [viewed February 2023] Available from: www.nhsconfed.org/resources/2020/04/nhs-reset

[4] Scottish Government (2012) AHPs as agents of change in helath and social care – The National Delivery Plan for the Allied Health Professions in Scotland, 2012 – 2015 – gov.scot (www.gov.scot) [online] [viewed 13/06/2023] AHPs as agents of change in health and social care - The National Delivery Plan for the Allied Health Professions in Scotland, 2012 - 2015 - gov.scot (www.gov.scot)

[5] Nancarrow, S. And Borthwic, A. (2020) *The Allied Health Professionals; A Sociological Perspective,* Bristol: Policy Press.

[6] NHS Education Scotland (NES) (2021) *Allied Health Professions Workforce Planning: Identifying the role and value of NES* [online] [viewed 13/06/2023] Available from www.nes.scot.nhs.uk/media/ctzlfxrr/allied-health-professional-workforce-planning . pdf

Fife Allied Health Professions (AHPs) Research, Innovation and Knowledge Strategic Framework 2023 to 2026

Implementation Date:

Last Review Date:

Next Formal Review Date:

Author(s): Dr. Grant Syme and AHP Research, Innovation and Knowledge Group

Approval Record:	Date
Fife Allied Health Profession (AHP) Research, Innovation and Knowledge Group	

Allied Health Professionals (AHPs)
Research and Development Research Strategy 2023 to 2026

1. INTRODUCTION

1.1 The National Health Service (NHS) is committed to supporting clinical research delivery to help shape the future of healthcare and improve peoples' lives.[1] The Scottish Government Health Department has highlighted the need to increase the scope, relevance and quality of research to meet the health and social care needs of the people of Scotland.[2,3]

1.2 NHS Fife aims provide the highest quality care to, and improve the health of the population of Fife, within the resources available, and in partnership with its staff, community planning partner organisations and the citizens of Fife.[4] These aims are underpinned by enhancing its research, innovation and knowledge capacity through:

- promoting a culture that supports and encourages research, innovation and knowledge as part of routine practice;
- building on the opportunities to work closely with academic and community planning partners to increase the volume and quality of research;
- promoting research within an appropriate governance framework;
- developing research knowledge and skills of staff and appropriate independent contractors;
- working in partnership with the citizens of Fife to ensure that research is person-centred.[4]

1.3 At an organisational level, health and social care organisations that engage in high quality and person-centred research, innovation and knowledge activities have demonstrated:

- higher rates of patient satisfaction,
- reduced mortality,
- improved performance,
- improved organisational efficiency

At a departmental level, a strong research culture is associated with:

- reduced staff turnover
- translation of evidence into practice

At an individual level, it is recognised that research activity can lead to:

- increased perception of skills and confidence in practice
- improved job satisfaction.[5,6,7,8]

1.4 Allied Health Professionals (AHPs) constitute a large proportion of the healthcare workforce offering significant potential to increase the quality of patient and population health and to improve services through research.[9] Allied Health Professionals make up approximately one third of the health and social care workforce in the United Kingdom (UK) with over 65,500 qualified staff registered with the NHS in 2018.[10]

The term 'Allied Health Professionals' is used within the UK to describe a diverse range of fourteen autonomous professionals including physiotherapists, occupational therapists, radiographers, paramedics, speech and language therapists, podiatrists, dieticians, operating department practitioners, orthoptists, osteopaths, prosthetists and orthotists, art therapists, music therapists and dance therapists.[11] Although the scope of each of these professions is unique, collectively they offer holistic care within the domains of prevention, health promotion, diagnosis, treatment, support and enabling functional independence.[12]

Allied Health Professionals (AHPs) have a proud record of producing high quality, patient-focused research.[13] Allied Health Professionals are, however, on the whole, relatively new academic disciplines and their influence on wider health, health care and social care research has not yet matched the significance of their impact on an individual's care journey, or on the wider delivery of health and social care across Scotland.[14]

Perceived obstacles to AHP research have been cited as:

- lack of confidence in research skills.
- perception that their knowledge and skills to be inferior to other healthcare colleagues
- limited opportunities for continued learning and development in research for practising clinicians.
- high clinical workload with limited time or resources to focus on research activity and sporadic support from managers
- poor research literacy of individual managers within allied health is also varied, leaving many ill-equipped to support staff research development or signpost to experienced clinical academics
- Language used to refer to research within academic institutions can also be perceived as intimidating to AHPs applying research to their own practice.[15]

1.5 In line with the NHS Fife Research and Development Strategy[4] and for the purposes of this AHP Research, Innovation and Knowledge Strategy.

Research is defined as: "All forms of clinical and population research involving patients or members of the public in Fife. This will include work that entails new data collection as well as the analysis of routinely collected data. It will also include research into care pathways that cross boundaries with other agencies"

Research capacity building is defined as: "a process of individual and institutional development which leads to higher levels of skills and greater ability to perform useful research"[16]

Development' is defined as: "any systematic evaluation of the application of the results of research into practice".[4]

Innovation is defined as a process leading to the successful exploitation of new ideas (inventions, discoveries, etc).[17]

Knowledge management focuses on gathering, organising and analysing the knowledge base of individuals and groups across the organisation in a way that an organisation can benefit through enhanced organisational performance.[18]

A *learning organisation* is defined as "an organisation that exhibit adaptability, learns from mistakes, explores situations for development and optimises the contribution of its personnel".[19] Learning organisations are those organisations that are visibly able to manage the knowledge that they have acquired over time.

Research, innovation, knowledge management and learning are separate entities, but are inextricably linked through the principles of a systematic approach, evidence gathering (explicit and tacit), analysis, dissemination, implementation and reflection, with the aim of ultimately enhancing patient care.

1.6 The Scottish Allied Health Professions Research and Development Action Plan (AHPRDP) was published in 2004 and identified research and development as a key priority for AHPs.[14] Whilst the document is somewhat dated and no further updates have been produced since, many of the key recommendations remain valid. Allied Health Professionals, however, share the objective of developing clinically effective, evidence based practice to meet the needs and expectations of service users.[13]

1.7 The key areas identified in the AHPRDAP were:

- Skills development in research awareness and critical appraisal;
- Research capacity and capability;
- Funding and support;
- Dissemination and development.

2. CURRENT RESEARCH ACTIVITY

2.1 There is currently AHP research being actively undertaken in Fife at both postgraduate and postdoctoral level. Whilst these activities should be captured through the NHS Research Ethics application procedures, locally and nationally, there was previously no AHP coordinated approach to AHP research in Fife. Furthermore, the majority of these research

activities appear to be self-directed and not related to any overarching AHP Service objectives, AHP research strategy or overarching scientific paradigm.

3. NHS FIFE'S ALLIED HEALTH PROFESSIONS (AHP) VISION FOR RESEARCH, INNOVATION AND KNOWLEDGE

3.1 The AHP Research, Innovation and Knowledge strategy and framework will support NHS Fife's clinical and Fife Health and Social Care strategies to provide the highest quality of care to service users, improve the health of the population of Fife in collaboration with its staff, community planning partner organisations and citizens of Fife.

3.2 The strategic purpose is to promote a culture of systematic and innovative problem-solving to enhance health care delivery, performance and outcomes for the people of Fife through the use of research and development.

3.3 The strategy provides a context and framework to promote and support research and development amongst AHPs throughout Fife. It is a clinical governance responsibility of NHS Fife to support AHPs in the achievement of this aim.

3.4 The overarching aim of the strategy is to ensure that a common framework, acceptable to AHPs practising in all applied health and social care systems and consolidating key research, innovation and knowledge skills and abilities across the professions would be helpful in supporting a strong AHP research, innovation and knowledge culture.

3.5 The NHS Fife AHP goal is to support and promote high quality clinical research, innovation and knowledge for the health benefits of the Fife population and to play its part in enabling NHS Fife to deliver high quality health outcomes.

4. OVERARCHING STRATEGY

4.1 The research, innovation and knowledge strategy is based on a framework initially proposed by the Nursing and Midwives Research Strategy in 2001.[20] It involves a three-phased approach to research and development under the following headings:

A. Enabling Activities;
B. Developmental Activities;
C. Application Activities.

4.2 Promoting an Environment that Enables and Encourages Research, Innovation and Knowledge

4.2.1 In the widest context the Research and Development profile and activity has continued to grow in NHS Fife, especially with regard to medical and nursing research. This increased activity is largely down to the innovative, supportive and dynamic NHS Fife Research and Development Department. Arguably, the lack of an active and organised AHP research, innovation and knowledge infrastructure, however, has left some AHP services unable to fully engage and keep pace with these developments.

Fife AHPs will promote an enabling environment which provides an appreciation of research, innovation and knowledge led practice by:

- Promoting a service culture and ethos, which supports evidence based practice (EBP) and research, innovation and knowledge;
- Encouraging and stimulating new and innovative ways of working;
- Developing the tools and skills required to undertake high quality service evaluations, clinical audit and research;
- Developing the tools and skills required to embrace evidence-based practice and transform theory into practice;
- Promoting an awareness of research governance structures with all staff;
- Linking existing established Clinical Effectiveness Networks and Practice Development initiatives to increase learning, and to provide potential opportunities for collaboration to enhance the quality of ongoing service developments.

4.3 Promoting an Environment that Encourages the Integration of Research, Innovation and Knowledge Skills into Practice

4.3.1 To promote an environment that encourages the integration of research, innovation and knowledge skills into practice Fife AHPs will:

- Review research, innovation and knowledge findings for applicability, transferability and robustness before implementing them into practice locally;
- Identify areas of concern as key priorities, which need to be addressed in order for AHPs to demonstrate value and evolve clinical practice;
- Identify areas of concern as key priorities, which need to be addressed in order for AHPs to compete with their colleagues within the wider NHS and Health and Social Care organisation on an equal basis for funding;
- Ensure research, innovation and knowledge initiatives are planned systematically and transformed from theory into practice using appropriate, and where applicable, valid and reliable methodologies, which adequately answer the question posed;
- Allow AHPs to actively engage in research from a service user/client focused evidence-based practice through to an academic perspective.

4.4 Promoting an Environment that Encourages the Application of Research, Innovation and Knowledge Capacity Locally, Regionally and Nationally with Appropriate Partners

4.4.1 To promote an environment that encourages the application of research and innovation capacity locally, regionally and nationally with appropriate partners Fife AHPs will:

- Actively monitor AHP research, innovation and knowledge performance;
- Facilitate the development of research, innovation and knowledge capacity, capability and infrastructure building within Fife AHP Services;
- Encourage AHPs to explore the range of options available for research and innovation funding within both the statutory and voluntary agencies;
- Help inform service providers, as well as colleagues, in the academic world of the current position of research and innovation within AHPs in Fife.

4.4.2 A common framework should be adopted that is acceptable to AHPs practising in all applied health and social care systems and consolidating key research and innovation skills, knowledge and abilities across the Allied Health Professions.[15] It is proposed that adoption and potential modification of the Allied Health Professions Research (CAHPR) Framework to a more user friendly matrix with supporting resources, be used as a starting point, to facilitate a strong AHP research, innovation and knowledge culture.[21]

6. Objectives for 2023 to 2026

6.1 The key objectives over the next 3 years for AHPs are to:

1. Increase awareness of research, innovation and knowledge management amongst AHPs through the implementation of a research, innovation and knowledge framework or matrix;
2. Increase dissemination of information from local, regional and national networks related to research and innovation;
3. Increase research, innovation and knowledge capability and capacity amongst AHPs through the development of an AHP research, innovation and knowledge framework or matrix with supporting resources;
4. Develop a recognised research and innovation culture within NHS Fife and Fife Health and Social Care AHP Services through key recognised actions:
    - research and innovation enabling managers/leaders make informed decisions about research activities
    - research and innovation seen as a means to increasing quality and efficiency in clinical practice
    - managers/leaders promote and endorse research and innovation
    - time created and protected for research and innovation
    - managers sign off on research and innovation applications
    - promote a positive research and innovation culture through leadership
    - managers/leaders are aware of the skills and competencies required for research and innovation translation.[22]

7. Reporting Structure

7.1 For governance purposes the AHP Research Innovation and Knowledge (RIK) Group will report to the NHS Fife RIK Oversight Group and the AHP Senior Leadership Team (SLT) SLT/AHP Clinical Advisory Forum (AHPCAF) (Appendix I).

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Appendix I

Allied Health Professions Research, Innovation and Knowledge (RIK) Group Reporting Structure

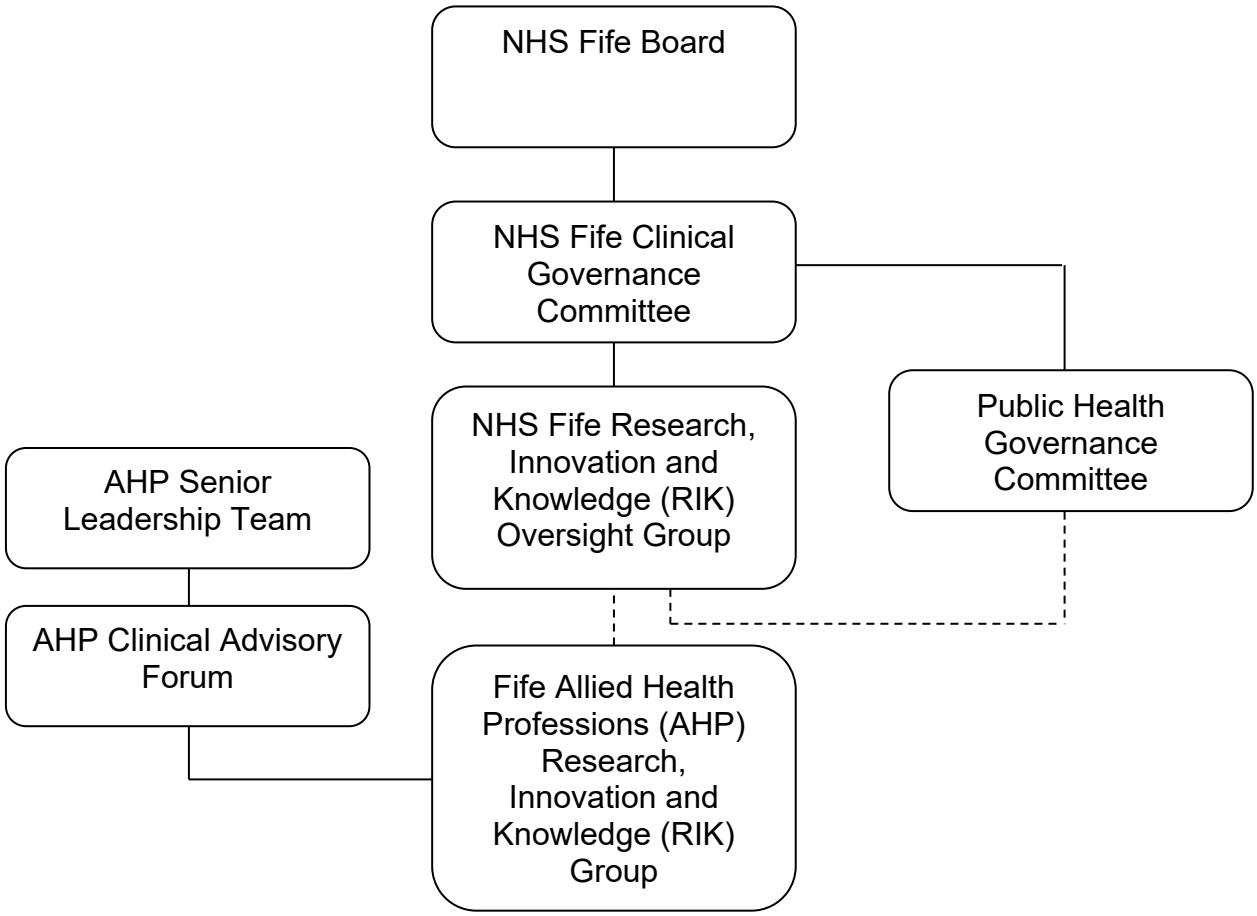

Figure Fife Research, Innovation and Knowledge (RIK) Group Reporting Structure

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**8 September 2023**
Title:	**Controlled Drugs Accountable Officer Annual Report**
Responsible Executive:	**Ben Hannan, Director of Pharmacy and Medicines / Controlled Drugs Accountable Officer**
Report Author:	**Geraldine Smith, Lead Pharmacist Medicines Governance**

1 Purpose

This is presented for:

- Assurance

This report relates to a:

- Legal requirement
- Local policy

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

- Safe
- Effective

2 Report summary

2.1 Situation

The purpose of this report is to update the committee on the work ongoing to ensure the safe and effective use of controlled drugs (CD's) within Fife. The detail captured in the report demonstrates the multiagency approach within Fife around CDs with input from Police Scotland P division, the NHS, Fife Council, the Local Medical Committee, the General Pharmaceutical Council and Care Homes. This report covers the period April 22 to March 2023

2.2 Background

The roles and responsibilities of Controlled Drugs Accountable Officer (CDAO), and the requirement to appoint them, are governed by the Controlled Drugs (Supervision of Management and Use) Regulations 2013. The CDAO is responsible for the management and safe use of CDs, for monitoring systems, and taking action where appropriate, and to ensure co-operation between responsible bodies. There is a legal duty to share information between bodies such as health boards, private hospitals and hospices, the Care Inspectorate, NHS Scotland Counter Fraud Services and the police. It is a requirement for all NHS Board CDAOs to establish a Local Intelligence Network (LIN) to support information sharing

2.3 Assessment

Please see attached Controlled Drugs Accountable Officer annual report in appendix 1

2.3.1 Quality/ Patient Care

Throughout the Controlled Drugs Accountable Officer annual report refers to quality of patient care and ensures where learning has been identified actions are taken and learning shared.

2.3.2 Workforce

To support the workforce with compliance against policies and procedures a number of presentations and supporting documents have been developed and are available on staff BLINK , or sent direct to General Practice, community pharmacies and care homes.

2.3.3 Financial

There are no direct budgetary concerns

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 CD incidents are monitored by Safe and Secure use of Medicine group and all categories of CD incidents will now be monitored in more detail through the formation of CD Governance group.

2.3.5 Equality and Diversity, including health inequalities

No requirement for Equality and Diversity assessment at this time

2.3.6 Other impacts

None

2.3.7 Communication, involvement, engagement and consultation

The attached report details communication, engagement and consultation with multiple agencies both internally and external to NHS Fife.

2.3.8 Route to the Meeting

This 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

- Pharmacy Senior Leadership Team 24th May 2023
- Area Drug and Therapeutic Committee 21st June 2023
- Executive Directors' Group 17th August 2023

2.4 Recommendation

The Committee is asked to consider this report for **assurance** with regards to operation of responsibilities of the Controlled Drugs Accountable Officer.

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3 List of appendices

The following appendices are included with this report:

Appendix No,1 Controlled Drugs Accountable Officer Annual Report

Report Contact
Geraldine Smith
Lead Pharmacist Medicines Governance
Email Geraldine.smith3@nhs.scot

Controlled Drugs Accountable Officer Annual Report

August 2023

Contents

1. Purpose of Report

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.

The CDAO is responsible for the following in relation to Controlled Drugs:

- governance
- obtaining and receiving
- storage and access
- prescribing
- dispensing and supply
- destruction
- transport
- stationery
- reporting and learning
- the operation of Local Intelligence Network.

The purpose of this report is to update the Committee on the work ongoing to ensure the safe and effective use of controlled drugs (CDs) within Fife. The detail captured in the report demonstrates the multiagency approach within Fife around CDs with input from Police Scotland P division, the NHS, Fife Council, the Local Medical Committee, the General Pharmaceutical Council and Care Homes.

The report covers the period from **April 2022 to March 2023.**

2. Governance

In NHS Fife, the Director of Pharmacy and Medicines also fulfils the role of CDAO.

Benjamin Hannan is registered as NHS Fife's CDAO, with Healthcare Improvement Scotland (HIS). The Controlled Drugs (Supervision and Management and Use) Regulations 2013 mandate that "*HIS must compile, maintain and publish from time to time, in such manner as it sees fit, a list of accountable officers of designated bodies in Scotland.*"

Standard Operating Procedures (SOPs) and policies are in place covering all aspects of CD management in NHS Fife and these are regularly reviewed and form part of the Safe and Secure Use of Medicines Policy and Procedures (SSUMPP). A programme of audit and assurance is overseen by the Safer Use of Medicines Group, which reports to the Area Drug and Therapeutics Committee (ADTC). Details on the assurance assessments undertaken in the reporting period are found later in the report.

A new Controlled Drugs Governance Group, which reports to Safer Use of Medicines Group was established in this reporting period, which has responsibility to ensure that safe and secure systems for CDs, covering ordering, supply, administration, storage, prescribing and use, are in place and monitored.

3. Controlled Drug Assurance Assessments

A programme of CD Assurance Assessments ensures that every ward/ department holding CDs in NHS Fife receives a pharmacy led visit, to assess compliance with legal and best practice requirements.

A comprehensive 59-point assessment is undertaken jointly by a member of the nursing team with a pharmacy professional. The outcome of the assessment informs compliance against the following procedural requirements for CDs– storage and access, obtaining and receiving, dispensing supply, transporting and stationery.

Standardised methodology for completion of this assessment is in place. One cycle of assessments was completed in 2022-23, with 104 areas assessed by January 2023. The assessment splits 59 questions into seven domains, which are aligned to the CDAO responsibilities (see table one).

Of note, mechanisms for seeking assurance regarding other requirements (destruction, prescribing, reporting and learning, and the operation of the CD Local Intelligence Network) are covered separately in this report.

Table 1 – Alignment of assurance assessment to CDAO requirements

Domain	Section Header	Storage and access	Obtaining and receiving	Dispensing and supply	Transporting	Stationery
1	CD cupboard					
2	Key security					
3	CD Record Book					
4	Patient's Own CDs					
5	Requisition entries					
6	Stock check					
7	Liquid CD check					

Following the assurance assessment, an individualised action plan for each area/ ward/ department is recorded and implemented, by the Senior Charge Nurse (SCN) or equivalent. Risk is stratified against the severity of non-compliance, and recorded on the Datix system – using Major, Moderate and Minor as descriptors.

Of the 104 areas assessed, only two areas were recorded as having a major non-compliance issue at the time of the assessment. Following investigation, both were identified as calculation errors with all medication accounted for and thus both incidents were downgraded. Eleven areas were recorded as having moderate concerns, with local improvement action plans implemented. Moderate concerns were due to the number of potential issues identified at the assessment (i.e., each issue on its own was minor however the total number of minor issues on each of these eleven assessments was an overall concern).

A detailed breakdown of findings per domain can be found below – it should be noted due to the comprehensive nature of the assessment, covering a detailed review over a 6 month

period, only two of 104 areas were noted to be 100% compliant; the detail below and variation across all settings is due to the scrutiny applied in reviewing each area individually.

An action plan has been developed to support staff to ensure learning is embedded into practice and will be reviewed in 6 months' time by the Safe and Secure Use of Medicines Group. Each ward/ department will undertake self-assessment reviews in between the main audit cycles. Full audit details have been sent to Head of Nursing for their areas to ensure all local actions have been completed.

a. CD Cupboard

CD cupboards were all found to be locked, and in good working order, apart from one area where the lock has now been fixed.

A small number of assessments noted that non-controlled drugs were being stored in CD cupboards and this was rectified at the time of the audit. Advice was also given to one area to ensure high strength CDs were segregated within cupboards.

The largest area for improvement was noted to be maintenance of stock lists: 21 areas were advised to update their stocklists, and 33 areas had not had a review of their stock list in the last 12 months. The pharmacy team have taken an action to rectify this.

All requisition books were held in the CD cupboard apart from one area where the CD cabinet was no longer large enough. A new CD cabinet has been ordered for the affected area. Another area held three CD requisition books, which was rectified at time of the audit.

b. Key Security

Keys were found to be securely stored away from other ward keys in all but two areas. Both areas now hold the CD keys separately.

CD stock should be checked twice daily at nursing handovers. The assessment involved reviews of records for the previous six months and noted that 28 of the 104 areas (27%)

had missed at least one of the twice daily mandated stock checks and 34 areas had not recorded key handover appropriately. The need to complete this record at each shift change is highlighted at time of audit, and these findings have been highlighted to Heads of Nursing.

Two areas did not have spare keys or did not know where they were. Advice was given to 10 areas to ensure they were recording weekly checks regarding the security of duplicate/ spare keys for cupboards. All areas were noted to retain spare keys in a secure place, with limited access, including wards not open 24/7. New guidance was launched in v10 of the SSUMPP, where spare keys will be held in a central location on each hospital site and monitored weekly. A rolling program has started with HSCP wards being the first areas to move to the new model with the aim of all ward/departments to have the new model in place by October 23.

c. CD Record Book

All areas were found to store the CD record book securely.

Nine areas were given advice on how to appropriately record balance transfers between books, which has improved from last year (where 22 areas were non-compliant). Administrative errors were noted across different recording requirements; however, no significant concern from any individual error was identified. 29 areas were running low of CDs or had too many CDs; the review of CD stock lists will support staff with compliance going forward.

d. Patient's Own CDs

All areas that use Patient's Own CDs are using the patient own CD book, storing correctly and records are clear. A few administrative errors were noted in the use of these books. Improvement action was noted in 17 areas regarding transferring of Patient's Own CDs.

e. Requisition entries

Across the sample there were a small number of administrative errors noted (e.g., missing signatures); advice was given to each area to rectify. 'Received by' is the largest non-

compliant area with 36, followed by requisition number not in CD register (18). All stock and transactions were accounted for at the time of the audit.

f. Stock Check

There is duplication in questions within this section regarding recording formulation and drug name, so will be removed from next audit cycle. No concerns were highlighted in this section regarding stock apart from one noncompliant entry, which after investigation was a recording error.

When stock was date checked one area had mixed batch numbers in a box and another area had cut off the expiry date. Both were removed at the time of the audit.

g. Liquid CD Check

23 areas who held stock liquids did not rebalance the stock in line with SSUMPP when a new bottle is opened. A video will be produced to support staff with compliance.

4. Destruction of Controlled Drugs

Destruction of controlled drugs is covered by the CDAO regulations. Appropriate SOPs are in place for the destruction of CDs and for the removal and destruction of illicit substances from patients. The process ensures that unwanted CDs awaiting destruction are recorded, not stored for an excessive length of time, and do not accumulate. Appropriate records are made when CDs are destroyed, and processes are in place for witnessing the destruction and disposal of stock CDs. The CDAO authorises individuals who can witness the destruction of stock CDs. In the reporting period, 77 authorised witness visits were undertaken by the pharmacy team. The Pharmacy Senior Leadership team developed a new key performance indicator to ensure that 80% of Authorised Witness destructions were completed within 12 weeks of request. During this reporting period this target was met with 83% completed within 12 weeks.

5. Prescribing

Prescribing reports are available and reviewed by the Lead Pharmacist for Medicines Governance to monitor prescribing of CDs across Fife. Prescribers are contacted where further information is required. Support is given with any recommended actions to address any concerns.

'*More'* reports are generated where individual patients are prescribed above the Scottish average quantity. Individual prescribers are asked to review the patient, the clinical indication and to review quantity prescribed. Any concerns by the CDAOs team are noted and actioned accordingly.

Hospital HBP pad usage was reviewed in detail by clinical teams and a short live working group was formed to ensure location of all prescription pads were appropriate. Where any concern was identified regarding quantities prescribed the original prescription was sought and discussed with prescriber to ensure no more than 30-day supply is given in future. A new process will be developed to ensure any request for supplies of new hospital prescription pads will be reviewed by the Pharmacy team.

As a result of an internal audit a new process is in place in version 10 of the SSUMPP regarding prescription security, storage, and usage. New prescription log sheets were developed to ensure there is a clear audit trail of usage of the prescription pad, along with new documentation and guidance regarding destruction of prescription pads.

Fife is a recognised outlier under National Therapeutic Indicators (NTIs) in opioids and gabapentinoids and has a higher-than-average involvement of such medicines implicated in drug related deaths. This has led to the establishment of the High-Risk Pain Medicines (HRPM) programme, a three-year patient safety programme with respect to the prescribing. This includes CDs such as opioids, benzodiazepines and gabapentinoids. It was recognised that there was a need to develop a whole system approach to managing pain to assure that the prescribing and use of these medicines is safe and effective, engendering collective responsibility and culture change in how these medicines are initiated, monitored, and reviewed to ensure patient benefit, safety, and reduction in patient harm as well as consideration of the expansion of non-pharmacological strategies for managing pain.

Monthly progress reports from the HRPM programme go via the Executive Directors Group (EDG), and a detailed report go via standing committees in 2023.

6. Reporting and Learning

Significant events involving CDs are dealt with as part of the Adverse Events Process. The CDAO works closely with the Medical Director and Director of Nursing regarding incidents of this nature.

Fife demonstrates an open culture that encourages reporting of CD related incidents. This is illustrated by a good reporting rate of incidents, with a low proportion of harm. 387 CD incidents were recorded via DATIX in the reporting period, an increase of 17 from the previous year.

The CDAO also receives reports from other sources including from community pharmacies, of which there are 86 across NHS Fife.

Incidents and concerns for this period have undergone local investigation and resolution. During this period there have been examples where information has been shared between responsible bodies including the police, Counter Fraud, private establishments, other Health Board CDAOs, the Care Inspectorate and regulatory bodies. Of the incidents involving 'suspicion of criminality', some have been subject to police or Counter Fraud Services investigation.

h. Managed Service Incidents

Graph 1 shows CD incidents reported via Datix by month of the 387 incidents reported.

- 269 incidents were recorded as no outcome in terms of harm.
- 70 incidents were recorded as minor outcome in terms of harm.
- 40 incidents were recorded as moderate outcome in terms of harm.
    - 11 of these incidents were CD audit records.
    - 5 of these incidents involved stock discrepancies.
    - 4 involved prescribing errors, with three involving methadone and one failure to prescribe oxycodone.

- 6 patients received the wrong medicine, and 4 patients did not receive their medication.
- 2 patients were accidentally given a duplicate prescription; the patients came to no harm.
- 6 of these incidents were due to missing stock. These incidents are investigated following procedures, with escalation as appropriate and downgraded.
- 2 incidents did not involve controlled drugs.

- 12 incidents were recorded as major outcome in terms of harm.
  - 6 of these incidents were due to missing stock. These incidents are investigated following procedures, with escalation as appropriate. Recommendations for the next 12 months will include the review of the attractive stock dashboard, which details all medication that may be desirable and therefore at increased risk of diversion. The aim of the review is to ensure every ward/dept is monitored on a monthly basis.
  - 1 incident concerned a prescribing error which involved a double dose of opioids, due to a breakdown in communication.
  - 1 incident involved waste medication being accidently discarded from a moving van, as the door was not properly shut. The review has 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.
  - The final 4 major incident are administration incidents. Three involved a wrong dose of palliative medication being administered. A short life working group has been established to review the Just in case policy and procedures and to support clinicians with education and training regarding medications involved in end-of-life care.

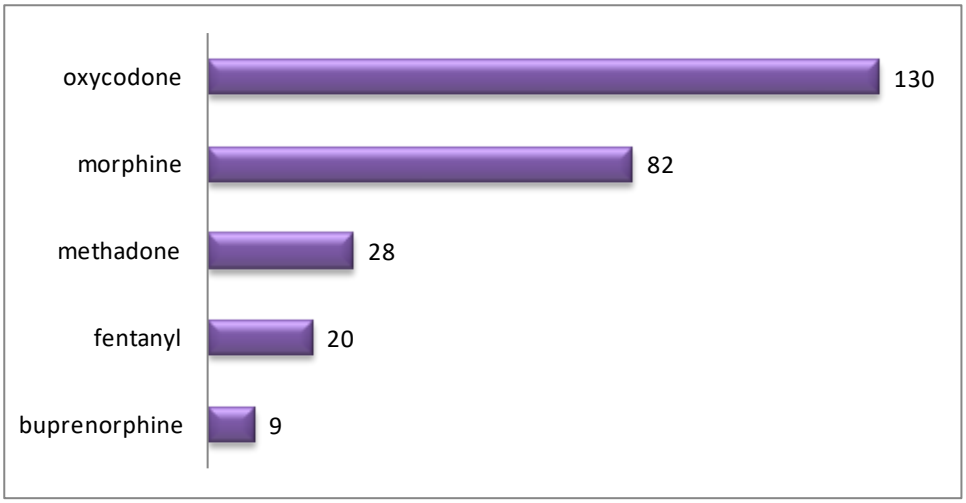
There is no change in the top 3 type of CD incidents reported with administration incidents (128) continue to be the most common type of CD incident reported, followed by discrepancy in CD stock register (48) and supply (29). A Sway newsletter has been developed to support staff with the most common themes and learning from CD incidents. Medication Safety Minute was launched in January 23. This is a new weekly safety briefing designed for quick dissemination of lessons learned from the previous week's medication

incidents across Fife. Several bulletins have focused on administration incidents to support staff by sharing learning from incidents.

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. They are often multifactorial reasons as to why the incidents happened. A detailed analysis of supply incidents will be undertaken this year as part of the action plan for the controlled drug governance group.

Graph 2 highlights the top 5 CD involved in CD incidents. Oxycodone continues to be the most reported drug followed by morphine. Medicine safety huddle education and awareness sessions continue with a focus on common errors and the safer administration of medicines, specifically highlighting the difference between oxycodone and morphine. A new 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. Lanyards and stickers are also being developed to support staff with oxycodone / morphine selection. Alfentanil is no longer in the top 5 replaced by buprenorphine.

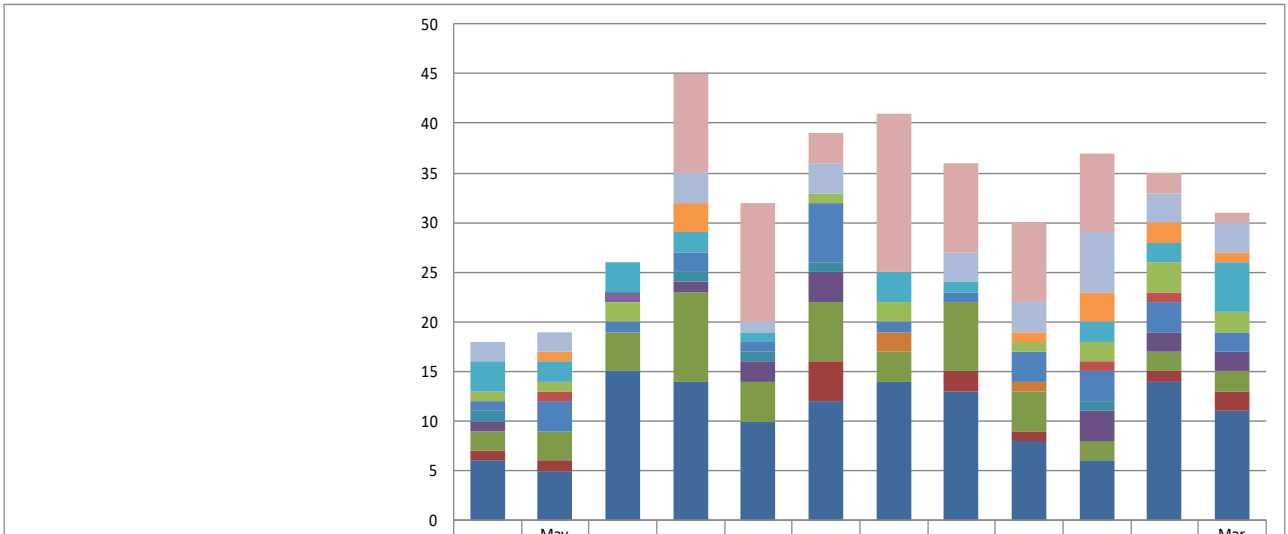
Graph 2– Top 5 reported CD incidents



There has also been continued reduction in reporting of transportation/ storage incidents, with only 8 reported via Datix. An internal transportation audit was conducted in 2019,

which highlighted areas for improvement. These were addressed in a detail action plan which has now been closed by internal audit. An internal transportation audit will be completed again during 2023.

Graph 1 CD incidents reported via Datix by month.



	Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
Ward CD Audit	0	0	0	10	12	3	16	9	8	8	2	1
Supply (delayed, missing, wrong medication)	2	2	0	3	1	3	0	3	3	6	3	3
Storage / Transportation	0	1	0	3	0	0	0	0	1	3	2	1
Spillage / Breakage	3	2	3	2	1	0	3	1	0	2	2	5
Remote Prescribing	0	0	1	0	0	0	0	0	0	0	0	0
Recording (Kardex / Medicine Reconciliation	1	1	2	0	0	1	2	0	1	2	3	2
Provision of information	0	1	0	0	0	0	0	0	0	1	1	0
Prescribing	1	3	1	2	1	6	1	1	3	3	3	2
Monitoring / Follow up	0	0	0	0	0	0	2	0	1	0	0	0
Missing/forged - prescription/CD stationery	1	0	0	1	1	1	0	0	0	1	0	0
Missing Stock (Grade as 'MAJOR')	1	0	0	1	2	3	0	0	0	3	2	2
Discrepancy in controlled drug register	2	3	4	9	4	6	3	7	4	2	2	2
Destruction / Disposal	1	1	0	0	0	4	0	2	1	0	1	2
Administration (Missed dose, Wrong dose / drug / infusion)	6	5	15	14	10	12	14	13	8	6	14	11

i. Community Pharmacy Incidents

Community Pharmacies in Fife must report CD related incidents to the CDAO.
Graph 3 shows the breakdown of incidents reported by Community Pharmacy. Of the 143 incidents reported between April 22 and March 23. 68 incidents were dispensing/ supply incidents. The majority of incidents no harm was caused to patients, with patient discovering wrong medication had been supplied before any incorrect medication had been consumed. Incidents where medication had been consumed the medication was the same, but the wrong strength taken, often a lower strength. Only 2 patients reported side effects from taking the wrong medication, but no further action was required. Detailed analysis was conducted where pregabalin and been dispensed instead of gabapentin or

vice versa and learning from themes provided to all community pharmacies, with individual action plans for some individual community pharmacies. Analysis of remaining supply incidents show procedural deviations as the root cause.

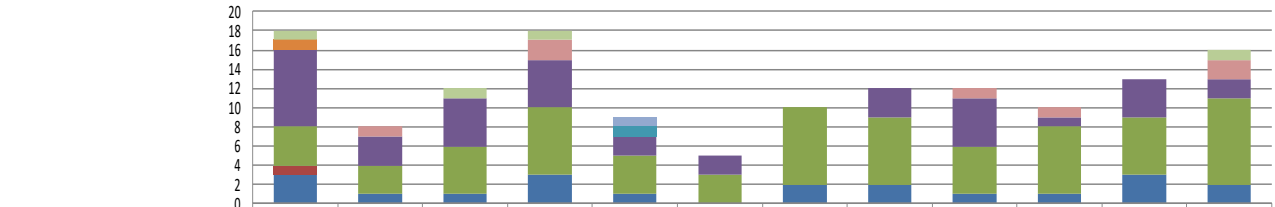
The next most common type of incidents was missing CDs or unexplained loss at 40 and CD register discrepancy (where there is an excess of CDs in the cabinet compared to the register) at 20. Excess is often a result of overage in manufacturing process for liquid medication or where a split pack has been given to a patient instead of a whole pack and patient has not come forward to say they have received less medication. The majority of missing medications was one or two missing tablets which have been thought to have been discarded with patient information leaflet where there is a loose strip, or where patients has received a whole pack of 30- tablets and only 28 of prescription. Prescribers were informed where the wrong amount had been discovered to be supplied to the patient and rectified.

Reporting of CD register discrepancies also increased, attributed to infrequent balance checks being undertaken because of staff shortages and workload. Assurance is always sought at the time of the reporting of the incident that weekly balance checks will restart, with checks also at point of dispensing. This is followed up to ensure there are no other issues.

A top 10 themes from CD incidents was produced to support community pharmacy with learning from CD incidents. Four suspicions of criminality were notified, and all incidents were reported to the police.

Methadone is still the most common medicine reported in incidents from community pharmacy. Guidance was issued to community pharmacies regarding dispensing instalment prescriptions and reminding them of legal requirements for prescriptions as well as best practice guidance before making a supply.

Graph 3 breakdown of incidents reported by Community Pharmacy by month.



	01/04/2022	01/05/2022	01/06/2022	01/07/2022	01/08/2022	01/09/2022	01/10/2022	01/11/2022	01/12/2022	01/01/2023	01/02/2023	01/03/2023
Suspicion of criminality	1		1	1								1
spillage		1		2					1	1		2
prescribing Incident					1							
other	1											
Missing prescription					1							
missing CDs or Unexplained loss	8	3	5	5	2	2		3	5	1	4	2
Dispensing / Supply Incident (from Pharmacy)	4	3	5	7	4	3	8	7	5	7	6	9
Destruction / Disposal Incident (CD)	1											
CD register discrepancy	3	1	1	3	1		2	2	1	1	3	2

7. Controlled Drug Local Intelligence Network

An East Region Controlled Drug Intelligence Network (CD LIN) meets twice a year, with the first one being chaired by NHS Borders in May 2022. The review of key security and the new processes developed by NHS Fife for key safe and storage of spare keys were shared.

NHS Fife chaired the second regional CD LIN in November 2022. NHS Fife presented the prescription stationery audit, which was previously presented to the NHS Fife audit and Risk Committee where areas of risk were identified, with resulting actions. Concerns were also raised about privately prescribed cannabis which is brought into hospital by patients or staff. Private prescribing of cannabis has increased and is expected to escalate. There are no policies in place in any Boards in Scotland on how to deal with not only *Epidiolex* but also preparations such as vaped cannabis flowers. A group has been set up to look at the gaps on a national basis and report back.

NHS Boards continue to share alerts where there have been fraudulent attempts to obtain medication from community pharmacy and GP practices. These alerts are then shared with NHS Fife community pharmacies and GP practices to raise awareness. Eight alerts were sent in this reporting period ranging from fraudulent private prescriptions being presented in various boards (none reported in Fife) to individual patients trying to obtain medication from GP practices with a national alert from Counter Fraud Services sent to all GP practices reminding them of the need where possible for face to face appointments and identity checks where desirable medication is being requested.

Counter Fraud Services also send alerts mainly from *crime stoppers* where allegations have been made regarding in the main patients or staff supplying medication. All are investigated at the time and the results of the investigation reported back to CFS and the police notified where appropriate.

The General Pharmaceutical Council, who regulate community pharmacy, carry out inspections of community pharmacies on a rolling programme. Inspection reports are available to the public to view on GPhC website. GPhC require improvement action plans to be filled in by the owner and superintendent pharmacist and completed in a specified time scale no longer than 60 days. The pharmacy is then revisited again in 6 months' time. Five Community pharmacies were inspected in Fife in this reporting period, with all meeting standards and no outstanding actions.

NHS Fife participate in the CD Accountable Officers Network (CDAON), which meets quarterly to develop detailed policies and documentation, and to develop and implement CD regulations and legislation. Peer review sessions are included in the programme. NHS Fife supports the network by reviewing documentation, sharing NHS Fife policy and procedures and support peers with advice and guidance.

The Care Inspectorate has powers to seek self-declarations about how care homes manage and use CDs. The CDAON reviews the information collected annually to inform improvement work and to promote information sharing. The Care Inspectorate also shares information in real time where there is a particular concern, while NHS Fife support with investigation and recommendations and share any learning. The Care Inspectorate continues to work closely with the CDAON to support effective communication and national monitoring of CDs, and improved practice in the care sector.

8. Controlled Drugs Accountable Officer Workplan

A workplan for continued improvement of management of CDs has been developed. Priorities for the coming 12 months are:

Action	Complete by
Implement peer review processes across Acute Service Division wards and departments to support continued assurance.	November 23
Review the inspection model for GP practices and start inspection process.	February 24
Issue self-assessment questionnaires to all Dental Practices in Fife.	September 23
Launch a new ward CD register, developed nationally, which has an improved index and recording of part used CDs.	September 23
Review NHS Lothian workbook for controlled drugs and how that can be incorporated within NHS Fife competency assessment	November 23
A Sway newsletter to be developed incorporating learning from CD incidents.	Completed and issued to all staff via BLINK. Next newsletter to be launched in October 23
Develop additional tools to support staff to highlighting differences between oxycodone and morphine such as lanyard, poster and stickers.	September 23
Develop new CD audit tool in electronic format and start next cycle of CD ward audits.	July 23
Develop a new medicines safety workshop series building on the launch of the Medicines Safety Minute, with oxycodone/morphine video being episode one	Complete first video by September 23.
Improvement plan from CQC self assessment to be developed	Finalise action plan by October 23
Develop a new electronic form for reporting CD incidents from community pharmacy	November 23

Action	Complete by
Develop new procedure for review of the attractive stock dashboard on a monthly basis.	New procedure developed and new KPI for Pharmacy to complete 100% review for each ward/dept from June 23 by senior staff. Training to be rolled out to all pharmacy staff from September 23.
Completed detailed analysis of supply incidents involving CDs via Datix	February 24

Update of previous work plan developed in October 22

Action	Update
Establishment of a CD governance group to strengthen scrutiny and assurance for the Accountable Officer. The membership will lead the completion of an organisational assessment on processes and procedures and levels of assurance they provide	Complete- CD Governance group has been established and meets every 2 months
Implement peer review processes across wards and departments to support continued assurance.	Peer review process for CD wards audits established in HSCP- still under development in Acute Services Division. Action to complete by November 23
Develop a bulletin for Community Pharmacy with key themes and learning from incidents reported locally and nationally.	Completed. Top 10 key themes shared locally and nationally. Next issue in August 23.
Review the Controlled Drug Assurance Assessment tool to better align this to the CDAO responsibilities	The CD assurance assessment tool has been reviewed and risks identified. A short life working group has been established to prioritise the risks

	identified to establish a work plan for CD Governance group aligned to CDAO responsibilities. Action plan to be finalised by October 23.
Review the inspection model for GP practices.	A new post will be advertised soon to support the work of the CDAO, and first priority will be to develop a new inspection model and start GP inspections by February 23.
Issue self-assessment questionnaires to all Dental Practices in Fife.	Self-assessment questionnaire has been developed with the aim to send to all Dental practices in September 23
Launch a new ward CD register, developed nationally, which has an improved index and recording of part used CDs.	SSUMPP has been updated to reflect new CD registers; once existing stock of CD registers is exhausted new registers are ready to order.

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**8 September 2023**
Title:	**High Risk Pain Medicines Patient Safety Programme – End of Year One Update**
Responsible Executive:	**Ben Hannan, Director of Pharmacy & Medicines**
Report Author:	**Garry Robertson, Programme Manager, CPMO/Finance**

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- 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 High-Risk Pain Medicines (HRPM) Patient Safety Programme remains a strategic priority agreed by NHS Fife in response to national and international growing concern of adverse effects and harm to patients when these medicines are used ineffectively or inappropriately, and, subsequent changes in policy and guidance on how chronic pain is managed.

The programme aims to understand how pain is currently managed across Fife, including identifying examples of good practice, with the objectives of seeking a reduction in the prescribing culture and use of High-Risk Pain Medicines across all NHS Fife settings and increased awareness and utilisation of non-pharmacological strategies for managing pain.

To achieve these objectives, the programme was structured over three annual phases (Appendix 1). The purpose of this paper is to provide assurance on progress to date at the end of year one and outline the areas of work being planned for year two.

2.2 Background

NHS Fife has higher rates of prescribing of these medicines compared to other healthboards, as measured by National Therapeutic Indicators, as well as a higher-than-average involvement of prescribed medicines in drug related deaths.

The day-to-day governance of the Programme is via the Programme Board (mandated by the Sponsoring Group/EDG).The programme reports into Clinical Care Governance and Population Health & Wellbeing Committees and shares information with the Health and Social Care Partnership through the Integrated Joint Board (IJB) and Senior Leadership Team.

2.3 Assessment

Since last year's mid-year one event in November 2022, the programme has made positive progress to deliver year one programme objectives to understand the problem. The main findings from year one are outlined in *Appendix 2: Summary Of Key Findings, Understanding The Problem Phase*. These findings were discussed at stakeholder engagement workshops which generated a significant number of change and improvement ideas. A further stakeholder engagement event reviewed these to identify key themes and priorities, which were deemed to be ambitious but realistic, given programme constraints of available time, cost, resource and the capacity of services to support change work among many competing challenges. The following year two priorities are proposed:

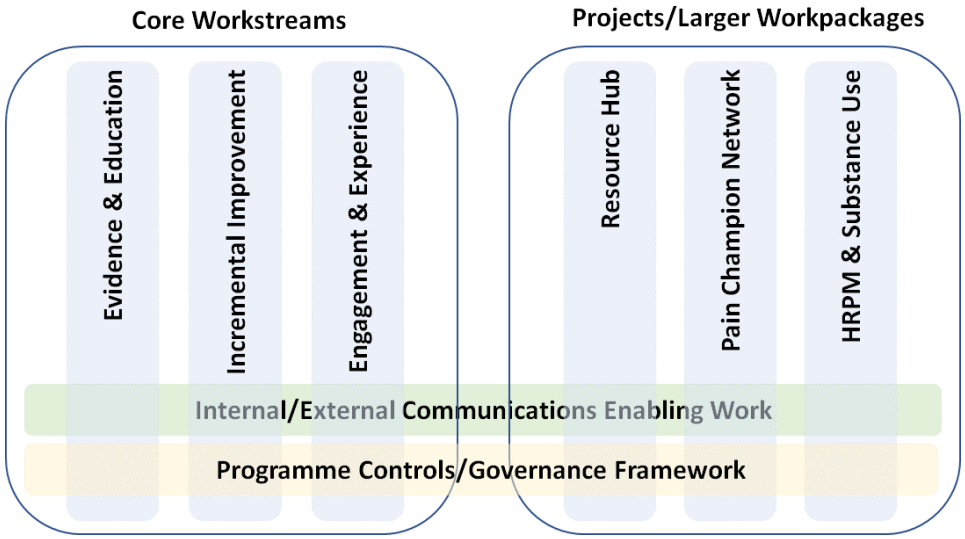
Programme Response / Main Product	Outline Description
Resource Hub	A re-occurring idea was the need for a single point to act as a resource site (similar to Mood Cafe) for clinicians, employers and patients to improve awareness and access to Supported Self-Management Solutions/resources based on area and individual circumstance. An exact scope will be worked through by the project process, but will likely include developing an online platform that offers patients information, take away resources and potentially self-referral (where appropriate) to some services. Clinicians should also have a single point to navigate from when seeking to signpost patients, access prescribing guidelines/guidance and when seeking information around more specialist service referrals.
Education Training Response	It was felt by stakeholders a training offer from the programme was required. The design and delivery of training should include the following areas: 1. Primary Care Lunchtime Education Sessions 2. Training for Junior Doctors/Consultants/ANP/Pharmacy/AHP around HRPM 3. Rolling base awareness training on HRPM for NMP 4. HRPM Training for Pain Champions (Pain Champions work outlined below) 5. Community Education/Awareness Sessions

Programme Response / Main Product	Outline Description
Pain Champion Network	To help support services with the management of patients with pain conditions as well as drive local process improvement activity, the creation of a pain champion network has been discussed. By creating this network, this should directly support improvement activity and tests of change identified by the programme, as well as act as a source for future improvement ideas/tests of change.
New Guidelines/Toolkit & Data Packs	Restructure our guidelines to be easier to use and become more of a 'toolkit' opposed to sizeable/static reference documents. Related to the toolkit theme is work around primary care data packs in relation to HRPM prescribing volumes. Regular data packs should be provided to primary care colleagues, to help focus their own improvement efforts in this area.
Improvement Activity/Tests of Change	Several tests of change/improvement activities have been identified across the Primary Care and Acute settings. The broad themes of these are to support improvements in communication between patient pathway interfaces, improve patient understanding and support clinicians in managing patient expectations.
Patient Experience Group	Patients have expressed a desire for ongoing programme involvement and their input into the design of solutions is highly valuable. Creating this group gives the basis for this and can act as a reference group to enable collaboration and co-production opportunities with patients, around of some of the public facing programme solutions (for example the recommended Resource Hub).
Promotional Campaign	A key finding was the need to manage expectations of patients to help support clinicians with conversations on alternatives to pain medication. Given the work needing progressed in the Fife context, waiting on a national campaign was not seen as an option. Therefore, the programme will work with communication colleagues to design a public facing campaign to be delivered during year two.
HRPM & Substance Use	As part of year one, a short life working group was established to support our understanding of HRPM involvement in substance use in Fife. This group will continue into year two, but the scope remains focused on: 1. Delivering a report that explains our understanding of HRPM and substance use in the Fife context 2. Provide recommendations based on these findings Any wider work related to substance use remains out of scope for this programme.

<u>Programme Composition Year 2</u>

The programme structure has been revised to support the co-ordination of activity and decision making required across multiple streams of work in year two.

The below illustrates the main groups that come under the programme.



There are three ongoing core workstreams recommended for year two of the programme.

1. **"Evidence and Education"** to co-ordinate the work required on prescribing guidelines, data and the programme's training response.
2. **"Incremental Improvement"** will support the planning, coordination and evaluation of identified service tests of change/process improvement work.
3. **"Engagement and Experience"** will establish a patient experience group to enable collaboration with patents and ongoing patient engagement around HRPM solutions, as well as help support patients accessing a patient peer support network to directly address patient feedback.

In addition to these workstreams, there will be some dedicated work packages to take forward the work of a pain champion network, as well as the continuation of the short life working group focused on HRPM and substance use. A full project team will also be formed to manage the creation of a new Pain Resource Hub.

Supporting the work across all streams and project groups will be NHS Fife Corporate Communication and Corporate Programme Management Office (CPMO) colleagues. Communications will help the programme define the desired public facing campaign and build their work plan in line with the communication needs of the core workstreams and individual projects/work packages. The CPMO will ensure the appropriate programme tools are in place to maintain activity alignment to desired programme outcomes, provide oversight and to help ensure change activity is controlled and coordinated as a whole.

The Clinical Leads of the programme will contribute as leads/members across all these groups as required.

2.3.1 Quality/Patient Care

The focus of this programme is to improve patient safety and care in relation to use of high-risk pain medicines. From patient engagement work in year one, the significant impact of pain on patients' health and wellbeing was clearly articulated. The work from year one has also identified a number of areas for improvement of patient care in relation to ensuring patients are better informed regarding their high risk pain medicines, more regular review and access to non- pharmacological ways of managing their pain.

2.3.2 Workforce

Dedicated workforce recruited to with no issues of concern to escalate. This programme will support delivery of education and training of the workforce to ensure they have the appropriate skills and knowledge to help patients manage their pain and ensure safe and effective use of high risk pain medicines.

2.3.3 Financial

Funding for the programme was agreed as a joint liability for Health and the Partnership. The budget for year one of the programme was £200,000. Spend forecasts assumed a 3% employee uplift. Following pay settlements and a review of outturn, year one costs total around £132,007, thereby an anticipated underspend of around £67,993 for year one activity. The underspend was due to delayed recruitment of the Engagement officer post and not utilising Pain Champions and sessional posts as initially anticipated in the "Understanding the Problem Phase".

The budget for year two of the programme is £200,000. The engagement officer is in place and pain champions are being recruited to, to facilitate delivery of Tests of Change. Year two activity is forecast to be within current budget, no financial implications are anticipated for this phase of the programme. There are risks to outcomes of the programme if either sector (Health or Partnership) were to reduce funding.

One of the programme benefits aims to reduce the prescribing of high risk pain medicines, with subsequent delivery of £50,000 medicines efficiencies.

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

This is a system wide programme of work, therefore will cover all areas across Fife including where health inequalities are experienced by local communities. A Stage 1 Equalities Impact Assessment (EQIA) has been published. It highlighted the need to build community links with opportunities for joint working to advance the equality of opportunity. Stage 1 also highlighted the need to capture both patient and staff experiences in the management of pain to foster good relations. These considerations having informed work plans now complete for year one with work progressed on engaging staff via events/surveys. Patients/carers have been engaged through the development of patient stories/surveys.

There is a requirement to complete a Stage 2 EQIA. A draft has been produced and work is ongoing. Early considerations include; ensuring that there is a method to evaluate the effectiveness of new training provided, the planned Resource Hub should include supported-self management resources as part of project scope, the programme should work with patients via the planned Patient Experience Group to ensure solutions do not have any disproportionate adverse impacts to identified groups, literature produced for patients should be in 'easy read' format as required.

The outcomes from the Stage2 EQIA will be reflected in all work plans of the programme.

2.3.5 Risk Assessment / Management

From the perspective of continuing to improve the overall health and quality of care for the people of Fife, the following risks are relevant to the programmes area of work:

Ineffective/ High Prescribing

There is a risk that patient safety, care and wellbeing is compromised due to limited staff/clinician knowledge of unintended consequences from extended, ineffective, or high prescribing of HRPM.

Ineffective Pain Management Pathways

There is a risk that patients experience poor quality of care and possible admissions due to inadequate pain management pathways.

The above risks are being mitigated by the ongoing work of the programme. The programme also uses a Risks and Issues Log, which is regularly assessed and reviewed to inform risk mitigations.

2.3.6 Climate Emergency & Sustainability Impact

Pain medicines are among the most widely used medications. As a result, the environment is becoming increasingly contaminated with analgesic residues created by the manufacture, consumption, and disposal of these medicines. As a result of the programme, improved prescribing initiation and monitoring of these medicines should lead to reduced volume of prescribing, an increase in appropriate destruction pathways and reduction of overall waste.

2.3.7 Communication, involvement, engagement, and consultation

Awareness and engagement are a fundamental parts of programme work. The following are key activities that have taken place to involve and engage internal and external stakeholders as appropriate across year one:

What	When
GP Cluster Quality Leads	August 2021
Pharmacy Senior Leadership team, Addiction Services	November 2021
Pharmacy Managed Service	December 2021
Physiotherapy Senior Management Team	February 2022
Senior Nurse Forum	March 2022
Royal Pharmaceutical Society Best Practice Event	May 2022
Grand Round, GP Cluster Quality Leads	June 2022
Fife Voluntary Action, Health & Social Care Forum	July 2022
GP Learn @ Lunch Session-awareness (also recorded/circulated)	August 2022
Grand Round	September 2022
ScotGem Medical Students GPST Lunchtime Training	October 2022
Phase 1: Understanding the Problem Event, GP Learn @ Lunch Session, Showcasing the Art of the Possible GP Cluster Quality Leads, data & engagement	November 2022
Patient gateway events to raise awareness and plan ongoing	December 2022

What	When
engagement	
GP Practice Visits – Oakley	December 2022
21 patient interviews 6 surveys (patient/carer and staff) 4 workshops (patient pathways/resources mapping, prescribing data/guidance review, staff and patient/carer perspectives)	March to April 2023
End of Year 1 event: "Steps Towards Solutions"	May 2023

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.

1. HRPM Steering Group, 6 December 2022
2. HRPM Programme Board, 20 December 2022
3. Executive Directors Group, 5 January 2023
4. Population Health & Wellbeing Committee, 11 January 2023
5. Clinical Governance Committee, 13 January 2023
6. HRPM Steering Group, 14 June 2023
7. HRPM Programme Board, 20 June 2023
8. Pharmacy Senior Leadership team 5 July 2023
9. HSCP SLT 7th August 2023
10. Acute SLT 8th August 2023
11. Executive Directors' Group 17th August 2023
12. Public Health & Wellbeing Committee 4th September 2023

2.4 Recommendation

The Clinical Governance Committee is asked to take **assurance** from the delivery of year one of the HRPM Patient Safety Programme, and plans outlined for year two.

3 List of appendices

Appendix 1: Three Year Programme Phases
Appendix 2: Summary of Key Findings from Year 1: Understanding the Problem Phase
Appendix 3: High Risk Pain Medicine Patient Safety Programme Year One Report

Report Contact

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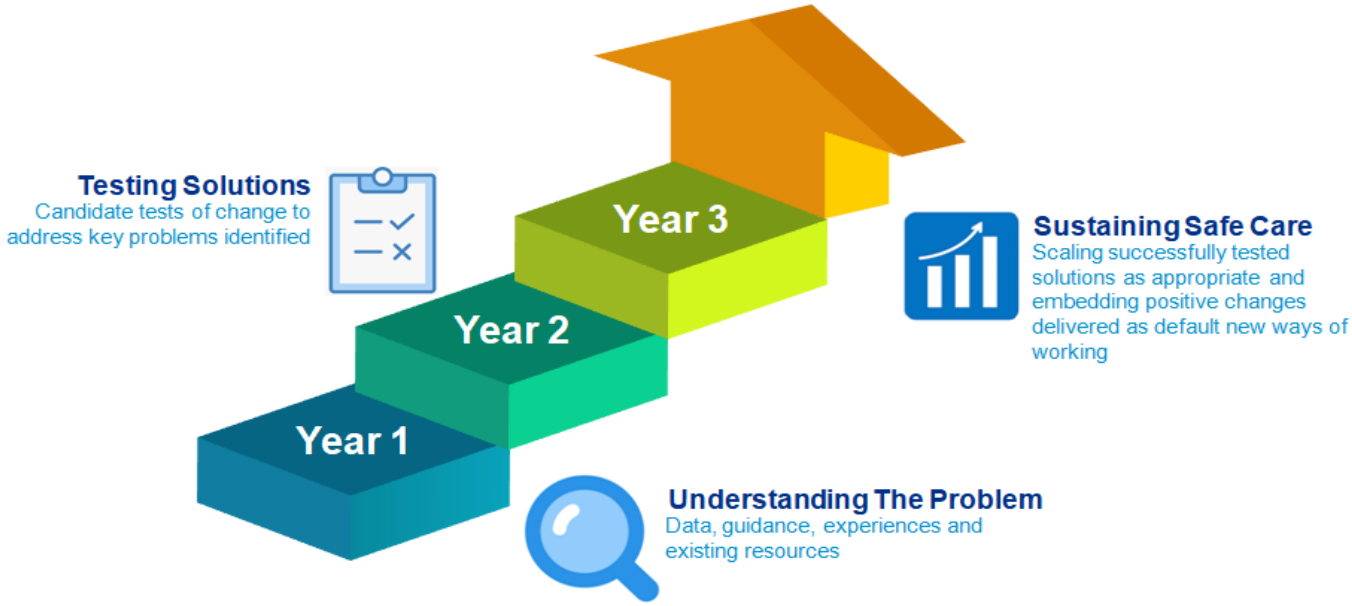
Appendix 1: Three Year Programme Phases



Appendix 2: Summary of Key Findings from Year 1: Understanding the Problem Phase

Problem Identified	Evidence or Understanding
High clinician confidence in delivering pain management in both sectors contrasting 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	• Clinician surveys in primary and secondary care • Guidance difficult to find, lengthy and not clear whether current or not on accessing • Pain teaching across professions usually focussed on acute (not chronic)pain management • Limited implementation of Surgery & Opioids guidance 2021 in acute hospital setting
Communication across services, sectors and between clinicians can be limited which impacts on clinician understanding and ability to support patients effectively	• Clinical audits evidenced only 25% of Secondary Care Clinicians initiating HRPM documenting treatment intent, duration and tapering plan • Patient surveys indicating information not being given regarding treatment plan • Primary Care Pathway analysis highlighted touch points and time points where key conversations should take place • Staff surveys highlighting a request for easier access to support
Cohorts of patients at greater risk of adverse effects from HRPM	• Practice level baseline data identifying high risk patient groups • National Registers of Scotland Report drug related death (DRD) report identifying prescribable medicine involvement and Substance use short life working group audit identifying what proportion of these were prescribed • 10% of patients in acute medical admissions units meet criteria for high dose opioid or high risk combination prescribing • Patients continuing on new and pre-existing HRPM, especially opioids, post surgically
Varying clinicians' perceptions on role and expectations of Fife Pain Management Service (outpatient chronic pain team and inpatient pain team) leading to missed opportunities to refer or inappropriate referrals.	• Staff surveys flagging various levels of understanding and differing expectations on what pain service provision should be

Problem Identified	Evidence or Understanding
Clinician and patient awareness and utilisation of services which would facilitate supported self management	• Staff, patient and carer surveys highlighting varying awareness and utilisation
High rates of prescribing of HRPM above Scottish average (measured by National Therapeutic Indicators) with increased risk of adverse effects, potential for diversion and waste	• large variation in prescribing in primary care and across wards/ services from prescribing data and audits • Involvement of prescribable medicines in DRD audit • Anecdotal evidence of waste from community pharmacy
Patient understanding of acute v chronic pain management, over reliance on pharmacological strategies for pain management and expectation of pain resolution through a medical model	• staff surveys highlighting challenges of supporting patient groups • Patient & carer surveys
Patients experiencing short and long term adverse effects from HRPM impacting on quality of life and overall health leading to cascade prescribing and increased utilisation of healthcare resources including hospital admissions	• Feedback from patient surveys and stories. • Case reports from clinicians across sectors and in patients pain team • Literature search and evidence from NHS England medicine safety programmes • SCOTGEM identification of HRPM high risk cohorts in Admissions Units
Patients' stories highlight that living with a pain condition has a significant negative impact on their physical and mental health/quality of life, as well as on the wellbeing of those who closely support them	• Patient and carer surveys • 1-2-1 interviews as part of patient stories
Patients felt there could be better information provided on their medicines, and would welcome more regular medication reviews	• Patient and carer surveys • 1-2-1 interviews as part of patient stories
Patients felt underrepresented and isolated, would welcome peer support and opportunities for further involvement in the work of the programme	• Patient and carer surveys • 1-2-1 interviews as part of patient stories
Patients would like information about alternatives to medicines and supported self-management solutions, but from one easy to find location (as the feeling was information was too dispersed and they did not know where to find it)	• Patient and carer surveys • 1-2-1 interviews as part of patient stories
There is involvement of prescribed HRPM in drug related deaths (25% of deaths had prescribed gabapentinoids implicated; 14% of deaths had prescribed benzodiazepines implicated; 11% of deaths had prescribed opioids/opiates	• Review of drug related deaths, prescribing data and medical examiners report.

Problem Identified	Evidence or Understanding
after excluding opioid substitution therapy (OST)).	
There are specific needs of people who use illicit substances in relation to the HRPM programme. Particularly in relation to their experiences of trauma and stigma; their needs in relation to alternatives to prescribing; the risks of deprescribing interventions; the needs to effectively manage dual issues of chronic pain and dependency; specific needs in relation to guidelines. And the need to avoid diversion through a universal approach to stewardship.	• HRPM/ substance use short life working group • Professionals focus group • Learning from multi-disciplinary drug death review group

Fife Health & Social Care Partnership

NHS Fife

Year one report

High-risk pain medicine patient safety programme

Managing pain,
a time for change

Published July 2023

www.nhsfife.org

Foreword

"I welcome this report at the end of the first year of our three-year High-Risk Pain Medicines Patient Safety Programme, which has been developed through engagement with communities and staff. Within NHS Fife and the Health and Social Care Partnership the safety of our population is paramount, and we want the people of Fife to live well, work well and flourish.

Growing evidence tells us we need to think differently about how we manage pain, and the medicines used to help manage it. We recognise the impact that pain can have on the quality of life and the wellbeing of our population. We need to ensure pain medicines are used safely and effectively and that there are meaningful alternative strategies to medicines available within our communities.

In our first year we have taken time to understand the needs of our patients by recognising the challenges they face in managing their pain, and the difficulties faced by carers and professionals supporting people to achieve this. As we move into year 2, we begin to explore opportunities to improve the care and support offered and reduce the risk of harm from pain medicines.

I'd like to take this opportunity to thank the patients, carers and colleagues who have taken time to share their experience and acknowledge the hard work of the programme team in delivering year 1.

I look forward to continuing to work with all."

Ben Hannan,
Director of Pharmacy and Medicines, NHS Fife

"It is testament to the values of NHS Fife and the Health and Social Care Partnership that they have recognised this important area of patient care and medicines safety and are taking a system wide approach to improving care and support offered to our population managing pain. Pain is a complex condition, and whilst most of us have some experience, it is often under recognised as a condition, not just a symptom of something else. As many as a third of our population may be managing a long-term pain condition. That means over 120, 000 people in Fife, perhaps your family, friends, colleagues or even yourself, are managing this condition which can be invisible to others yet have an overwhelming impact on how you live your life. Our year 1 of understanding, has given us valuable insight. For us to know how to improve, we need to understand our current experience, positioning and offer.

I am honoured to lead on this programme and to work collectively with all those involved, and I wholeheartedly thank the contributions from patients, carers and colleagues and the enthusiasm and hard work from the programme team and I look forward to continuing to work with you all. Roll on year 2 and making a difference".

"Managing pain, a time for change."

Debs Steven, Programme Director,
HRPM Patient Safety Programme

Contents

1. Introduction

1.1 Purpose

The High-Risk Pain Medicines (HRPM) Patient Safety Programme seeks to understand how pain is currently managed across Fife. This area of work was identified as a corporate objective in response to national drivers around change in evidence of medicine benefit in chronic pain, prescribed medicine dependency, involvement of prescribed medicines in drug related deaths and identification of Fife as an outlier compared to other health boards with a particular focus on the prescribing of opioids, gabapentinoids, non- steroidal anti-inflammatory drugs (NSAIDs) and benzodiazepines.

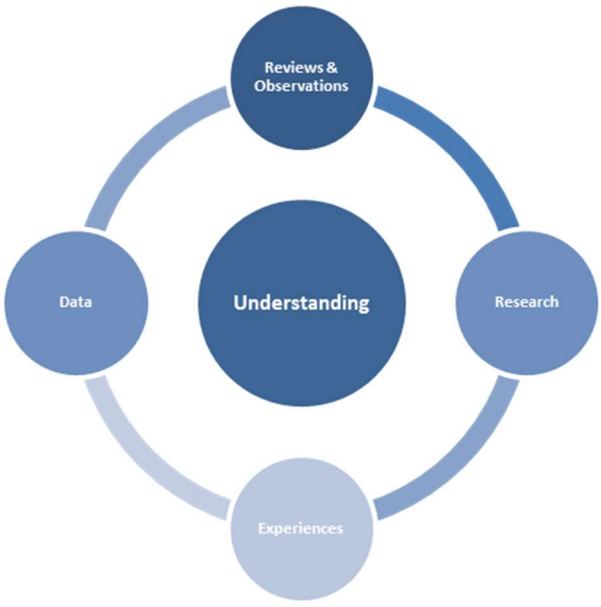
The programme also aims to reduce the prescribing culture and use of High-Risk Pain Medicine (where appropriate) and raise awareness of alternatives to prescribing across all NHS Fife settings.

Phase one 'understanding the problem' covered the programme's initial year.

The purpose of this report is to present the main findings from the programme's efforts in developing this understanding, as well as recommend initial Tests of Change/Projects for the next phase, which aim to inform and enable system improvements.

1.2 Approach

Several programme workstreams were established to support the activity of phase 1. Across these workstreams analysis work has been undertaken to help with our understanding of the problem. The diagram below outlines the main ways this understanding has been developed:



Reviews & Observations: Review work has mainly centred on understanding how well our HRPM existing guidelines inform and are used in practice. Existing resources have also been reviewed, for example the Pain Management Jigsaw, to identify levels of awareness and use of these resources to bring alternatives to our patients. Process/Patient Journey Mapping is another tool adopted to understand patient flow, process interfaces, and identify what key services/staff roles are involved in supporting processes.

Research: Desk research complimented with site visits and lessons learned from other similar work help to establish context. They also develop an understanding on what has gone well or could be further improved. Survey work has also been undertaken to baseline key stakeholder awareness, staff knowledge/skills and attitudes regarding the use of HRPM in the management of pain conditions.

Experiences: Qualitative information has been captured on our patient/carer and staff/prescriber experiences of both living with and managing pain conditions. This has been done using stories/case examples, developed through semi-structured interviews. Surveys have also been used to indicatively establish a generalised sense of peoples' experiences.

Data: Measures have been agreed and new measures created to help us better understand our prescribing data across the system. This includes the analysis of prescribing data recorded in management systems, as well as the use of manual audits to help bridge known data gaps across the wider system.

Overall, the triangulation from the methods outlined above ensure the problem is considered from multiple perspectives. These combine to improve our understanding of:

- Prescribing data across the system.
- High risk pain medicines prescribing guidelines awareness and utilisation.
- Awareness and utilisation of existing supported self-management resources.
- The experiences of patient/carers and staff/prescribers living with and managing pain conditions.

Described in the main body of this report are the main findings from the totality of this analysis work completing phase 1 of the programme.

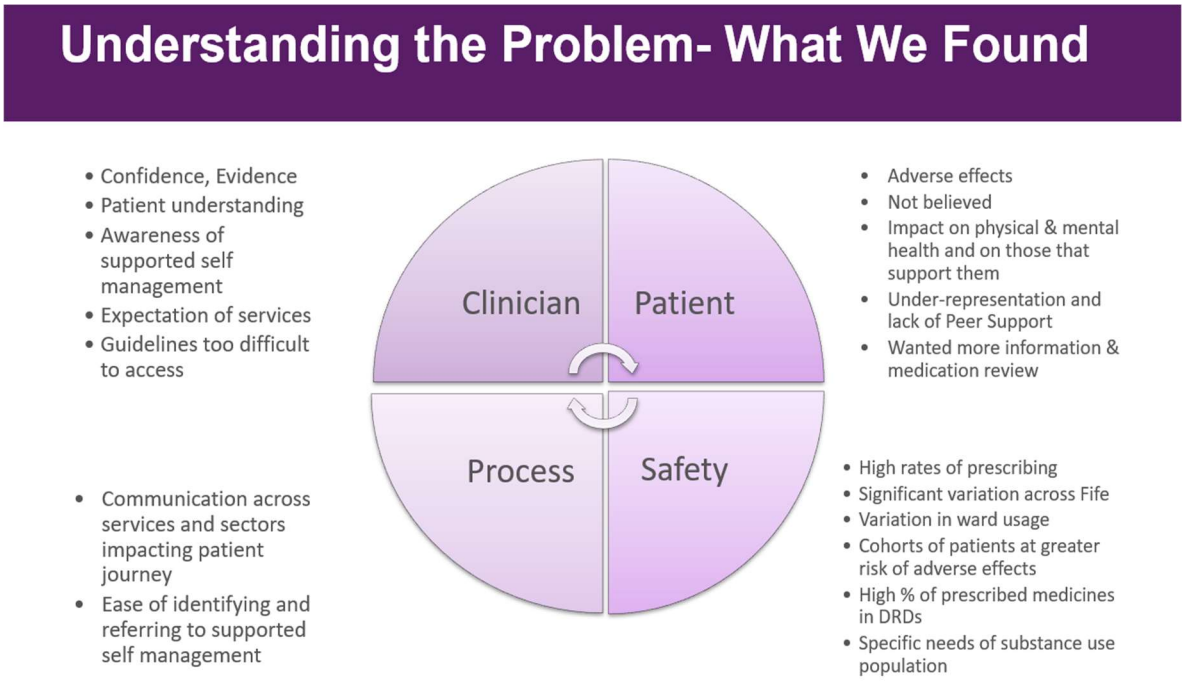
2. Key Findings & Conclusions

2.1 The Problem Summary

Problem Identified	Evidence or understanding
High clinician confidence in delivering pain management in both sectors contrasting 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.	• Clinician surveys in primary and secondary care. • Guidance difficult to find, lengthy and not clear whether current or not on accessing. • Pain teaching across professions usually focussed on acute pain management. • Limited implementation of Surgery & Opioids guidance 2021 in acute setting.
Communication across services, sectors and between clinicians can be limited which impacts on clinician understanding and ability to support patients effectively.	• Clinical audits evidenced only 25% of Secondary Care Clinicians initiating HRPM documenting treatment intent, duration and tapering plan. • Patient surveys indicating information not being given. • Primary Care Pathway analysis highlighted touch points and time points where key conversations should take place. • Staff surveys highlighting a request for easier access to support.
Cohorts of patients at greater risk of adverse effects from HRPM.	• STU Practice level baseline data identifying high risk patient groups. • National Registers of Scotland Report drug related death (DRD) report identifying prescribable medicine involvement and Substance use short life working group audit identifying what proportion of these were prescribed. • 10% of patients in acute medical admissions units meet criteria for high dose opioid or high-risk combination prescribing. • Patients continuing new and pre-existing HRPM, especially opioids, post surgically.
Varying clinicians' perceptions on role and expectations of Fife Pain Management Service (outpatient chronic pain team and inpatient pain team) leading to missed opportunities to refer or inappropriate referrals.	• Staff surveys flagging various levels of understanding and differing expectations on what pain service provision should be.
Clinician and patient awareness and utilisation of services which would facilitate supported self-management.	• Staff, patient and carer surveys highlighting varying awareness and utilisation.
High rates of prescribing of HRPM above Scottish average (measured by National Therapeutic Indicators) with increased risk of adverse effects, potential for diversion and waste.	• Large variation in prescribing in primary care and across wards/ services from prescribing data and audits. • Non prescribed involvement of prescribable medicines in DRD audit. • Anecdotal evidence of waste from community pharmacy.

Problem Identified	Evidence or understanding
Patient understanding of acute v chronic pain management, over reliance on pharmacological strategies for pain management and expectation of pain resolution through a medical model.	• Staff surveys highlighting challenges of supporting patient groups. • Patient & carer surveys.
Patients experiencing short- and long-term adverse effects from HRPM impacting on quality of life and overall health leading to cascade prescribing and increased utilisation of healthcare resources including hospital admissions.	• Feedback from patient surveys and stories. • Case reports from clinicians across sectors and in patients pain team. • Literature search and evidence from NHS England medicine safety programmes. • SCOTGEM identification of HRPM high risk cohorts in AMAUs.
Patients have described various situations that demonstrate living with a pain condition has a significant negative impact on their physical and mental health/quality of life, as well as to the wellbeing of those who closely support them.	• Patient and carer surveys. • 1-2-1 interviews as part of patient stories.
Patients felt there could be better information provided on their medicines and would welcome more regular medication reviews.	• Patient and carer surveys. • 1-2-1 interviews as part of patient stories.
Patients felt underrepresented and isolated, would welcome peer support and opportunities for further involvement in the work of the programme.	• Patient and carer surveys. • 1-2-1 interviews as part of patient stories.
Patients would like information about alternatives to medicines and supported self-management solutions, but from one easy to find location (as the feeling was information was too dispersed and they did not know where to find it).	• Patient and carer surveys. • 1-2-1 interviews as part of patient stories.
There is involvement of prescribed HRPM in drug related deaths (25% of deaths had prescribed gabapentinoids implicated; 14% of deaths had prescribed benzodiazepines implicated; 11% of deaths had prescribed opioids/opiates after excluding opioid substitution therapy (OST).	• Review of drug related deaths, prescribing data and medical examiners report.
There are specific needs of people who use illicit substances in relation to the HRPM programme. Particularly in relation to their experiences of trauma and stigma; their needs in relation to alternatives to prescribing; the risks of deprescribing interventions; the needs to effectively manage dual issues of chronic pain and dependency; specific needs in relation to guidelines. And the need to avoid diversion through a universal approach to stewardship.	• HRPM/ substance use short life working group. • Professionals focus group. • Learning from multi-disciplinary drug death review group.

2.2 Recommendations/Change for Year 2



Overall, from the main findings of year 1 of the programme our stakeholders generated a significant number of change and improvement ideas. These ideas have been explored with stakeholders in several ways including site visits, 1-2-1 conversations and across several workshops leading to the finalising of the 'understanding the problem' phase. Although the programme would like to do everything suggested to the fullest level, sadly several programme constraints exist in terms of available time, cost, resource and the readiness of in scope Services to be able to support change work among many competing challenges.

That said, when discussing ideas in the context of constraints it was felt the below recommendations found a balance for year 2 of the programme, across the next 'testing solutions' phase. It is felt the programme response outlined below remains ambitious but at the same time is realistic to deliver on over the next phase:

2.2.1 Resource Hub

A re-occurring idea was the need for a single point to act as a resource site (like Mood Cafe) for both clinicians and patients to improve awareness and access to Supported Self-Management Solutions/resources based on area and individual circumstance.

It is proposed a dedicated project be established to define and plan this work. The exact scope would be worked through by the project process but will likely include developing an online platform that offers patients information, take away resources and potentially self-referral (where appropriate) to some services. Clinicians should also have a single point to navigate from when seeking to signpost patients, access prescribing guidelines/guidance and when seeking information around more specialist service referrals.

2.2.2 Education Training Response

The findings highlighted some gaps in knowledge/skills regards pain management. They also implied some assumptions are made perhaps based on historical training. It was felt by stakeholders a training offer from the programme was required. Consequently, it is recommended work is progressed on the design and delivery of training across the following areas:

- Primary Care Lunchtime Education Sessions
- Training for Junior Doctors/Consultants/ANP/Pharmacy/AHP around HRPM
- Rolling base awareness training on HRPM for NMP
- HRPM Training for Pain Champions (Pain Champions work outlined below)
- Community Education/Awareness Sessions

2.2.3 Pain Champion Network

To help support services with the management of patients with pain conditions as well as drive local process improvement activity, the creation of a pain champion network has been discussed. It is recommended as part of year 2, the programmer creates a work package to define the pain champion role (to cover both pain as a subject and improvement support), work with services to identify candidates to undertake such a role and support the role with a training offer (referenced above).

By creating this network, this should directly support improvement activity and tests of change identified by the programme, as well as act as a source for future improvement ideas/tests of change.

2.2.4 New Guidelines/Toolkit

Based on the findings from guidelines reviews, the identified low levels of frequency of use and feedback on ease of use, it is recommended guidelines be restructured in a more consumable manner and attempt to become more of a ‘toolkit’ as opposed to sizeable and more static reference documents.

Related to the toolkit theme, is work around primary care data packs in relation to HRPM prescribing volumes. It is also recommended that regular data packs be provided to primary care colleagues, to help focus their own improvement efforts in this area.

2.2.5 Improvement Activity/Tests of Change

Key findings from 4 workshops formed the basis for the conclusion of year 1 of the programme and several tests of change/improvement activities were identified. These broadly sought to support improvements in communication between patient pathway interfaces and to support clinicians in managing patient expectations. Activity areas recommended to define, plan and evaluate across year 2 are outlined in the tables below:

Primary Care	
What?	**Why?**
Test Acute limit on prescriptions.	To reduce waste, minimise risk of sharing medications, encourage review and help manage patient expectations.
Test Pharmacists dealing with discharge letters.	To better identify patients at risk from HRPM (Perhaps targeting scope on post-surgical patients because of evidence around not managing people well at that point leads to medicines going on long-term repeat. Make this just a HRPM review not all drugs. Look at pre surgery HRPM meds and have an overall conversation. Should be alert to risky combinations and volumes.)
Test using 'Managed Repeats' in a different way to increase timely review of HRPM.	To enable an improved/ automatic process to trigger medication reviews.
Test 3-6 months Acute to Chronic Pathway (de-prescribing).	To improve conversations/ awareness of alternative options for those living with longer-term pain.
Test patient (concertina) information cards.	To enable early patient conversations and drip feed key messages on drug harms/alternatives.
Test standardised consultation format/ template in GP system.	To enable consistent patient discussions, improve the review approach and associated admin.
Test Community Pharmacy HRPM Patient Safety Bundle.	To help raise awareness and increase the opportunities to inform patients of the risks associated with HRPM.

Secondary Care	
What?	**Why?**
Test pre-operative identification of complex cases for flagging to inpatient pain team.	To help alert pain team to patients earlier in the process to improve advice to patients regards pain management.
Test post operative Immediate Release (IR) v Modified Release (MR) opioid use.	Implementation of surgery and opioid guidance. Use of immediate release (IR) preparations rather than modified release (MR). There is reasonable application within some areas of planned surgical, but this need applied across all surgical settings.
Test implementation of Post operative standardised leaflet with individual patient care plan.	To help raise awareness and increase the opportunities to inform patients of the risks associated with HRPM.
Test prescribing plan in Discharge Letters.	To improve communication, care continuity and overall patient experience when moving across services.
Test criteria for in-house pain team referral.	To ensure appropriate referral to the in-house pain team to improve advice to patients regards pain management.

2.2.6 Patient Engagement & Experience

Through the engagement efforts of year 1, the programme has found patients have been willing to engage significantly. Patients have also expressed a desire for ongoing programme involvement.

To create the basis for this, it is recommended the programme establish a 'Patient Experience Group'. This group can act as a reference group to enable collaboration and co-production opportunities with patients, around some of the public facing programme solutions (for example the recommended Resource Hub).

2.2.7 Public Health Campaign

A key finding was the need to manage expectations of patients to help support clinicians with conversations on alternatives to pain medication.

Given the work needing progressed in the Fife context, waiting on a national campaign was not seen as an option. Therefore, it is recommended the programme team with NHS Fife Communication colleagues to design a public facing campaign to be delivered during year 2, that supports the work and objectives of the overarching programme.

2.2.8 HRPM & Substance Use

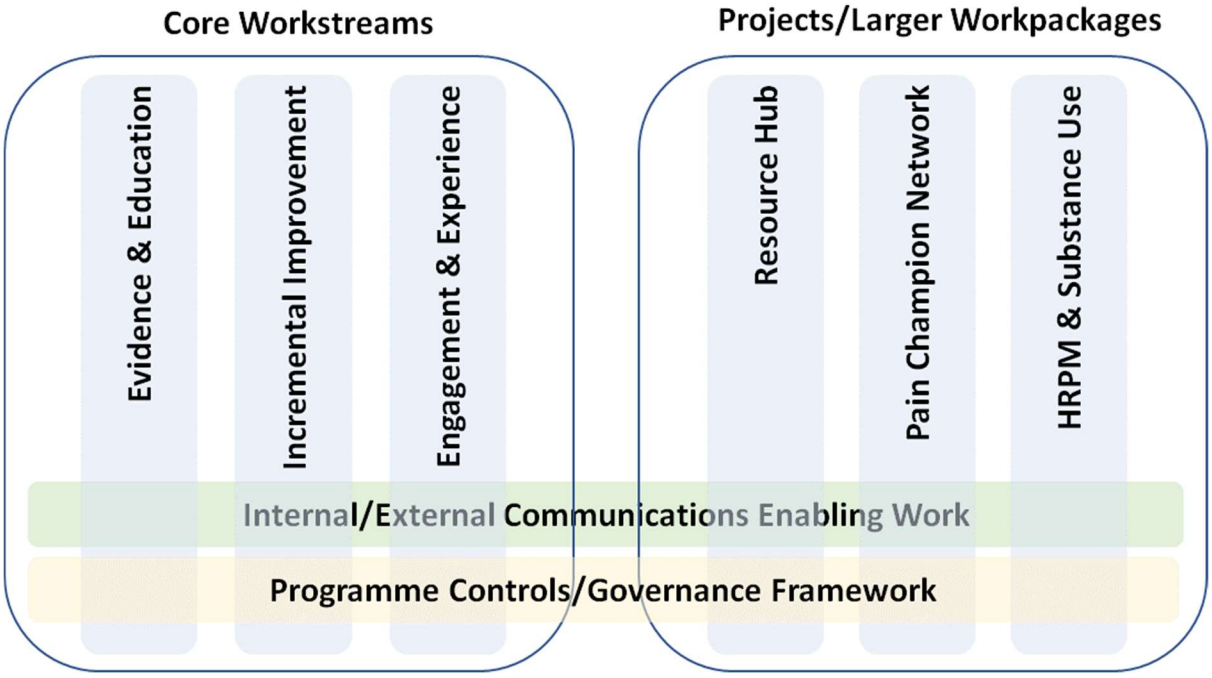
As part of year 1 a short life working group was established to support our understanding of HRPM involvement in substance use in Fife. It is recommended this group continue into year 2, but the scope remain focused on:

- Delivering a report that explains our understanding of HRPM and substance use in the Fife context
- Provide recommendations based on these findings

Any wider work related to substance use remains out of scope for this programme.

2.2.9 Year 2 Programme Structure

To support the work recommended above, the below illustrates the suggested programme structure for year 2:



There are three ongoing core workstreams recommended as part of year 2 of the programme. “Evidence and Education” would be responsible for the work outlined under 2.2.2 and 2.2.4. “Incremental Improvement” would support the planning, coordination, and evaluation of work under 2.2.5. “Engagement and Experience” would establish and provide the ongoing management of work outlined in 2.2.6 as well as support the wider engagement work of the programme and its related workstreams/projects.

In addition to these workstreams there will be some dedicated work packages to take forward the work of a pain champion network (in 2.2.3), as well as the continuation of the short life working group focused on HRPM and substance use (in 2.2.8). A project team will also be formed to manage the Resource Hub work (in 2.2.1).

Supporting the work across all streams and project groups will be our NHS Fife Corporate Communication and Corporate Programme Management Office (CPMO) colleagues. Communications will help the programme define the desired public facing campaign (in 2.2.7) and build their work plan in line with the communication needs of the core workstreams and individual projects/work packages. The CPMO will ensure the appropriate programme tools are in place to maintain activity alignment to desired programme outcomes, provide oversight and to help ensure change activity is controlled and coordinated as a whole.

3. What Insights Can Be Gained from Our Data?

3.1 Prescribing Of HRPM

3.1.1 Background

HRPM are initiated or prescribed through a range of routes within NHS Fife in Primary and Secondary Care. Differences in technology and recording systems mean some areas are easier to identify and analyse than others. HRPM issued in Primary Care (mainly GP systems) are electronically recorded in national Public Health Scotland data systems and can be readily accessible using nationally available dataset presentations such as National Therapeutic Indicators Dashboard or be downloaded to allow local analysis via Digital & Information colleagues using MicroStrategy.

Secondary Care initiated HRPM are far more challenging to understand as currently prescribing in inpatient settings is manually using Kardexes. In outpatient settings most initiation is via prescription recommendations to the patient's GP which may be by a clinic letter or recommendation slip issued to the patient. Occasionally patients may be issued with patient packs or a hospital (blue HBP) prescription for presentation to Community Pharmacy. This makes central understanding of the prescribing challenging. The introduction of the HEPMA hospital electronic prescribing system soon, should make ongoing understanding and monitoring easier. Other routes to identify use are analysing stock supply to ward systems. This can give some limited insight to overall use caveated that it lacks patient specific information and can be confounded by stock returns.

3.1.2 Primary Care Prescribing - General

The NHS Fife Primary Care gross ingredient cost (GIC) for all analgesics over the financial year 2021/22 was £6.62 million. The number of items issued for all analgesics over the financial year 2021/22 was 1,012,509. These figures exclude benzodiazepines which do not normally fall under analgesic prescribing but have been included in HRPM due to use as a muscle relaxant and increased risk of harm due to concomitant use in pain and mental health co-morbidities. Pain medicines account for around 8.5% of the total Primary Care spend and 14% prescription volume. Items and GIC noted for benzodiazepines separately as predominantly fall under mental health and difficult to determine exact pain use.

2021-22	GIC	Items
Opioids	£3,004,898	402468
Gabapentinoids	£758,027	139478
NSAIDs	£ 992,160	166306
Analgesic HRPM Total	**£ 4,755,085**	**708252**
Benzodiazepine & Z drug total	£ 642,204	120156
HRPM Total	**£ 5,397,289**	**828408**

3.1.3 Primary Care Prescribing - National Therapeutic Indicators (NTIs)

There are 8 National Therapeutic indicators relating to HRPM. The first four relate to volume of use defined by DDDs (daily defined doses). The second 4 relate to specific safety recommendations with HRPM regarding rising risk on increasing Morphine equivalent daily (MED) dose and high dose gabapentinoid use.

The table below outlines NHS Fife position on Mar 22 and the percentage change needed to achieve at or below Scottish average on March 22:

Mar-22	National therapeutic Indicator	Measure	Fife	Scotland	% difference +/- from Scotland average	% change in Fife required to achieve Scotland average @ Mar 22	HB position
1	Gabapentinoid	DDDs	25.04	19.58	27.90%	21.80%	1st
2	Strong Opioid	DDDs	18.28	12.72	43.70%	30.40%	2nd
3	Hypnotics & Anxiolytics	DDDs	23.57	21.91	7.60%	7.00%	3rd
4	NSAID	DDDs	31.13	31.52	-1.20%	-1.30%	11th
5	High dose opioid>120MG MED	Percentage	1.74	1.58	10.10%	9.20%	6th
6	Increasing opioid risk > 50mg MED	Percentage	7.22	6.24	15.70%	13.60%	4th
7	Long term opioid (> 2yrs)	Percentage	56.64	60.1	-5.80%	-6.10%	11th
8	High dose Gabapentinoid	Percentage	0.4	0.45	-11.10%	-12.50%	7th

On March 22 Fife was above Scotland average in 5/8 indicators and below Scotland average in 3/8 indicators. In most instances, current guidance on prescribing would suggest it would be better to be at or below Scottish average.

The data from the NTI dashboard was used to create a local MicroStrategy dashboard which allowed us to look at Cluster and practice level NTI performance under a RAG status as below.

Practice/Cluster > Fife average & > Scotland	Practice or Cluster indicator is higher than both Fife & Scotland average - generally an area that requires significant improvement
Practice/Cluster < Fife average & > Scotland	Practice or Cluster indicator is lower than Fife but higher than Scotland average - generally an area that requires improvement
Practice/Cluster < Fife average & < Scotland	Practice or Cluster indicator is lower than both Fife & Scotland average - opportunities for improvement but may not be a priority area
Practice/Cluster > Fife average & < Scotland	Dependent on the measure - e.g. for NSAIDs the whole of Fife may be better than Scotland average but still an important area to work on

RAG Status Cluster Level Quarter 1 Apr-Jun 22

RAG Status for Destinations										
Indicator		value								
	QUARTER	Cowdenbeath	Dunfermline	Glenrothes	Kirkcaldy	Levenmouth	North East Fife	South West Fife	Fife	Scotland
Analgesics (gabapentanoid DDDs) (weighted)	22_23 Q1	27.45	21.37	27.12	27.38	45.73	17.83	21.74	25.67	19.83
Analgesics (opioid DDDs) weighted	22_23 Q1	23.23	14.61	20.71	18.82	31.42	12.89	16.54	18.73	12.79
Hypnotics and Anxiolytics (DDDs) weighted	22_23 Q1	29.25	24.64	23.48	18.24	35.87	20.23	21.61	23.80	21.78
NSAIDs (DDDs) weighted	22_23 Q1	30.34	30.07	36.88	27.24	47.51	26.28	28.06	31.73	32.43
Opioid and gabapentinoid dependency (high dose gabapentinoids %)	22_23 Q1	0.45	0.62	0.51	0.52	0.27	0.27	0.52	0.46	0.41
Opioid and gabapentinoid dependency (high dose opioids %) 120mg	22_23 Q1	0.81	0.88	1.40	1.27	1.37	0.89	0.78	1.07	1.54
Opioid and gabapentinoid dependency (high dose opioids %) 50mg	22_23 Q1	6.34	4.25	6.37	5.88	6.27	4.86	4.44	5.51	6.10
Opioid and gabapentinoid dependency (long term opioids %)	22_23 Q1	53.27	48.67	59.71	53.15	62.03	50.86	52.22	54.13	60.00

The table above shows variation between clusters. North East Fife has the highest number of green indicators (7/8) with Levenmouth the lowest (1/8).

This data has been driven down to practice level and will be shared with Practices as part of a data pack to help drive their own understanding and encourage local quality improvement work. The proof of concept has been disussed and agreed at Cluster Quality lead level and also at 4/7 cluster are meetings. It has helped identify potential outlier practices which could be offered additional engagement to support understanding and potential tests of change.

3.1.4 Primary Care Prescribing – Scottish Therapeutic Utility (STU)

The Scottish Therapeutics Utility (STU) was developed to improve safety, optimise efficiency, and reduce avoidable waste (processes and costs), particularly in relation to repeat prescribing. STU is intended for use by healthcare professionals and GP practice staff to monitor and review repeat prescribing systems at practice level. The utility allows users to interrogate their prescribing in real time and provide active patient lists to support local targeted review.

Nine STU indicators relevant for the HRPM programme have been identified. Some are linked to the NTI's, and others are safety measures. Practice level searches were conducted in each GP Practice by the pharmacy team to provide a base line number of patients for each measure Dec 22-Jan 23. The intention is that the STU data is collected every quarter by the pharmacy team to track change and progress over the duration of the programme. The data collated to cluster and board level quantifies the number of patients in high-risk cohorts.

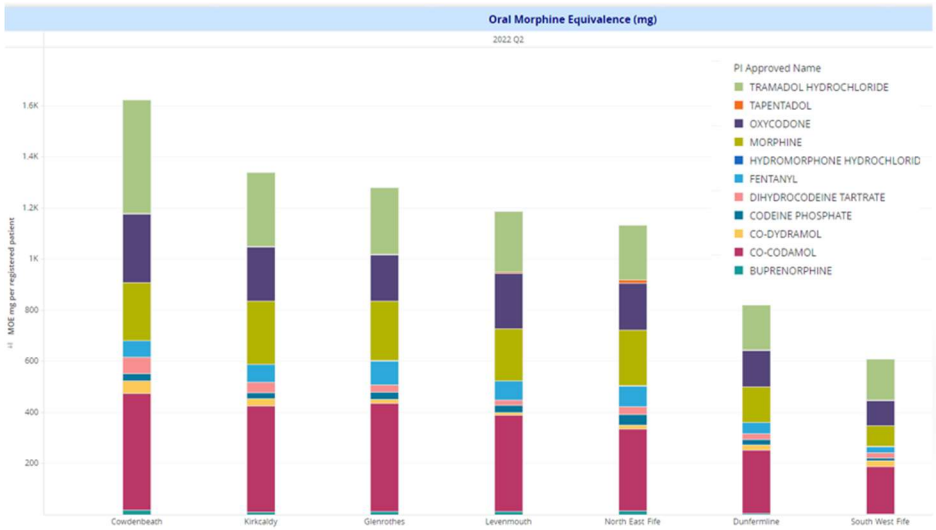
STU Data Practices Nov22-Jan 23.									
Total No. of patients for each measure by Cluster	High dose opioid >120mg	High dose opioid >90mg	High dose opioid >50mg	Opioid > 2 yrs.	Gabapentinoid dependency: >4800mg gabapentin	NSAID > 75 years (no PPI)	Triple whammy AKI (NSAID /ACE/ Diuretic)	Opioid and Benzo/z drug	Benzo or Z drug > 8 weeks
Kirkcaldy	133	195	597	1111	0	29	34	35	948
Lochgelly	62	107	475	1101	0	19	35	26	835
Dunfermline	67	97	362	777	0	24	23	38	1109
SW Fife	39	61	235	488	<10	12	16	31	547
Levenmouth	87	132	442	974	0	26	50	23	706
NE Fife	87	119	354	681	<10	58	51	39	969
Glenrothes	107	170	529	1123	0	35	59	30	910
Fife Total	**582**	**881**	**2994**	**6255**	**<20**	**203**	**268**	**222**	**6024**

In line with guidance, we would hope to see a reduction in all the above columns throughout the programme.

3.1.5 Primary Care Prescribing – Morphine & Gabapentinoid "load"

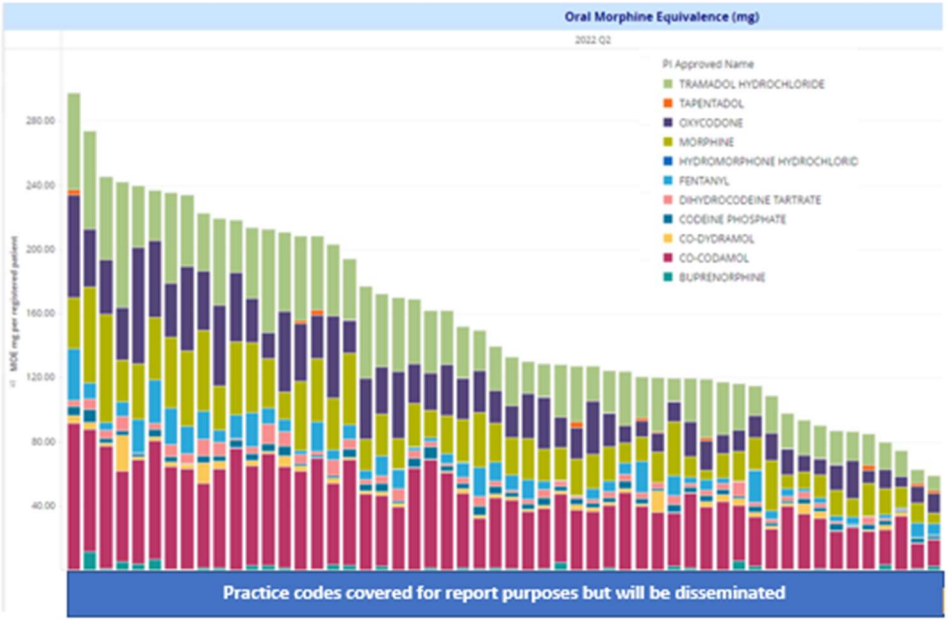
Whilst prescribing data can be looked at from a volume and cost perspective this is not always helpful when considering risk. The programme may result in moving from one opioid or gabapentinoid to another or reduction in dose which, whilst reducing overall risk may not be reflected in a reduction in volume or cost. We know morphine and gabapentin have increasing risks of harm as dosage increases. Oral Morphine Equivalence (OME) is a known measure for comparing different opioids, using conversion factors. It is sometimes known as Milligram Morphine Equivalence (MME) or Morphine Equivalent Dose (MED). We used this to develop the concept of Morphine "load" per registered patient per quarter to allow us to compare the total use of opioids at practice and cluster level and thus put a determinant on areas of greater risk. This measure also allowed us to look at the range of opioids used and those which are formulary and non-formulary.

Graph Oral Morphine Equivalence per registered patient per quarter Q2 Jul-Sept 22 by cluster



Variation can be seen across clusters with a 2.5 fold variation between the highest load cluster (Cowdenbeath) and the lowest load cluster (South West Fife).

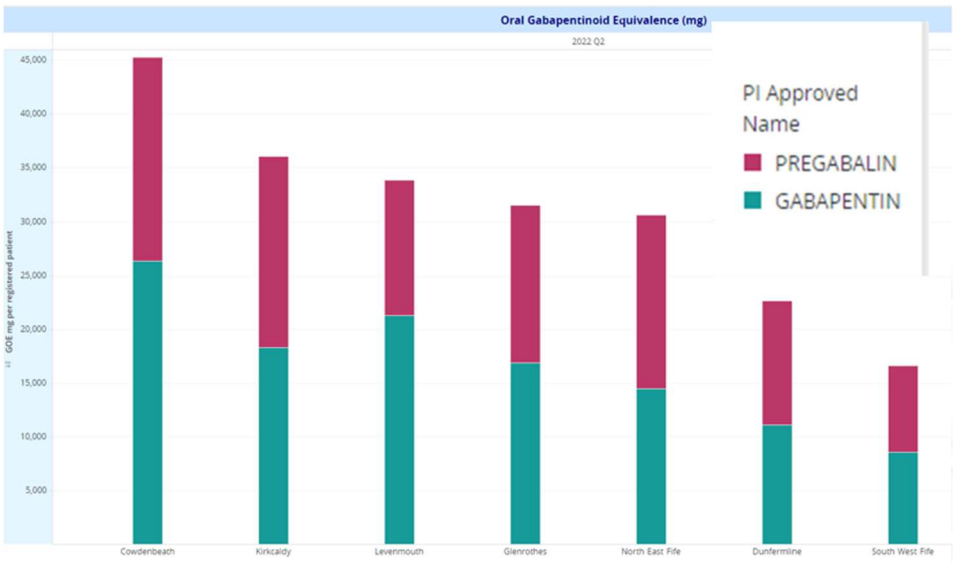
Graph Oral Morphine Equivalence per registered patient per quarter Q2 Jul-Sept 22 by practice



Variation can be seen across practices with a 5 fold variation between the highest load practice and the lowest load practice.

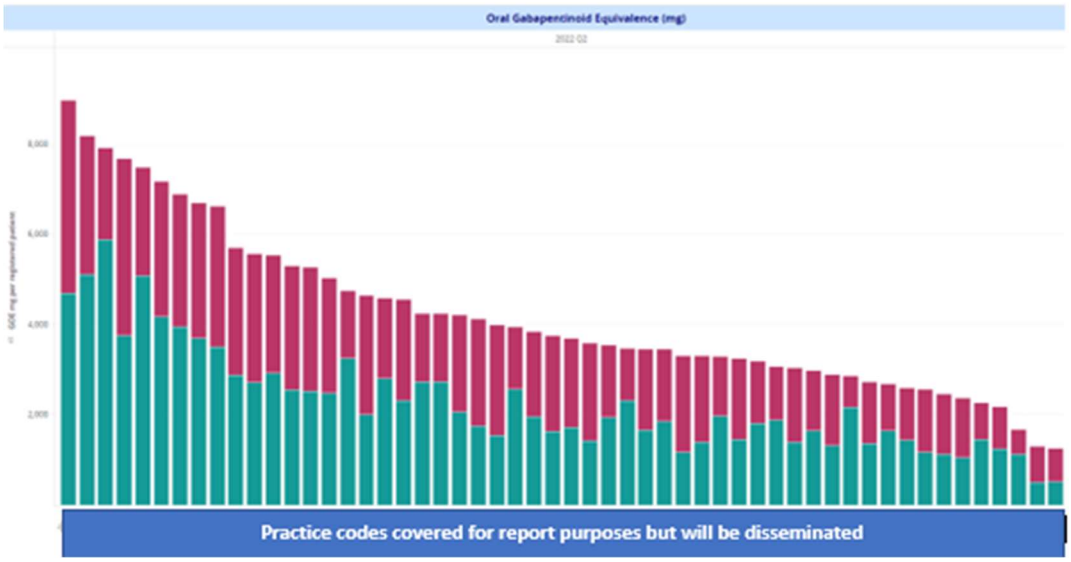
A comparable exercise was repeated for gabapentinoids and whilst there are not the same universally utilised conversion rates between pregabalin and gabapentin an informal conversion rate was identified and verified by a number of research sources which allowed calculation of gabapentinoid “load” per registered patient per quarter.

Graph Oral Gabapentinoid Equivalence per registered patient per quarter Q2 Jul-Sept 22 by cluster



A similar variation can be seen across clusters with a >2.5 fold variation between the highest load cluster (Cowdenbeath) and the lowest load cluster (South West Fife).

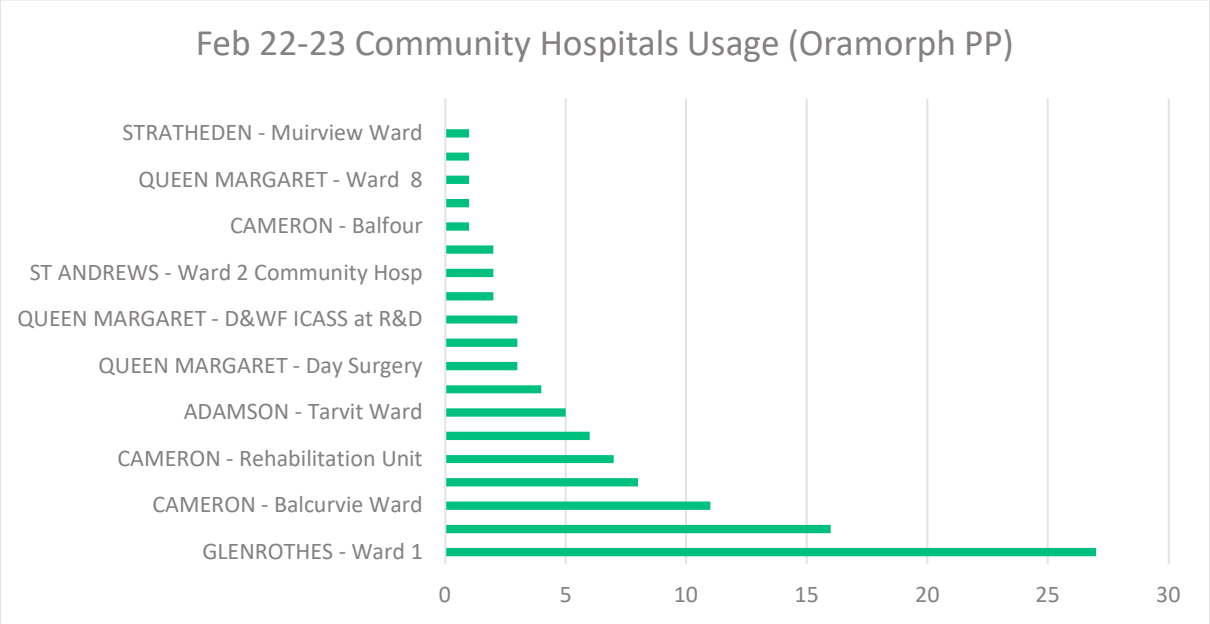
Graph Oral Gabapentinoid Equivalence per registered patient per quarter Q2 Jul-Sept 22 by practice



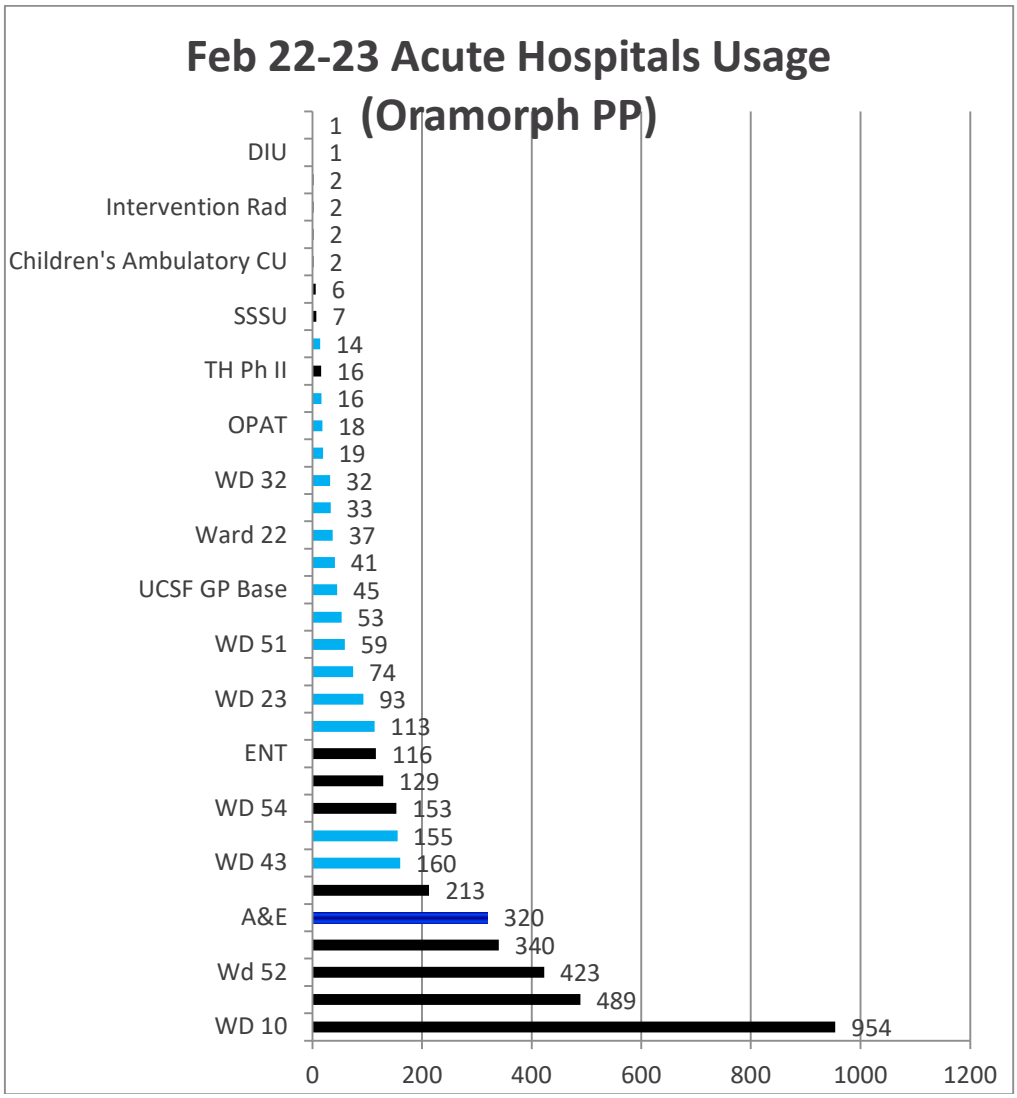
The greatest variation was seen in this measure with >8.5 fold variation between the highest practice and the lowest practice. This information can be disseminated to practices and Cluster Quality Leads with the practice data pack to encourage reflection and action. We would hope to see a reduction in overall load as we progress through the programme.

3.1.6 Acute Setting – Prescribing HRPM

As noted in background, in the absence of electronic systems acute setting prescribing is challenging to understand. Supply systems can be looked at to explore volumes supplied to wards and areas and help identify any outliers. An review of supply over a 12month period of Oramorph (oral morphine solution) patient packs was undertaken in the acute hospital and community hospital setting. Oramorph patient packs were chosen as this is given as a single pack per patient and is a surrogate for usage.



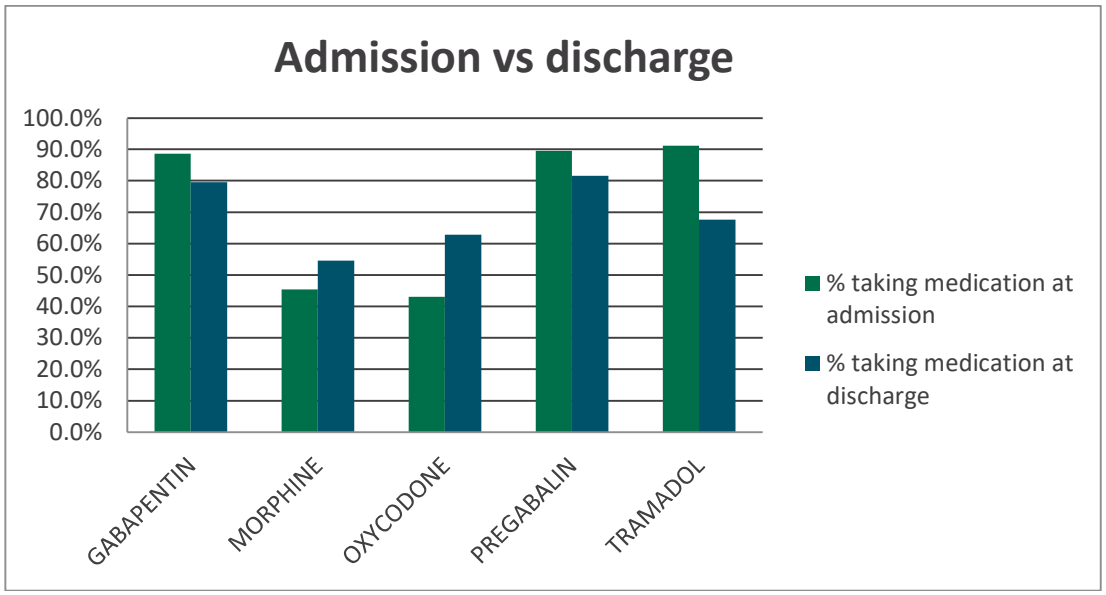
Usage is relatively low within the community hospitals however there does seem to be differing practice in a couple of the wards therefore this will be investigated further.



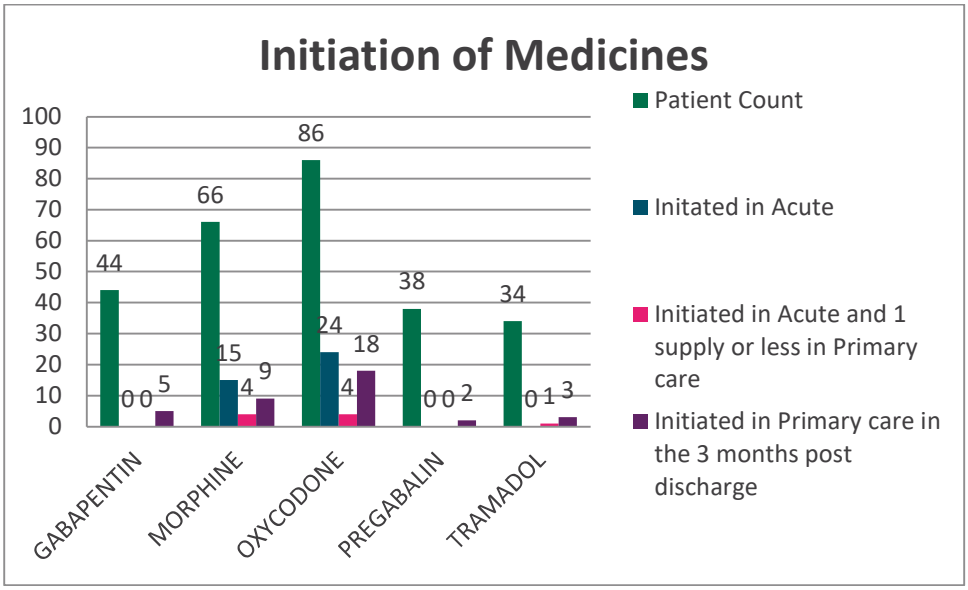
Not unsurprisingly in the acute setting the greatest use was found in elective and trauma surgical wards. Another area of use was in A&E -this is worthy of further understanding. GP feedback from surveys and workshops flagged a concern that use of Oramoph in OOH or ED seemed to be increasing and can build patient expectation to have GP continue the prescription.

There are several areas that warrant further investigation, the above chart displays surgical wards in black and medical wards in blue therefore medical wards 43 and AU1 also seem to be outlier having greater usage than some surgical areas.

A retrospective audit was also conducted this included all patient in a 1 month period (April 2022) who were discharged on Oxycodone, Morphine, Gabapentin, Pregabalin or Tramadol. The data was then cross referenced with PIS data looking at supplies in the three months prior to admission and the 3 months post admission. The reason for admission was not necessarily for a pain condition so pain medicines may not have been considered for review during stay. This audit did not look at patients on combinations of HRPM. The admission versus discharge data is shown below.



From this data there evidence of some review of pain medicines during admission as there is a reduction in the medications for neuropathic pain (approx 10%) and weaker opoids (tramadol 20%). The main medications started within the acute setting are strong opioids. 50% of the tramadol reduction was due to patients receiving stronger opioids and 50% were stopped. We do not have data on the clinical indication for initiation, it may be assumed that a large proportion of this is related to post operative acute pain management, which would align with our guidelines. This is further explored in the chart below.



The chart above shows the number of patients receiving these medications at any point in the 7 months of data capture. Of the patients intiated within the acute setting 14% of thoses intiated on Oxycodone and 21% of those initated on Morphine were continued beyond 1 additional supply, therefore indicative that this was indeed for acute pain. The data also shows that several patients were started on HRPM medication from each of the categories in Primary Care within the three months following admission (these are new initiations as those already receiving have been captured in the other categories). It can be seen that the initiation of HRPM occurs in both the primary and secondary care setting.

Opportunities for improvement around admissions and discharges on HRPM

- There is an opening to use every admission as a potential opportunity for review of HRPM, potential deprescribing and clear plan documented
- Where acuteness of presenting condition does not allow for review, clinician should flag HRPM issue as part of discharge to Primary Care team.

3.1.7 Acute Setting – Out of Hours Prescribing HRPM

Another route of prescribing identified for supply of HRPM is Out of Hours (OOH) services. OOH use ADASTRA system and at May 23 we are still in early stages of analysis which will include indication for use. Scoping of other areas had shown involvement of OOH in Lanarkshire QI work.This is an important area to understand so will be completed as part of early year 2 work and include learning from other areas.

3.2 Audits

3.2.1 Background

In the absence of sound electronic data of use of HRPM medicines in the acute setting several manual audits were undertaken to understand the use of HRPM, particularly in relation to perioperative prescribing. Consultant Anaesthetist and lead medic acute setting for HRPM, Dr Fiona Bull co-ordinated audits to aid understanding in acute setting.

In March 2021 the Faculty of Pain Medicine released Surgery & Opioids Best Practice Guidelines-[1] a multi-collegiate document with clear detailed recommendations for each stage of the surgical pathway, including post- discharge management. The guidance focuses on the key principles of shared decision making with the patient and the professionals' duty of care to ensure the following:

- that opioids started in the perioperative period are not continued unnecessarily. Research shows that 6% of surgical patients (versus 0.4% of the non-surgical cohort) persistently use opioids 90-180 days after surgery
- that patients taking opioids are identified before surgery.
- identify risk factors for opioid misuse disorder (e.g., anxiety, depression, and use of other psychoactive drugs) and ensure patients have access to relevant preoperative and/or subsequent care
- deprescribing procedures/mechanisms exist at the interface between hospital and Primary Care (e.g., letter/ leaflet/ communication with General Practitioner) and that there is effective communication with both the patient and their General Practitioner (GP) and other relevant healthcare professionals such as nurse prescribers and pharmacists.
- that chronic post-surgical pain is recognised and treated appropriately.

Pre-operative Recommendations

- **Pre-operative assessment-** patient screening for chronic pain and pre-operative opioid use
- **Pre-habilitation-** optimal pain management and education/ expectation discussion
- **Complex cases-** referral to pain specialist in advance of operation and opioid weaning considered
- **Peri-operative management plan**- between patient and care teams

Intra-operative Recommendations

- Multimodal analgesia and use of opioid sparing techniques
- Procedure specific analgesic techniques
- Tailored to individual patients

Post-operative Recommendations

- Pain relief should be optimised - before leaving post op recovery area
- Functional pain assessment- as well as pain intensity should be undertaken
- Immediate- release opioids- are preferred when simple analgesics are insufficient
- Advice on medicine self-administration-education re-enforced by a leaflet
- Clear discharge plan on letter to GP
- Identification and support of patients for de-escalation of opioids prescribed prior to surgery which may no longer be required-
- Guidance about any necessary medicine review post discharge and max of 5-7 days' supply issued

Post-discharge Recommendations

- Post operative opioids must not be added to repeat and should be reviewed by a prescriber at each issue
- Any patient not normally on opioids still taking them 90 days after surgery should be reviewed and further assessment triggered including review by operating surgeon.
- Gabapentinoids should be tapered off if no longer indicated
- Pain and opioid related re-admissions should be notified to inpatient pain team.

Several audits were undertaken to assess how well this guidance was being adhered to and aid our understanding of HRPM use.

3.2.2 Pre-assessment Audit To Aid HRPM Understanding

Two audits were undertaken in the surgical pre-assessment clinics , one in 2021 (n=124) and one in 2022 (n=92). The results were as follows:

Meds prior to surgery	2021	2022
n=	124	92
Gabapentinoid	15%	19%
Opioid	25%	37%
Benzodiazepine	2%	9%

Oral Morphine Equivalence prior to surgery	2021	2022
n=	124	92
0-50mg	74%	58%
50-90mg	19%	15%
>100mg	7%	15%
		*12% not documented

HRPM combinations	% patients on meds	
	2021	2022
single opioid	68%	63%
>1 opioid	6%	4%
Opioid + gaba	23%	21%
Opioid + benzo	0%	8%
Opioid+benzo+gaba	3%	4%
Benzo + gaba	0%	0%

It should be noted these audits were undertaken in the post pandemic recovery period where waiting times for elective operations significantly increased and this may have resulted in increased prescribing of HRPM medicines.

- The % of patients on opioids prior to surgery was 25-37% with an increase seen in 2022
- There was also an increase in gabapentinoid and benzodiazepine use in 2022 with a 4% increase in Gabapentin (19%) and a 7 % increase in Benzodiazepine use (9%)
- In 2022 there was a greater % of patients on the highest morphine equivalence dose > 100mg.
- In both audits it can be see that over 1 in 4 patients were on a combination of HRPM prior to surgery which increases risks of central nervous system or respiratory depression.

Education and expectation management was not specifically assessed in the audit, but current understanding suggests opportunities for improvement with greater staff understanding of the implication of HRPM use particularly in chronic pain management. High risk patients (on high dose opioid or HRPM combinations) are not currently flagged to the inpatient pain team before the operation. Audit paperwork also identified issues with staff knowledge of drug names and drug groups which could have implications for clinical care.

<u>Opportunities For Improvement in Surgical Pre-assessment</u>

- Targeted information discussed with patient at appointment and re-enforced by a leaflet being developed -"Managing pain after surgery"
- Staff training of team undertaking pre-assessment clinics to:
    - Aid identification of high risk patients and promote understanding of HRPM risk and management of chronic pain
    - Promote expectation management identifying those who may need additional support to reduce preoperative anxiety and catastrophising
- High risk patients identified to the in patient pain team before the operation
- Aspirational:- prehab engagement of pain team or surgical pharmacist and involvement in potential opioid weaning pre surgery.

3.2.3 Theatre Audit to Aid HRPM Understanding

Audits were undertaken in Phase 2 (elective ortho theatres), n=29 and Phase 3 (main theatre suite) n=85. This again identified HRPM use in patients prior to admission for surgery and then HRPM initiated immediately post-surgical. The results were as follows:

Meds prior to admission	Phase 2	Phase 3
n=	29	85
Paracetamol	59%	31%
NSAID	14%	13%
Gabapentinoid	14%	4%
Opioid	38%	22%
Benzodiazepine	0%	0%

Meds given post op	Phase 2	Phase 3
n=	29	85
Paracetamol	91%	98%
NSAID	16%	29%
Gabapentinoid	X	X
Opioid	85%	95%
Benzodiazepine	X	X

- Opioid use prior to admission ranged from 22-38%. A higher % was seen in the elective orthopaedic theatres.
- There was high use of opioids in both theatre settings.
- The audit did not assess high risk combinations.

- Post operatively the use of standard paractamol was high in both theatre suites in line with guidance recommendations though NSAID use was higher in the main theatre suite compared with elective orthopaedics.
- Reassuringly neither gabapentinoids or benzodiazepines were initiated post operatively. Pre pandemic there had been evidence of some post operative initiation of gabapentinoids in some specialities but this has subsequently not been supported by evidence.

The opioids used post operatively were audited on two bases, the use of morphine as first line formulary choice and the use of Immediate release preparatons in line with Surgery & Opioids guidance. The results were as follows:

Post op Opioid	Phase 2	Phase 3
% opioids Morphine	75%	85%
% IR	76%	86%

- Morphine was the most used opioid in at least ¾ of patients
- The immediate release (IR) formulation was used in over ¾ of patients in both settings in line with the guidance.
- The inpatient pain team have been driving use of IR v MR over the last year

<u>Opportunities For Improvement in Surgical Post-Operative management</u>

- Consideration to increase oral standard analgesia use pre-operatively (paracetamol +/- NSAID)
- Whilst both relatively high, there are further opportunities to increase first line morphine use and use of IR preparation,
- Upskilling of ward teams in pain assessment and standard pain management
- Utilisation of in patient pain team for specialist advice when standard pain management measures are not effective

3.2.4 Primary Care Discharge Audit

Dr Shabnam Hussain, Lead GP HRPM undertook an audit of 100 patients discharged post surgically to assess compliance with the Surgery & Opioids Guidance. 14 patients were subsequently excluded based on surgery was for investigative procedure or patient was under 18.

86 patients were fully audited.

Operating speciality	Patient number	%
Orthopaedics	35	41%
Gynaecology	9	10%
Neurosurgery	3	3%
Urology	20	23%
General surgery	19	22%
Total	86	

The results were as follows:

- 22/86 (26%) were already prescribed an opioid analgesia pre-surgery- this was roughly in line with acute setting audits.

- 40/86 pts (47%) were discharged on post operative opioid analgesia. This was slightly higher for orthopaedics (19/35= 54%) than non ortho (21/51= 41%)
- 10/40 pts (25%) had clear plan on the discharge letter for reducing analgesia , this was slightly higher for orthopaedic patients (6/19 =32%) versus non-ortho specialities (4/21 =19%)
- It was not clear from letters if staff were counselling patient's pre discharge with regards to their newly prescribed opioid analgesia, dosing, weaning, storage and disposal as per guidance.

With regards post discharge management, Dr Hussain explored how many patients had direct contact with her practice pharmacotherapy team to discuss their analgesia and also whether any patients had their post operative opioid automatically added to repeat prescribing.

- 27/40 (67.5%) had a practice initiated pharmacy review post operatively on receopt of discharge letter to practice. From pharmacotherapy audit results in the pharmacy service it has been stated approximately 50% of patients receive a call from the pharmacotherapy team post admission about discharge medication in general.
- No patients had an opioid added to repeat without consultation with a GP post discharge.
- 7/40 (17.5%) remained on their post operative opioid at 1 month.
- This reduced to 3/40 (7.5%) at 3 months- it is not known if these patients were reviewed at this time in line with guidance.
- The 22 patients who had been on an opioid prior to admission had changes made to these opioids either as part of admission or on review after discharge. The outcomes of these reviews were as follows

Pts on Opioid Pre surgery n=	22	%
Opioid stopped	7	32%
Opioid reduced	6	27%
Continued as previously	9	41%

<u>Opportunities For Improvement in Peri-operative Prescribing of Opioids from A Primary Care Perspective</u>

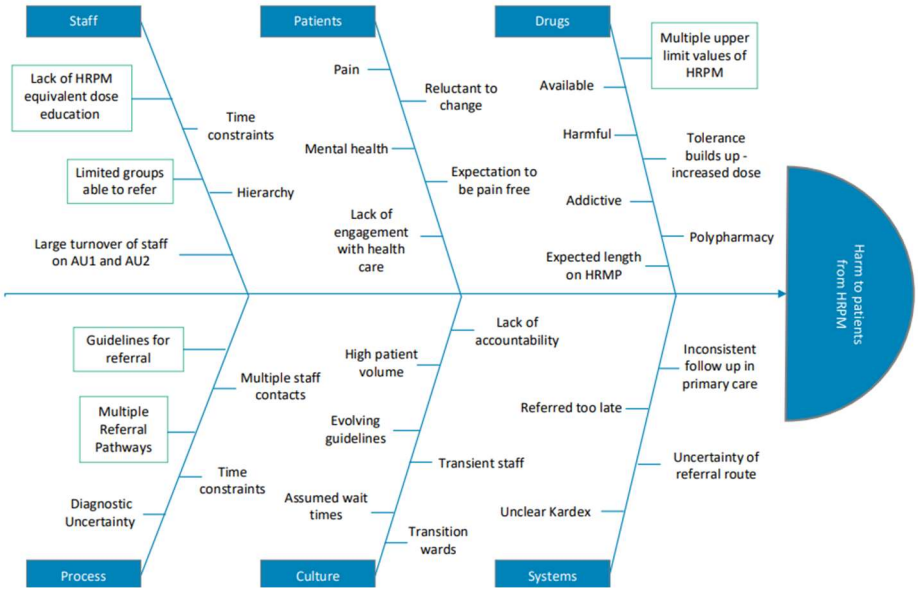
- **In Secondary Care/ interface**
  - Surgical speciality ensuring clear documented analgesic tapering plan in discharge letter
  - Including education/ information discussed with patient as part of letter or documenting issue of new standard post surgical opioid leaflet which could include individualised plan and expectation management of tapering and stopping analgesia.
- **In Primary Care**
  - There is an opportunity to prioritise opioids as a medication triggering a pharmacotherapy discharge medication review including discussion of pre-operative analgesic use.
  - Implement a flagging system which identifies patients remaining on previously prescribed opioid or post surgically initiated opioid at 1 and 3 months to facilitate de-prescribing or post-surgical reassessment of ongoing pain by appropriat service.
- **In both settings**
  - Planned or adhoc review of pre-operative analgesia to assess ongoing need.

3.2.5 SCOTGEM Admissions Audit

Scottish Graduate Entry Medicine (SCOTGEM) students on placement with NHS Fife In February 23 undertook a QI project to understand HRPM prevalence in acute medical admissions units (AMAU 1&2) at VHK and explore opportunities for increasing early referral to the inpatient pain team from

the AMAU. A known challenge for the inpatient pain team is recieving referrals to engage with complex pain patients too near to their anticipated discharge date to effect meaningful intervention. The project also gave the opportunity for raising awareness of HRPM programme and risks associated with the medicines.The SCOTGEM students undertook a fishbone analysis and identified several potential areas for improvement to reduce risks to patients.

Fishbone diagram highlighting potential contributing factors to patient harm from HRPM. Split into 6 key domains. Contributors in boxes were directly addressed by changes made in this project



393 patient kardexes were screened as a snapshot during the project to quantify those patients at highest risk of adverse effects from HRPM based on two critera:

1. On an opioid with Oral Morphine equivalence of >90mg/ day
2. On an opioid with Oral Morphine equivalence of <90mg/ day but co-prescribed a gabapentinoid, opioid or benzodiazepine

39 patients met the above criteria. It was broken down as follows

Criteria	No.Of Patients Identified
1. On an opioid with Oral Morphine equivalence of >90mg/ day	14
2. On an opioid with Oral Morphine equivalence of <90mg/ day but co-prescribed a gabapentinoid, opioid or benzodiazepine	32

The team also explored barriers to in patient pain team referral which included awareness/ ambiguity of referral criteria, role of the pain team, accountability (who should refer), patient turnover, capacity/ time and kardex challenges.

The SCOTGEM project aided understanding of prevalence of highest risk HRPM use in patients presenting in HRPM, approx 10% of patients screened. The project did not look at the possible involvement of the medicines in the presenting condition. The project team made a number of

suggestions for improvement which were limited by the time they had to undertake the project but which could be further developed as part of Year 2 in HRPM.

Opportunities For Improvement in Management of Patients at Greatest Risk of HRPM Adverse Effects Presenting in AMAU 1&2

- Agree referral pathway and criteria for HRPM associated patients to in patient pain team as appropriate for support during admission.
- Further develop training and posters created by SCOTGEM to support awareness and increase consideration of HRPM adverse effects in presenting condition.
- Explore role of Pharmacist & Pharmacy technicians in identifying patients for advice or review.
- Develop leaflet which can be given to patients to support their understanding and awareness, signposting for further medication review at appropriate time.

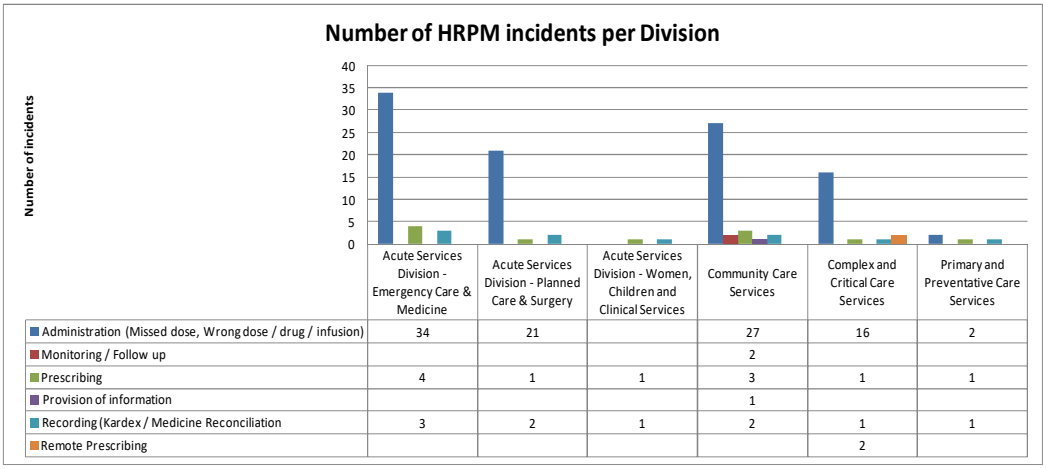
3.2.6 ED HRPM Presentations Audit

It has been established that adverse drug reactions or effects can result in avoidable hospital admissions with NSAIDS and Opioids in the top five drug groups[2,3] It had been hoped to undertake an audit of patients presenting at the Emergency Department (ED) to assess how many attended that were currently prescribed HRPM and in how many presentations could HRPM be potentially implicated. Early meetings were held to discuss and there was good engagement from ED consultants to take forward. Unfortunately service pressures in Winter/ Spring 22-23 meant this area of work did not progress. This area may merit further exploration to help identify impact of HRPM on healthcare resource.

3.2.7 HRPM Datix Analysis

An analysis was carried out on Datix for all medication incidents from April 22 to November 22 and filtered to identify incidents that involved HRPM (Opioids, gabapentanoids, benzodiazepines and NSAIDS). There were 209 incidents in total. 83 incidents were excluded from further analysis as being incidents that lay outwith the scope of HRPM work relating to supply, breakage, controlled drug register disctepancy or Ward audit.

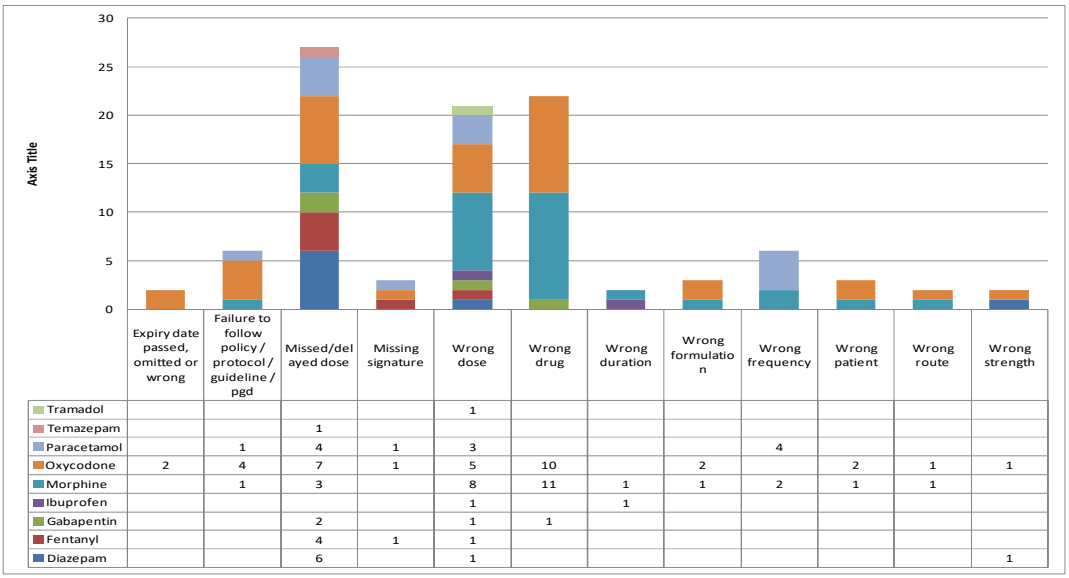
Graph -Number of HRPM incidents per division



	Acute Services Division - Emergency Care & Medicine	Acute Services Division - Planned Care & Surgery	Acute Services Division - Women, Children and Clinical Services	Community Care Services	Complex and Critical Care Services	Primary and Preventative Care Services
Administration (Missed dose, Wrong dose / drug / infusion)	34	21		27	16	2
Monitoring / Follow up				2		
Prescribing	4	1	1	3	1	1
Provision of information				1		
Recording (Kardex / Medicine Reconciliation	3	2	1	2	1	1
Remote Prescribing					2	

- The greatest number of incidents were in Emergency Care & Medicine followed by Community Care Services

Graph Datix Administration incidents broken down by medication



Outcome in terms of harm	No. Datix
Major	3
Moderate	4
Minor	13
No harm	106

- The greatest number of incidents related to missed or delayed dose which were typically graded as no harm if the patient had not indicated they were in pain at the next given dose. This could still lead to poor pain control, or given the nature of the opioids and gabapentinoids, potentially put the patient into withdrawal which may manifest itself as an overall worsening of presentation/ health rather than just pain.
- Wrong drug was next most common at 22, with only one gabapentin (should have been pregabalin) incident, the rest being oxycodone and morphine involved. CD governance group are currently developing tools to support selection of Morphine and oxycodone, such as presentation, lanyard posters and stickers.
- 21 incidents involved the wrong dose being administered, with morphine being the most common medication involved in this type of incident.
- Consistent with findings previous to HRPM work, and despite previous intervention, Morphine and Oxycodone continue to have the greatest number of datix.
- Issues relating to prescribing and recording were not specific to one drug and included issues such as missing information, not complying with Controlled Drug legislation and failure to follow protocols.

<u>Opportunities For Addressing Issues Highlighted by Datix</u>

- Linking with CD Goverance group to identify training needs which can be supported as part of wider understanding of pain management & raising awareness of risk of loss of pain control or tipping into withdrawal with missed doses.

3.3 HRPM & Substance Use

3.3.1 Background

National Registers Scotland publish an annual drug related death(DRD) report, latest was for 2021 in July 2022[4]. Four of the HRPM medicne groups are regularly implicated in DRD- Opioids, Gabapentinoids and Benzodiazepines. Fife has a higher involvement of some prescribable medicines in DRD than most other health boards, particularly gabapentinoids with involvement in 53% of DRD versus 47% for Scotland. They are often implicated as part of a complex polypharmacy mix of substances but it is unclear why there is greater involvement of gabapentinoids in Fife than other areas though it could be speculated that higher local rates of prescribing lead to greater patient access or increased volume in the community which may lead to diversion.

People with a dependency and substance use who also manage a chronic pain condition can find it difficult, as with all people with pain as a long term condition, to effectively manage their pain and address the impact of pain on their lives. In the substance use cohort this can be compounded by stigma, lifestyle challenges and access to the right support services.

In order to explore this area more a short life working group (SLWG) was established, lead by Dr Catherine Jeffrey Chudleigh, Public Health Consultant NHS Fife with key stakeholders from the Alcohol & Drugs Partnership, Addiction Services and 3rd sector agencies. It was agreed to focus on four areas:

a. Audit and analysis of the drug related deaths in NHS Fife in the year 2021 to identify how many involved HRPM and establish whether the person had been being prescribed the HRPM at time of death or not. This will help understand the source of supply, whether through a legal medical route or whether from another illicit source such as diversion through relatives and friends, local networks or other route e.g. internet.
b. Literature search
c. Multi-professional focus group with staff from NHS services, and substance use third sector agencies.
d. Substance Use Lived Experience engagement through either focus group or survey

3.3.2 Analysis of HRPM Involvement in Drugs Related Deaths in Fife

To understand the extent that prescribed HRPM medicines were implicated in drug related deaths, we reviewed the medical records of all people who died of a drug related death in 2021 and identified the prescribed high risk pain medicines estimated to be available to the patient at time of their death and of these, those that were assessed to have been implicated in or contributed to their cause of death (according to the medical examiners report) to produce some summary statistics. Some data was not available, so the following figures are estimates based on the available data.

In this review, prescribed high risk pain medicines were implicated in 41% of drug related deaths in Fife in 2021. After excluding methadone and buprenorphine OST, prescribed high risk pain medicines were implicated in 30% of drug related deaths. There were no deaths where prescribed medicines were the only drugs implicated.

Where high risk pain medicines were prescribed and implicated, a median of 5 drugs (illicit or prescribed) per person were implicated in drug related deaths (range 2-7). Of these a median of 2 high risk pain medicines were prescribed to the person which were implicated in the death (range 1-4). After removing buprenorphine and methadone OST from the analysis, a median of 1 high risk pain medicines were prescribed to each person.

This supports evidence from the professionals focus group held to inform this project that use of medicines, other than as prescribed, is complex and unlikely to be the primary driver of drug related death. Furthermore, whilst misuse of prescribed medicines might be observed in people who use substances, this is typically associated with complex drug use also involving illicit substances, and associated history of trauma or mental health problems.

Prescribed opioids/ opiates were the most likely group of prescribed medicines to be implicated in drug related deaths (38% of deaths). However, the vast majority of opiates/ opioids implicated in drug related deaths were opioid substitution therapies, so not prescribed for pain. Excluding methadone and buprenorphine OST, only 6 people had been prescribed an other opiate/ opioid which was implicated in their death (11% of deaths) indicating that prescribed opiates/ opioids, other than OST, were relatively rarely implicated in drug related deaths, even in combination with other substances.

The NRS drug related death report for 2021 identified methadone (from all sources) implicated in 53% of all drug related deaths and buprenorphine implicated in 4%. The results suggest that more than half of methadone implicated in drug related death could be prescribed. Illicit or diverted methadone is likely to be implicated regularly. Gabapentinoids are the most likely prescribed high risk pain medicine to be implicated in drug (25% of deaths) after opiates/ opioids and probably of greatest concern of all the prescribed medicines implicated in drug related deaths in Fife in this review. Prescribed Pregabalin and Gabapentin were equally implicated in the drug related deaths.
The NRS drug related death report for 2021 identified that gabapentinoids were implicated in 53% of Fife drug related deaths. The results suggest that just under half of gabapentinoids implicated in drug related death could be prescribed.
Diazepam and Nitrazepam were the only prescribed benzodiazepines/ Z drugs implicated in drug related deaths (14% of deaths), with the majority involving Diazepam. The NRS drug related death report for 2021 identified that benzodiazepines were implicated in 70% of Fife drug related deaths, of which 26% were estimated to be prescribable. Diazepam was implicated in 23% of deaths. The results suggest that the majority of Benzodiazepines implicated in drug related death appear to be from an illicit or diverted source, However, just over half of prescribable benzodiazepines implicated in drug related death could be prescribed.
NSAIDs did not feature as prescribed high risk pain medicines implicated in drug related deaths

3.3.3 Literature

Public Health Fife and Fife Alcohol & Drug Partnership are currently undertaking a literature review of the UK only evidence base to understand the prevalence of factors which contribute to and the nature of use of prescribed medicines other than as prescribed. The review will also look at interventions to reduce misuse and diversion of prescribed medicines which might help elicit interventions suitable for test of change in Fife. The review is currently ongoing.

3.3.4 Multiprofessional Focus Group

A multi-professional focus group was held with four staff members from substance misuse pharmacy, substance misuse nursing, harm reduction service and substance misuse third sector service in March 2023. The purpose was to consider the drivers for misuse and diversion of HRPM, potential interventions to address these and to consider the needs of the people who misuse substances in the context of the HRPM patient safety programme workstreams. This is an executive summary of the themes arising in the discussion.

A question set was used to guide the discussion, which was shared with participants A thematic analysis of the discussion was undertaken.

Focus group question set

- Do some of your patients/ service users have a dependence on HRPM?
- In your experience, have patients who use HRPM been initially prescribed these for a clinical indication?
- How might people access HRPM prescriptions medicines (not prescribed to them) from your experience?
- What do you think might reduce misuse or diversion of HRPM?
- How should we best support patients with an HRPM dependency to manage their chronic pain condition in your view?
- What are the risks of alternatives to prescribing for this group?

This summary reflects the perspective of the participants of the focus group, amongst whom there was considerable consensus on these issues. It provides some helpful insights into some of the drivers for misuse and potential interventions to reduce inappropriate use in the patient group who are at risk of or who are inappropriately using prescribed medicines. However, it cannot be assumed that this necessarily reflects or captures the breadth of perspectives of the wider multi-professional group of colleagues involved in providing support for addiction in Fife in relation to these questions.

Drivers for misuse/diversion

The drivers for ongoing misuse of HRPM are complex and interrelated and likely to be influenced by trauma, poor mental health and compounded by poverty. Many people in contact with addiction related services in Fife are using prescription or prescribable HRPM. However very few people in contact with addiction services (and who die of a drug related death) are solely misusing prescription medicines, usually this is in the context of polypharmacy including illicit substances.

It is not uncommon for people who are known to misuse high risk pain medicines (HRPM) to have been initially prescribed HRPMs for a legitimate clinical indication at some point in the past and this use sometimes escalates and can transition to illicit or diverted sources over time. For some people, medicines have been prescribed in the past and continue to be prescribed and are being taken alongside illicit substances, but this use of HRPM may not so easily be characterised as misuse, even if the appropriateness of long-term prescribing is questionable.

There is thought to be large amounts of HRPM in cupboards throughout the community with significant potential for misuse and diversion. Family, friends, and neighbours are thought to be likely sources of diverted medicines as well as the internet. The volumes of HRPM supplied between reviews and infrequency of reviews in Primary Care; are all thought to significantly influence the availability of HRPM in the community and thus potential for misuse and diversion of HRPM. Some people particularly those prescribed in the more distant past, report that not understanding how powerful the drugs were that they had been prescribed, or the long-term consequences and potential for dependence were contributory factors to their subsequent dependence, highlighting the role of prescriber/patient communication.

Historic de-prescribing programmes are also thought to be a considerable contributor to ongoing prescribed medicine and also illicit misuse in our communities for example programmes to reduce opiate/opioid prescribing reportedly contributed to increased gabapentinoid prescribing which is also associated with dependency and harms, and efforts to reduce benzodiazepine prescribing was observed to contribute to increases in illicit benzodiazepine use.

Interventions to reduce misuse/ diversion

Reducing the amounts supplied per patient and potentially implementing supervised consumption particularly where there is a perceived higher risk of dependence, misuse or diversion might reduce this. Increasing the frequency of reviews, particularly at an early stage in prescribing would also reduce potential for inappropriate long-term use and potential dependence or misuse/ diversion. Clinicians should also be aware of the potential for anyone to become dependent or divert medicines and apply a universal approach to amounts supplied and frequency of reviews. Lastly ensuring that people are aware of the nature of the drugs prescribed and potential for dependence is important, although it is recognised that this is being done far better presently than it was historically.

Alternatives to prescribing

It was recognised that Primary Care colleagues have limited access to alternatives to prescribing including to treat the drivers for inappropriate/misuse like adequate support for mental health or co-occurring chronic pain and addiction. There is an unmet need for satisfactory chronic pain support for people who are also have problematic substance misuse who might be under the care of the addiction service but without shared care and expertise to address underlying pain. Appropriate alternatives to prescribing that could be implemented might include adequate support for pain or mental health needs at an early stage; mitigating barriers to access and support for alternatives; social prescribing; potential role for Primary Care link workers supported by 3rd sector addiction support for more complex patients.

Risks and mitigations associated with de-prescribing

There is a considerable perceived risk of unintended consequences associated with de-prescribing interventions or reducing access to prescribed medicines. Some such programmes have historically contributed to people resorting to alternative prescribed medicines or harmful illicit substances to address their needs and could result in higher rates of harm and potentially drug related death.

It was felt to be important to take an anticipatory holistic approach to supporting people through de-prescribing. This will include people who are assessed to be at immediate risk of illicit substance use. It should also include consideration for people with potential dependency/ addiction to prescribed HRPM who are currently not accessing services or even using other substances but may be at higher risk of illicit substance use as an alternative to address their need for example through being affected by poor mental health or trauma. Implementing de-prescribing interventions alongside a trauma informed package of support for people at greatest risk of resort to illicit alternatives and preparedness for increasing demand for substance misuse services were proposed approaches to mitigate these risks.

3.3.5 Multiprofessional Focus Group High Level Summary

Drivers of misuse/ diversion

Drivers for misuse or diversion – patient	Drivers for misuse – patient and prescriber/ system	Drivers for misuse or diversion – prescriber / system
• Initial clinical indication • Poverty • ACEs and trauma • Mental health • Difficulty engaging with alternatives • Ease of availability (family, friends, internet)	• Advice communicated to patient and their understanding • Support for people with pain and addiction • Support for mental health	• Amount supplied • Frequency of reviews • Significant impact of historic deprescribing programmes

Potential Interventions

Interventions to reduce misuse/ diversion	Alternatives to prescribing	Mitigating harms from de-prescribing
• Reducing amounts supplied • Regular reviews • Potential for daily supervised therapy • Awareness of potential for anyone to become dependent or divert medicines	• Adequate pain and mental health support at an early stage • Mitigate barriers to access to support • Social prescribing • Role of link worker supported by 3rd sector.	• Anticipatory support in the community for de-prescribing • Preparedness for increasing demand for substance misuse services

3.3.6 Substance Use Lived Experience Engagement

At the time of report writing the SLWG were in early discussion how to take forward this area and would anticipate it continuing into year 2. This will be important to understand routes of diversion and supply of prescribed medicines locally; reasons for use; and the experiences of chronic pain and support managing this amongst people who are using substances.

3.3.7 Key Findings/Recommendations HRPM & Substance Use

There is a plan to develop recommendations following a workshop with members of the short life working group and other stakeholders in August 2023. Some early reflections are presented for this report.

Prevention/ early intervention - It is well understood that prevention and early intervention is vital to avoiding the harms and deaths associated with substance use. This includes addressing the social factors that contribute to initiation and escalation of drug use. In the context of this project, implementation of evidence-based guidelines around prescribing, in the early stages of pain management, are likely to have the potential to prevent addiction to prescribed high risk pain medicines and the harms associated with this. Early consideration and intervention to address the factors that could be contributing to medicine use other than as prescribed such as poor mental health, dependency, complex pain needs, and other social needs would ideally be considered and be integrated in pathways of care developed to improve patient safety associated with high-risk pain medicines. It is also recognized by substance use professionals that there is the potential for anyone to divert high risk pain medicines, not just people who are assessed to be at high risk of substance use/ dependency. Often the reported source of diverted high risk prescribed medicines is older people who may not necessarily be perceived to misuse or divert substances.

When developing interventions and guidelines relating to appropriate high risk medicine prescribing, it will be important to consider the potential for anyone to divert medicines (either intentionally or unintentionally).

All communications and interventions are trauma-informed and stigma-free - The drivers of high-risk pain medicine substance misuse, as with all substance use are complex and commonly associated with experiences trauma and unmet mental health needs. Unfortunately, stigma and shame are frequently experienced by people using substances and felt through their contact with services. Communications, interventions, training and guidelines for this programme should be trauma informed and consciously avoid stigma at all stages.

Guidelines and processes systematically consider the needs of people who use substances - The extent of prescribed gabapentinoids implicated in drug related deaths in Fife is considerable and highlights the importance of guidelines which are embedded in systems of care and support evidence-based prescribing to minimise the risk of harms to the patient, diversion of medicines and drug related death. Prescribed benzodiazepines are also implicated in a high proportion of drug related deaths and similarly evidence-based guidelines should be implemented to support their appropriate use to mitigate harms, diversion and drug related death. Guidance on prescribing high risk pain medicines for people who use substances and their needs, would preferably be systematically embedded in all guidance relating to HRPM. Reducing amounts of medicines supplied and increasing regularity of reviews where high risk pain medicines with dependency potential and diversion potential are also thought to be likely to support more appropriate prescribing and use.

De-prescribing interventions and need to mitigate the significant risk of harm to people who use substances
A potential significant risk of harm to people who use substances has been identified for de-prescribing interventions, which have been observed, in the past, to contribute to diverting people to illicit and potentially more harmful substances. Proactive assessment of need and anticipatory care should be in place for people who are having medicines reduced as part of prescribing stewardship interventions, who also use illicit substances or are potentially dependent on prescribed medicine, potentially with the support of third sector services experienced with supporting people experiencing substance use.
Alternatives to prescribing consider the needs of people who use substances - People who use substances are more likely to experience barriers to accessing services including through ability to travel or pay for travel, digital exclusion or other barriers to accessing services. How to mitigate these inequalities should be systematically considered as alternatives to prescribing are developed and implemented, including potentially the locations of support services and potential roles for third sector services involved in addiction, and others, in support in supporting and signposting. People who have been self-medicating (with prescribed medicines/ illicit substances) for long periods of time might have difficulties engaging with alternative methods of support for their pain. The needs of people who use substances in relation to alternatives to prescribing should be considered and addressed. It is hoped the literature review and lived experience survey might help us develop this further.

Support for chronic pain needs of people who use substances and people who are dependent on prescribed medicines - There would be benefits from a formalised pathway for supporting people with addiction and chronic pain needs/ prescribed high risk pain medicine dependency to meet both needs
(With input from both services). This may contribute to optimal prescribing for this patient group. Pathways for prescribing pain relief post operatively in people on OST is also likely to improve care. There is also a need for accessible guidance for professionals in substance use around where to signpost and materials/ information to give for people who experiencing pain and substance use, including non-digital materials to reduce digital inequalities.

4. What Insights Can Be Gained from Our Reviews?

4.1 Prescribing Guidelines Review

The Data, Prescribing and Guidance workstream of the programme reviewed NHS Fife's Prescribing Guidelines/ Guidance.

The table below outlines the consensus of the workstream following this review:

Positives	Potential Improvement Considerations
1. Guidelines base content is in-depth and covers the material well 2. Guidelines were reasonably up to date speculation prior to the review was this may not be the case	1. Current guidelines were lengthy, in a long format and diffcult to consume, especially when trying to check something quickly 2. It may not always be clear if the guidelines being accessed are current or not, therefore last reviewed/modfified version control in the document would help inform how current they are (potentially with a note of changes between versions to see what has changed at a glance) 3. Access would be improved by having one central location where the most recent versions are held

The focus of subsequent guidelines discussion was to better understand how often these are used. From an Awareness Primary Care Staff Survey undertaken by the programme over March 2023, the table below summarises findings when asked about the frequency of access and ease of use:

How <u>often</u> do you access the following local guidance?						
Guidance	**Daily %**	**Weekly %**	**Monthly %**	**Rarely % (<1 month)**	**Yearly %**	**Never %**
Fife Formulary Section 4 CNS 4.7 Analgesics	2	17.6	17.6	25.5	3.9	33.3
Appendix 4C Guidance on the management of chronic non-malignant pain	3.9	13.7	11.8	37.3	7.9	25.5
Appendix 4G Strong opioid Guideline & Educational Pack	2	7.8	5.9	33.3	7.8	0
Appendix 4H Opioids Quick reference guide	0	11.8	7.8	31.4	7.8	41.2
Appendix 4J Strong Opioid Withdrawal guidance	2	3.9	11.8	33.3	13.7	35.3

How easy do you find the guidance to use?						
Guidance	**Very Easy %**	**Easy %**	**Neutral %**	**Difficult %**	**Very Diffic.%**	**I do not use %**
Fife Formulary Section 4 CNS 4.7 Analgesics	5.9	21.6	25.5	3.9	11.8	31.4
Appendix 4C Guidance on the management of chronic non-malignant pain	5.9	21.6	23.5	5.9	7.8	35.3
Appendix 4G Strong opioid Guideline & Educational Pack	3.9	13.7	27.5	3.9	7.8	43.1
Appendix 4H Opioids Quick reference guide	3.9	17.6	25.5	3.9	5.9	41.2
Appendix 4J Strong Opioid Withdrawal guidance	2	11.8	29.4	5.9	7.8	43.1

Overall “rarely” or “never” consistently represented a significant proportion of responses regards how often the guidelines were accessed, with only between 14% to 28% indicating they find the guidance “easy” or “very easy” to use.

When asked to select the barriers to applying the guidelines in practice, over 80% of the barriers fell into 6 main categories, shown in the table below:

Category	Count	% (nearest whole)
Time	31	25
Patient expectations	22	17
Lack of familiarity	22	17
Difficult to navigate/find what is needed	17	13
Accessibility/not sure where to find them	9	7
Do not match experience	9	7

When asked for ideas to improve the guidance the main suggestions included:

- One defined place for guidance
- Searchable, modern, user friendly
- Shorter, more focused
- Clear steps with concise information
- Simplify
- Highlight when updates/changes
- Accessible to patients

For those who did access guidance figures A and B show how this is most accessed at present and the preferred method of access:

Figure A: How guidelines are accessed currently

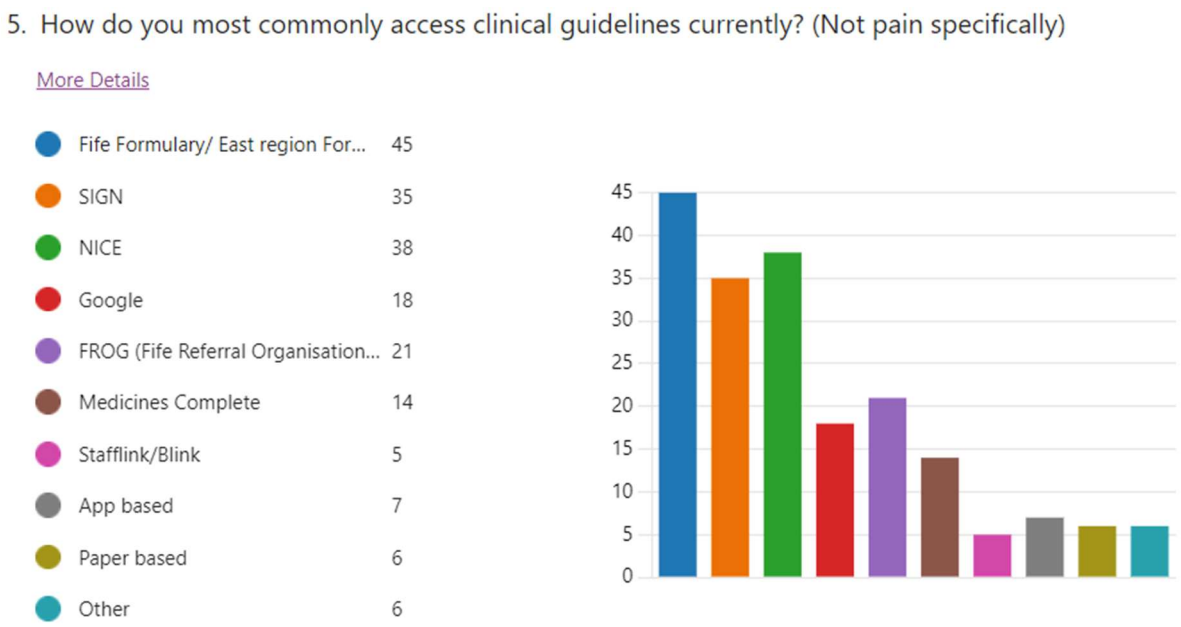


Figure B: Preferred way to access guidelines:

Appendix 1 contains a list of supporting documents that can provide a full summary of findings from the Awareness Primary Care Staff survey. The staff perspective findings are also discussed further in section 6.1 of this report.

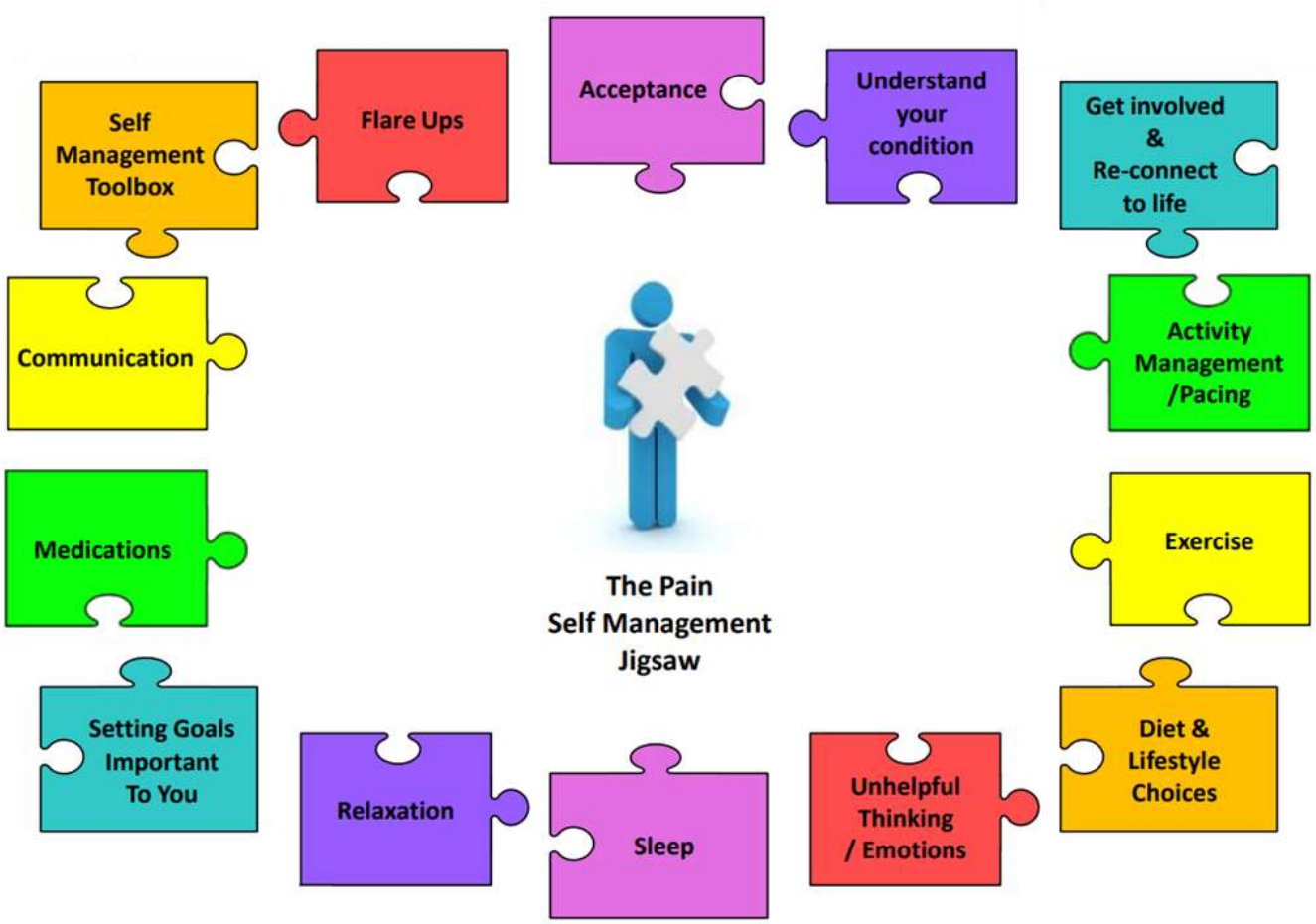
Overall survey findings show consistency with the previous review work and anecdotal feedback. There is a high proportion of Primary Care staff “rarely” or “never” accessing prescribing guidelines with ease of use, accessibility, structure, and presentation of the guidelines coming through as areas for consideration to inform improvement. Although there is an indication of the preferred method to access guidance, work will need to be done around understanding any business rules/technology limitations on where these should be held. However, attempts will be made to ensure this is a single location to address some of the key improvement areas staff highlighted.

Into year 2 of the programme, these findings will directly inform a proposed revised set of guidance that seeks to make the existing guidelines less of a static document and more of a toolkit to support

staff. Any revised guidance will seek to improve accessibility and ease of use. It is likely this will be framed around the key stages of; initiation, continuation, de-escalation and dis-continue, to better support prescribing and medication review decisions.

4.2 Pain Management Jigsaw

The Fife Pain Management Jigsaw is an interactive resource that outlines a range of interlinked factors that need to be considered as part of pain self-management. For each factor or 'jigsaw piece' several additional resources are located together, with direct links provided to help advise and guide patients. It has been developed and used as an internal resource within Fife Pain Management Service (FPMS) and underpins the ethos of the service of supported self-management. It is currently hosted on the FPMS webpages. It was rapidly developed as part of the pandemic response and was being reviewed by the FPMS. The Fife Pain Management Jigsaw is illustrated below:



Over the duration of the first phase of the programme, the Supported Self-Management Solutions Workstream were invited to feedback on the Fife Pain Management Jigsaw in conjunction with FPMS.

The table below summarises the consensus from key stakeholders:

Positives	Potential Improvement Considerations
1. The jigsaw provides a good visual depiction of the range of factors that may need to be considered when talking to patients about how they are coping with the pain caused by their condition. 2. Is a useful resource as it attempts to bring all relevant information into a single location. 3. Visual format helps make each aspect more consumable and easy to follow.	1. There are some technical navigation issues/linkages that need to be resolved. 2. There is likely limited overall awareness of the Pain Management Jigsaw. 3. Some of the signposting and video materials could be updated/replaced with other identified examples (some specific suggestions have been received for the 'Diet and Lifestyle Choices' and 'Activity Management/Pacing' sections).

As the Fife Pain Management Jigsaw has been reviewed, work has also been undertaken to update the Workbook used by professionals in the Pain Management Service. As this Workbook resource will align with any changes to the Jigsaw, there is also potential for the workbook to be shared with selected services outwith the existing Service. The proposal would be to advocate for Fife wide use of the interactive jigsaw in various services. Therefreshed jigsaw will be finalised as part of year 2 work.

4.3 Existing "alternatives to prescribing" Services Review

As part of the first phase of the programme, the Supported Self-Management Solutions Workstream alongside key partners/stakeholders also mapped the resources that help support those living with pain conditions.

Part of this process led to the creation of Summary Service Descriptors (details available from a separate document identified in Appendix 1), that defined the main purpose of health, social, community and tertiary care services offered. This helped create a base sense of awareness, as anecdotal feedback from those working in such areas suggested that even staff do not understand what each Service could offer. Therefore, it is unlikely our patients/service users will have that awareness.

The mapping also sought to identify where such services were located across Fife, as well as identify by service grouping the main method used in the delivery of each service (available in Appendix 1).

The original grouping and presentation of Services (by Primary, Secondary, Tertiary, Community etc) was thoroughly discussed, given some services overlap/are integrated and could feasibly occupy multiple groupings. Overall this presentation was thought to not be that useful. Instead the service offering could be better viewed more as a tier model. This would involve identifying and grouping service offerings in lower tiers as items suitable for self-directed service and potentially self-referral. With higher tier services being those requiring professional referral and specialist input.

This re-grouping of service offerings around a tier model principle will be picked up as part of year 2 activity of the programme. This could help inform the business rules required for any prospective pain 'Resource Hub' future capability, implemented via the parent programme.

5. What Do We Know About the Awareness And Experience Of Our Patients/Carers?

5.1 Patient Awareness

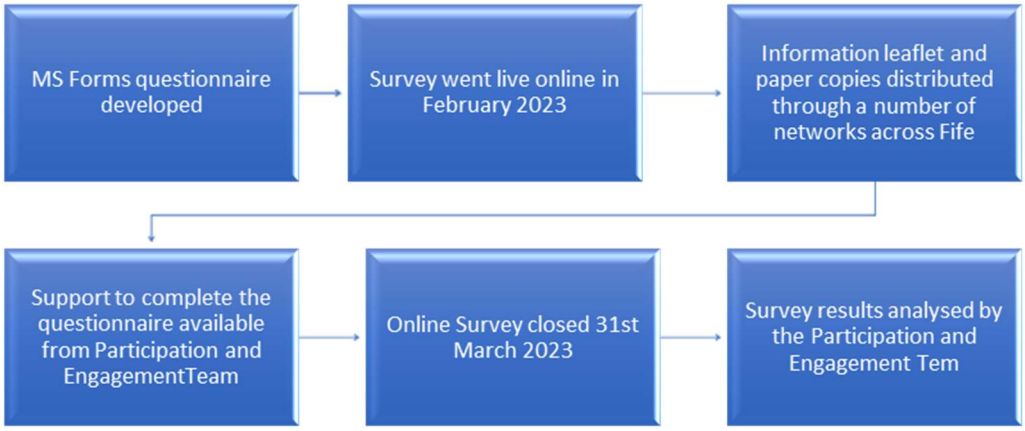
5.1.1 Background

Patient and Carer Surveys were developed to capture the experiences of people living with long-term pain or caring for someone that does, and people across Fife were invited to share their experiences of managing pain and pain medicines by completing the survey.

The results of the survey will help to inform the current and future work in managing pain, prescribing pain medicines, and improving the patient's experience.

In Section 5 of the survey – Supported Self-Management – patients were asked to share their experiences of alternatives to pain medicines. This information forms part of the report but NHS Fife are not endorsing non-evidence alternatives and cannot supply the range of methods used.

5.1.2 Approach



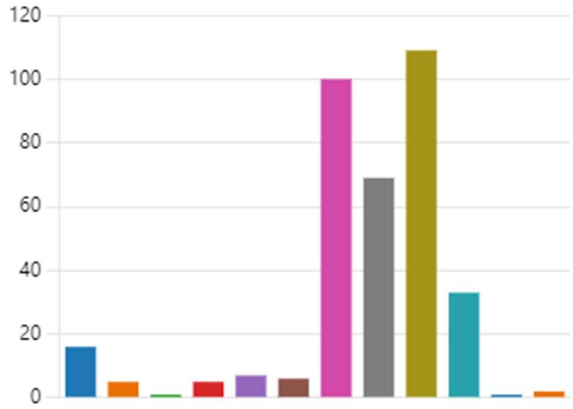
The surveys were promoted online and via social media by NHS Fife, Fife Health and Social Care Partnership and Fife Carers Centre. Paper copies were available on request. Survey flyers with QR code to access surveys and paper copies with prepaid envelopes were also distributed by the Participation and Engagement Officer attending Pain Association Scotland Meetings, via all GP practices in Dunfermline,1 in Southwest Fife, 3 Community Pharmacies in the Dunfermline and Cowdenbeath cluster area and to patients attending Fife Pain management Service.

5.1.3 Background Information

A total of 193 people completed the Patient survey for those with lived experience of chronic pain. Most responses from the Patient Survey were from those in the 45-54 and 55-64 age groups.

A total of 186 people who completed the Patient Survey were white, with 160 people identifying as Female and 32 Male. Of the 193 people who completed the Patient Survey,191 responded that they did not consider themselves to be trans or have a trans history. 1 person preferred not to say.

People were asked about their other health conditions and had the option to choose all that applied to them. 109 people indicated that they had a Long-term illness, disease, or condition, 100 people had a physical disability and 69 people had a mental health condition. Full details provided below:

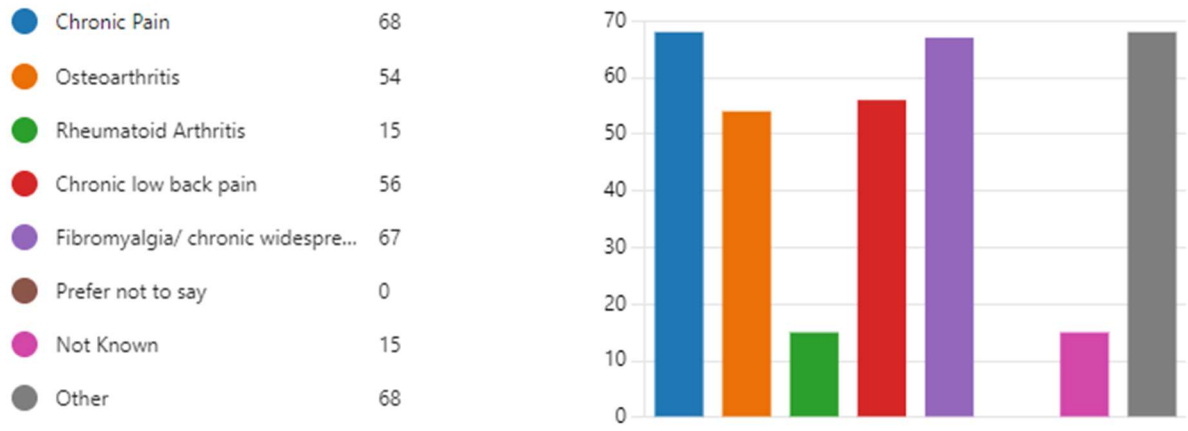


The highest number of responses came from people who lived in Dunfermline with 46 responses and Northeast Fife with 36. The lowest number was from Southwest Fife with 6 responses.

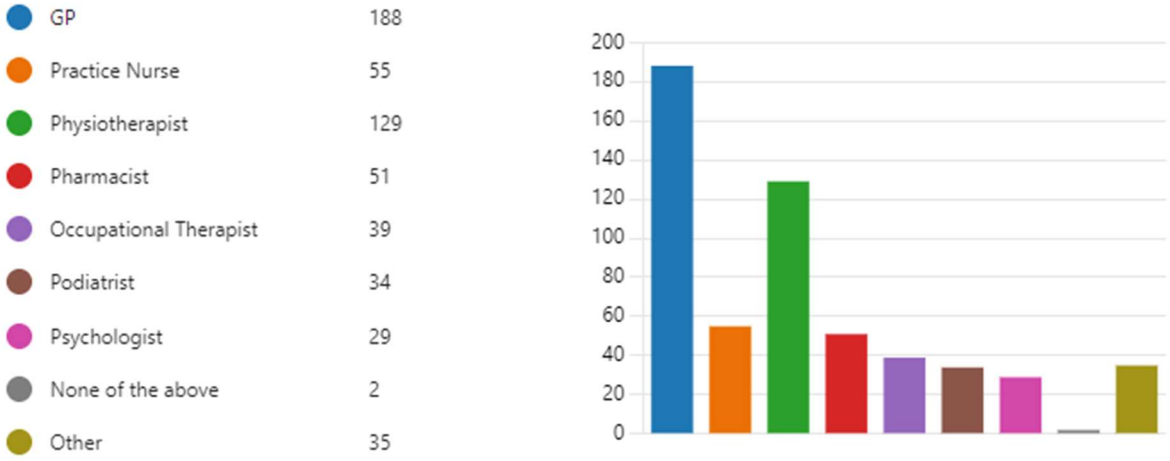
5.1.4 Patient Experience

Over half of the people who responded had been managing pain for more than 10 years with 42 people managing pain for 5-9 years. 6 people had been managing pain for 3-11 months.

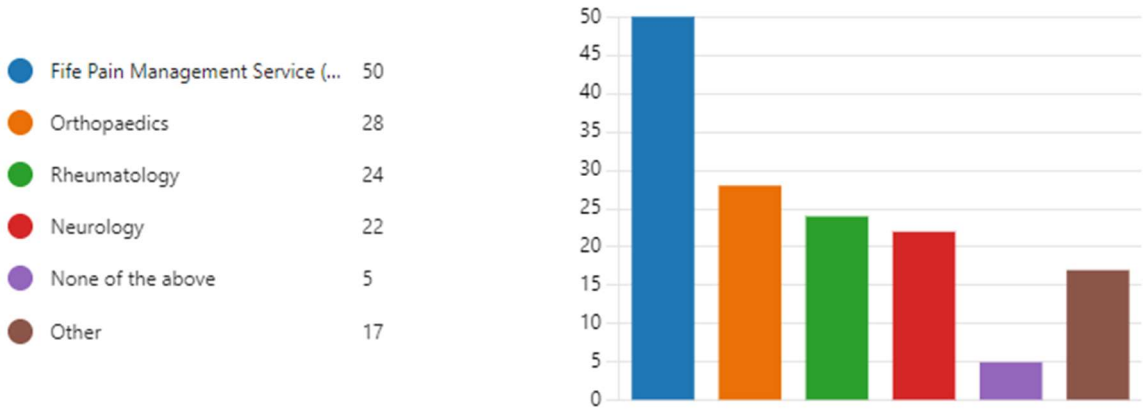
68 people who responded had been diagnosed with Chronic Pain and 67 had Fibromyalgia with 68 people having a condition that was not listed. The conditions in the other section were wide ranging and included trigeminal neuralgia, ankylosing spondylitis, endometriosis, migraine, neuropathy, hypermobility, Ehlers Danos Syndrome, Raynaud's disease, irritable bowel syndrome, ulcerative colitis, lupus, and hip dysplasia.



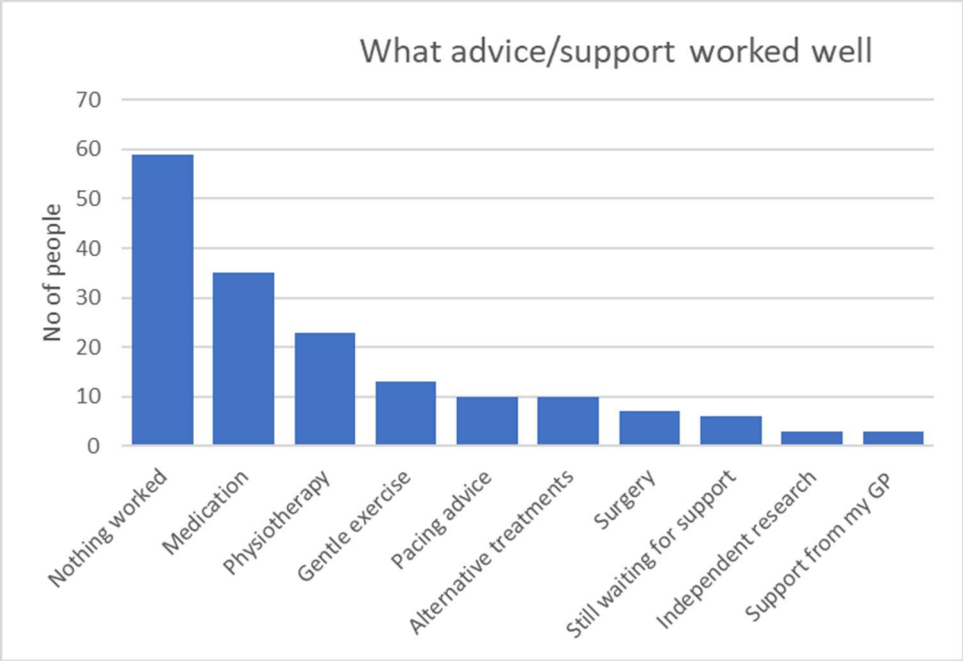
Nearly all the people who responded had been seen by their GP and over 60% had also seen a physiotherapist. 35 people had seen professionals who were not on the list including gynaecologist, chiropractor, dermatologist, rheumatologist, and other specialist consultants. Full details below:



More than half of the people had been referred to specialist services with the remainder who had not. 17 people had been referred to services which were not on the list including, gynaecology, urology, endocrinology, and pain clinics in other areas. Further information on which services they had been referred to is included in the table below:



Over a quarter of the people who completed survey said that nothing had worked well for them. 17% said that medication was helpful.



Comments included:

"None really, tried various medications with little success"

"Absolutely not had any support or advice. When fibromyalgia mentioned, can hear their eyes rolling across the room"

"Taking regular analgesia has some effect. Not had much in the way of advice apart from that"

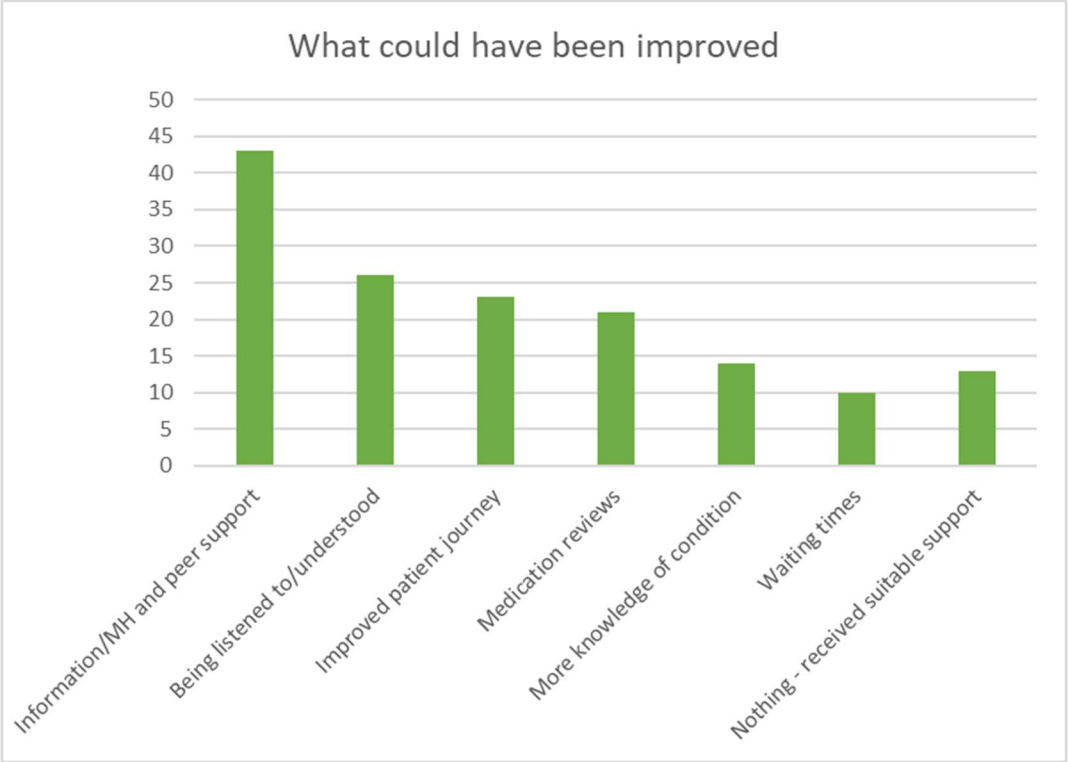
"Rituximab recently but many other drugs have been successful for some time but then ceased to work, e.g., Cimzia, Etanercept, Methotrexate, Sulphasalizine plus painkillers such as Co-Codamol. In addition steroid injections to help manage flares."

"General advice from pain management and other NHS physios.

"Hands-on treatments from physios in the past improved my functioning a lot, but the NHS seems unwilling or unable to provide that now- I now have to pay to access this from a private physio, along with massage therapy which is also very helpful."

5.1.5 What Could Have Been Improved About the Advice or Support from Healthcare Professionals

Almost a quarter of people felt that having additional information, particularly around peer support and mental health support would have helped. Over 12% did not feel that they had been listened to and understood.



"Don't put everything down to being overweight. It isn't always the reason. I lost weight and pain is the same"

"A better understanding of fibromyalgia from all healthcare professionals and be empathetic towards the person. Also, not to belittle the persons pain"

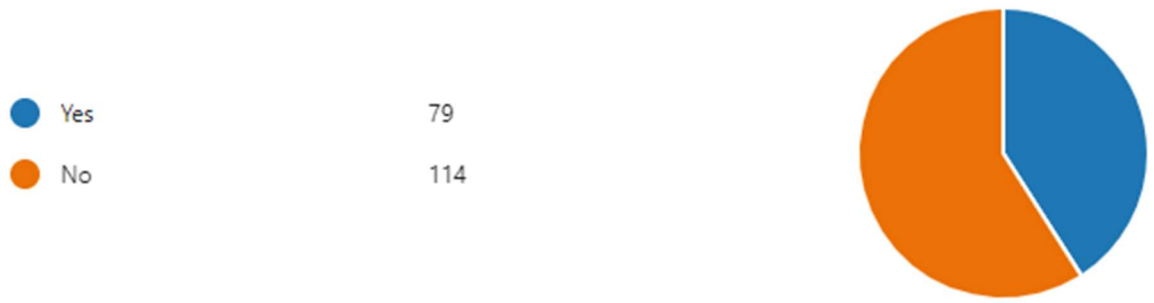
"Not everyone has the same symptoms or deals with it the same way"

"No follow up after medication prescribed. Simply on repeat prescription for months/years"

"I struggle with Fibromyalgia pain on an ongoing basis, experiencing frequent flare-ups and varying degrees of pain and life being quite impacted by the symptoms. I manage the condition with painkillers and trying alternative therapies on an ongoing basis. I've never been referred to Rheumatology or the Pain Management Service. I've had one physical examination prior to diagnosis and have had telephone consultations following on from this over the years. I feel advice and support is quite limited"

5.1.6 Paying Privately for Support to Manage Pain

79 people who completed the Patient Survey had paid privately for support to manage pain with 114 people answering that they had not paid for private support.



Approximately 16% of people paid privately for physiotherapy treatment with 10% paying for massages. Other privately purchased services included acupuncture, chiropractor, and podiatry with single numbers of people paying for a range of other services including private scans, appointments with consultants and alternative therapies.

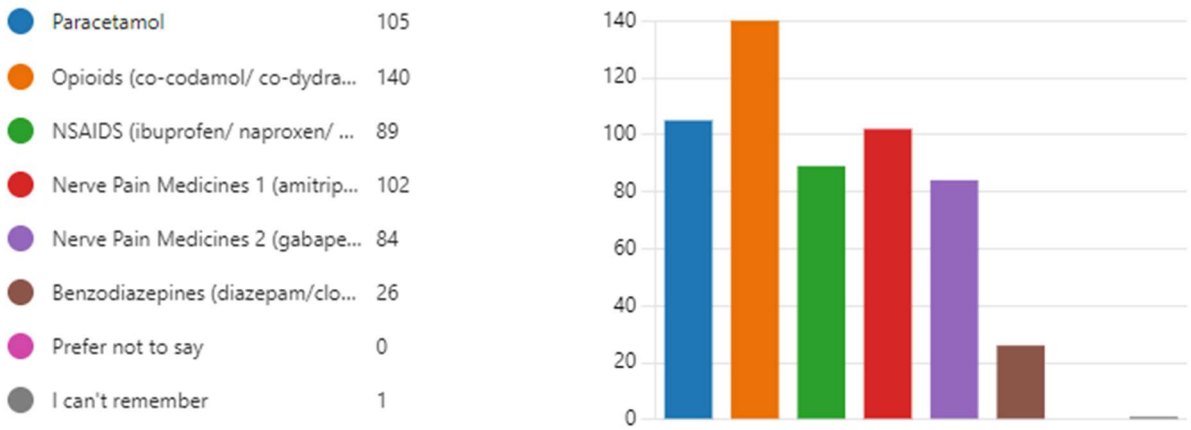
5.1.7 What Helps & Hinders

More than half of people said that their pain was helped by pain medicines with around a quarter of people feeling that heat and rest helped pain. 10% felt that exercise helped with lower numbers mentioning tens machine, moving around, sleep and CBD oil. Sixteen people responded that nothing helped their pain.

A quarter of people said that their pain was made worse by exercise with approximately 15% saying that stress, over exertion and cold weather made it worse. Other things that made it worse included remaining still for too long, lack of sleep, fatigue, and lack of medication.

5.1.8 Prescribed Medicines

178 people had been prescribed medicines to help with their pain with 15 people not having medicine prescribed:



43% of people had not had their medicines reviewed by a healthcare professional within the last 2 years with 23% reporting that a review had happened within the last 3 months. 44% of respondents who answered this question reported having had their medicines reviewed in the last 12 months.

Over one third of people purchased a range of vitamins with approximately 10% buying over the counter medicines including paracetamol, ibuprofen, and aspirin. People also bought CBD oil and gels/rubs with one person purchasing cannabis.

34 people had borrowed medicines with 144 people answering that they had not.

Approximately 20% of people said that nothing had gone well with their experience of pain medicines with 15% mentioning specific medications that had helped to ease pain. 10% of people said that their medicine eased the pain with lower numbers stating that it helped them for short periods and enabled them function or to sleep.

"The doctors seem content to prescribe so I am not in pain. They are accessible and can be ordered easily through the pharmacy. I appreciate prescriptions being free as it would be expensive to manage my pain otherwise."

"Over time I've been able to get just about the right level of pain medicines to help. I currently take paracetamol, dihydrocodeine. I can't take naproxen or diclofenac as it results in mouth ulcers. I take a triptan medication for migraines"

"They mostly take the edge off my pain and help me carry out everyday tasks"

A quarter of people mentioned the side effects of pain medicines and approximately 15% said that their medication did not work. 5% said that it only helped for a little while and single numbers of people mentioned that they had experienced a lack of follow up, support and that they had not felt listened to. 3 people were concerned about addiction.

"Built up tolerance to pain medicines and they have little to no effect"

"Differing advice, not following up referral and not having regular review"

"Limited effectiveness for the type of pain I have, inability to maintain daily function when needing to take high dose opiates"

93 people felt that they had been given enough information about pain medicines with 79 indicating that they had not. 6 people preferred not to say.

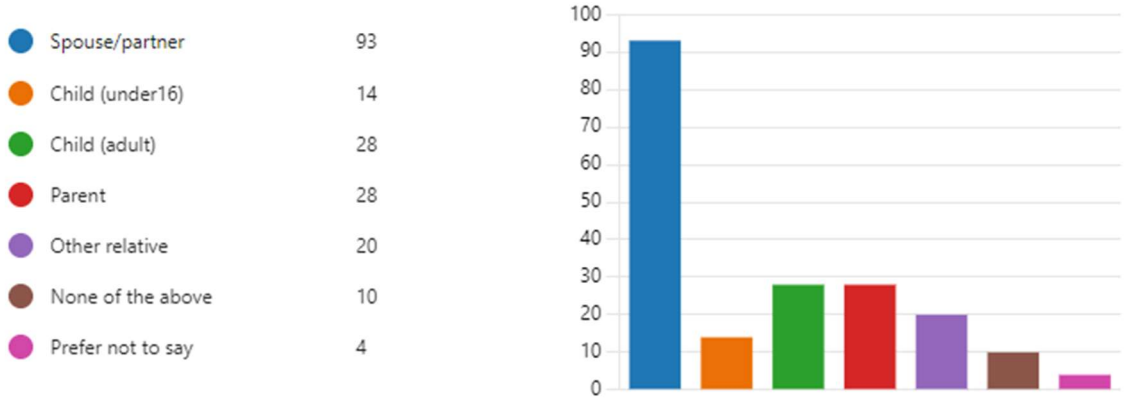
Around 20% of people felt that they would have liked more information on side effects with 12% feeling that better communication would have helped. Single numbers mentioned that they felt advice on using medication, more frequent reviews of medication and alternatives to medicines would have been helpful.

"Brief explanation of what they were designed to achieve to know if they were actually doing that - the blurb that comes in packs can be overwhelming with so much info that by the time you've read it all, you've forgotten what it said at the start"

"More explanation on what the side effects are and what to expect"

"The dangers of long-term use should have been made known to me, and medical reviews have been few and far between (sometimes lapsing for years)"

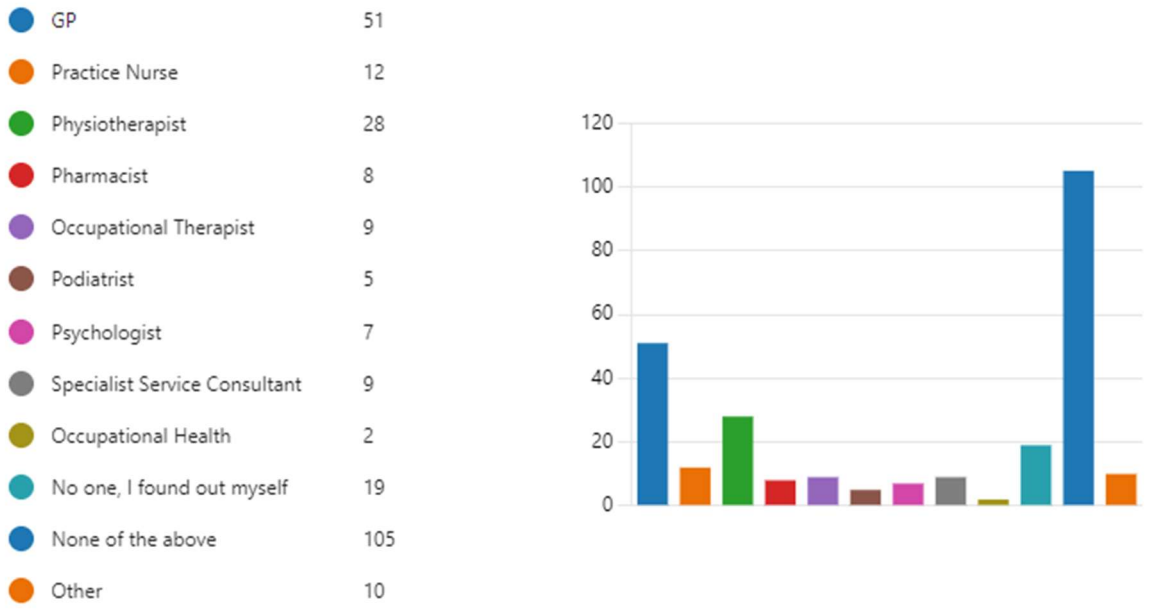
More than half of the people relied on others to support with day-to-day tasks and almost a third of people did not. Most of the people who relied on support received this from a partner with others relying on parents and adult children. 14 people who responded were supported by a child under the age of 16.



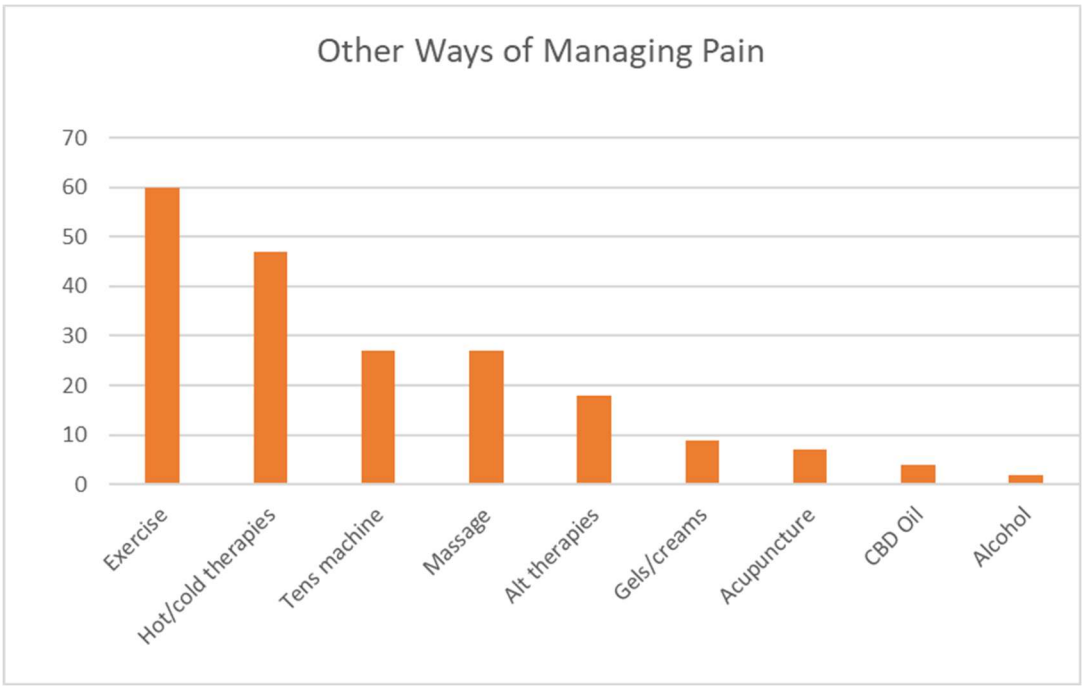
5.1.9 Supported Self-Management

Over one third of people understood the term to be things that they could do for themselves while being supported by health professionals and another third did not know what the term meant. 10% understood it to mean that they had to fix themselves.

More than half of people who responded had not been spoken to by any of the professionals listed in relation to supported self-management. A quarter of people had been spoken to by their GP and others had discussed with a physiotherapist. Further details in the diagram below.



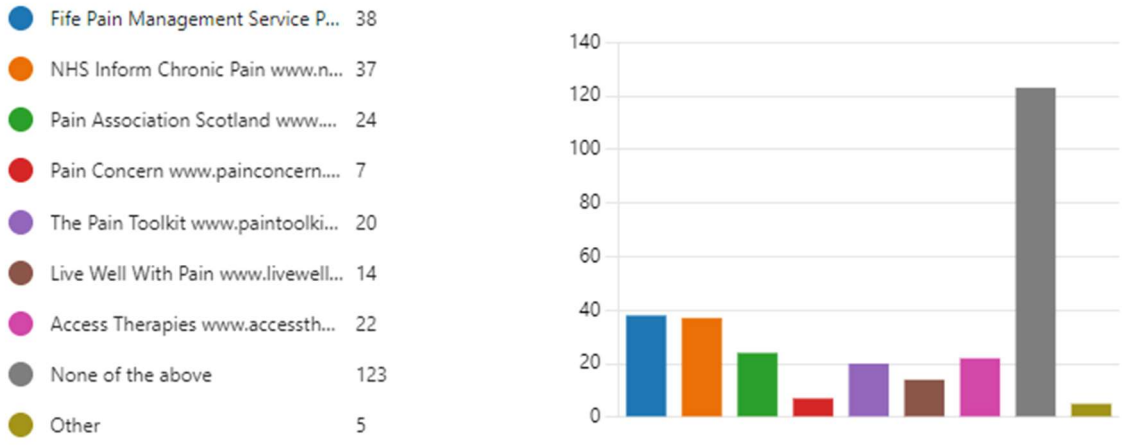
75% of the people who responded had used other ways to manage pain as outlined in the diagram below.



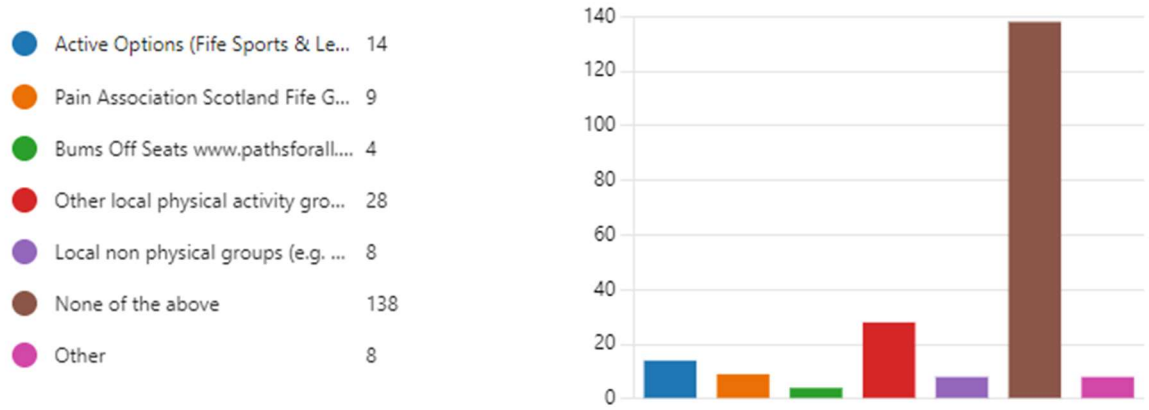
A quarter of people said that using other ways to manage their pain gave them some short term/limited relief. Around 10% felt that they didn't help at all, 7% felt that they reduced pain levels

with another 7% saying that they distracted them from the pain. Single numbers of people mentioned that they improved mobility, reduced **stiffness,** and helped with their mental health.

More than half of the people who responded had not used any of the listed website resources to help manage pain. Approximately 20% of people had used Fife Pain Management Service Pain Jigsaw. Full details in the diagram below:



Almost 60% of people had not used any of the listed services or groups. Approximately 15% of people had used local physical activity groups with others attending Active Options (Fife Sports and Leisure Trust).



Additional patient comments on supported self-management included:

"Despite having suffered with back pain for many years, the suggestion of attending a pain management clinic has only just been offered by my GP. I am currently awaiting a physio review and after that I will be referred to attend the pain management clinic. Given that acupuncture and manipulation have been helpful in managing my pain it would be fantastic if these could be offered through the NHS. Other boards in Scotland also offer free classes at local sports centres if a clinical benefit is identified and I think I could benefit from this by attending something like aqua aerobics (but I don't think Fife so this)".

"Would be a good idea to give patients some information on self- management on diagnoses."

"When you have a physical disability and physical activity worsens your pain being told repeatedly physical activity will help you get over it is not helpful. When you have a neurodivergent brain mindfulness isn't always an option and when you suffer with personality disorders this again is an

issue. Too many of these websites are aimed at people with the sole focus of pain but there are many comorbidities alongside pain that is not considered here"
"Pain clinic team are stand out 11/10 and have a real positive impact on quality of life. Everything is so connected and well ran through them it's a pleasure to be supported by them"

5.1.10 Patient Overall Experience

17% of people highlighting that they wanted to be listened to with 10% feeling that better understanding of their pain condition would have helped. 10% of people would have liked more information and support to manage their condition and 6% mentioning having more effective medication. Small numbers of people felt that an earlier diagnosis and face to face appointments would have made a difference.

"Being listened to, understanding and taken seriously"

"A mandatory review with nurse/GP An overview of ladder of painkillers covering all options available"

"Health professionals need to listen to patients and not play Russian roulette with people's health and lives"

"Finding someone who believes the amount of pain I'm in and finding something that works"

"Better understanding of psychology/mental health from NHS staff in general- not just those in pain management"

One quarter of people stated that the most important thing was being able to function daily with 15% wanting to feel there was more understanding of their condition. 15% of people felt that having effective pain relief was the most important thing and 13% felt that quality of life mattered most. Single numbers of people wanted to feel that they had been believed and others wanted some pain free, comfortable spells.

"To allow me to continue to be as active as possible to help support my disabled wife and daughter"

"Getting the correct medications and advice from professionals"

"Access to the exact information to help yourself or supplement medication with exercise/movement and where to source it. I hated taking medication, but it did help initially"

"Mental health support because you feel so guilty and a burden to your family. Being listened too, you know your body and what it's telling you"
"Understanding! Too much bias out there and thinking it's all in your head. Fibromyalgia is awful! But I've learnt to manage it"

Additional patient thoughts, comments, and ideas included:

"To check up yearly on pain management and regular reviews of pain medication"
"Maybe not make the person feel so alone when having this condition and help instead of saying well we have tried everything there's nothing life to try just take you opoids which make me like a zombie so again that's no way to live. Doctors are so easy to give up on people with long term pain conditions and don't believe them when they say how much pain they are in. Doctors and other health professionals need update literature and have a degree of understanding of what its like to live day to day with this."
"I believe mentorship would help (positivity from historic sufferers)"

"I think it would be beneficial that when patients are in pain for over a set period, they should be referred for pain management review. Every specialty or GP should be supporting patients to access the best possible advice and care"

"There has been no offer of (and, no, I haven't asked for) mental health support, despite my crying/upset in front of 3 different GPs. One of whom prescribed me codeine at one visit and Tramadol at another. Had I not been as strong a character as it seems I am, it's a worry what I could potentially have done with all this dangerous meds!!! (And, yes, I tried to use them as pain relief, but they made me feel worse in different ways.)"

"Further training for health care staff regarding fibromyalgia. Some still don't even believe it exists and this is very upsetting for patients"

"I want to feel seen, understood and believed when I talk about my pain."

"Pain is one of the biggest barriers in my life, when I feel like I have to justify its existence to doctors I feel like I am not seen or understood."

"It would be helpful if there was more information available about the pain management clinics. Perhaps self-referral would be good as it seems to work well with podiatry

5.1.11 Conclusions

The response to the surveys highlighted that the pain population of Fife were keen to engage with the Pain Medicines Patient Safety Programme. People responded from across Fife, and we have gathered a lot of quality data which will inform the work of the Programme as it moves into Year 2 and Year 3.

The key themes that emerged are:

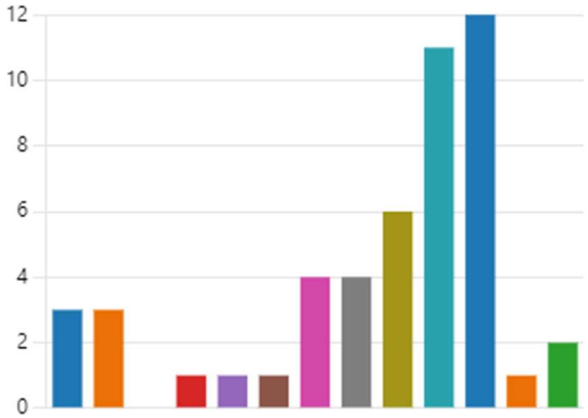
- Most people living with long term pain have been managing pain for more than 10 years.
- Chronic Pain and Fibromyalgia were the most common conditions and nearly half of the people had not had a review of their medicines for over 2 years.
- Most people who responded had been referred to specialist services with many of those referred to Fife Pain Management Service (FPMS).
- Almost all the people who responded had been prescribed pain medicine and over half of them felt that they had been given enough information about their medicines.
- Those who had not had enough information would have liked more frequent reviews, better communication, and more information about side effects.
- To ensure safe and effective use of pain medicines guidance is that medicines should be reviewed regularly (at least annually). Despite current challenging times within the NHS post pandemic, 44 % had received review.
- Reviewing medication is not the sole responsibility of the GP, this can be carried out by other health professionals across the system either planned or adhoc.
- In some instances, reviews may have happened but may not have been well enough communicated with the patient which does not reflect the Realistic Medicine principles of shared decision making.
- Two thirds of people living with long term pain conditions rely on support from family members with day-to-day tasks.
- More than half of the people understood the term Supported Self-Management, but the remainder did not understand this approach and had not been spoken to by any professionals. Many who did not know said that they would have liked more information about this.
  Many people had, however, tried alternative ways to manage pain.
- Many people wanted to feel that they were being listened to and their pain condition was understood by health professionals. Being able to function and have a good quality of life was what mattered most.

5.2 Carer Awareness

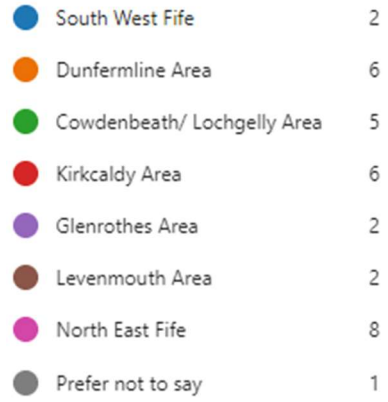
5.2.1 Background Information

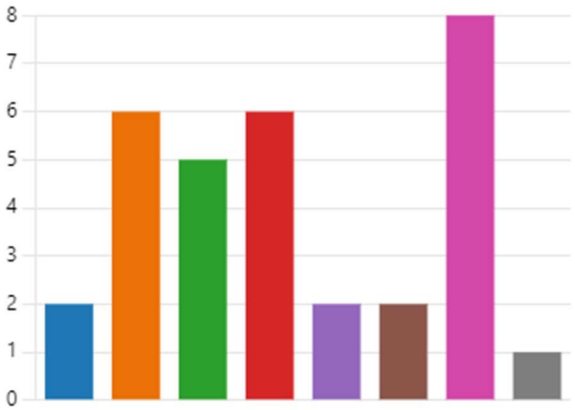
A total of 32 people completed the Carer survey for those who are carers/relatives of people living with chronic pain. Most responses from the Carer Survey were from the 45-54 and 55-64 age groups. People who completed the Carers Survey were White, 1 person was African, Scottish African, or British African and 1 preferred not to say. 18 people who completed the Carers Survey identified as Female, with 14 identifying as Male. None of the people who completed the Carers Survey considered themselves to be trans or to have a trans history.

Carers were asked about their health conditions with 11 people indicating they themselves had a long-term illness and 6 people had a mental health condition. The diagram below provides a breakdown:



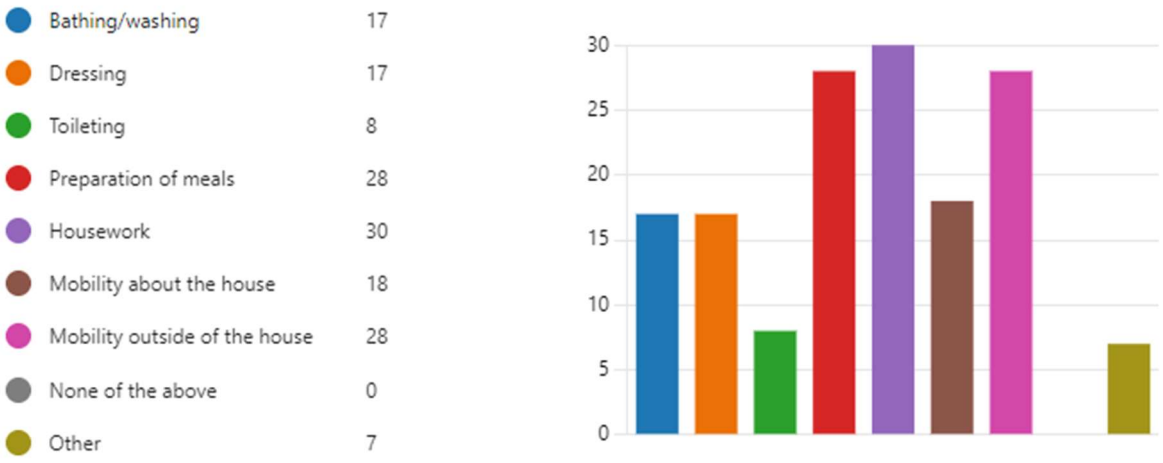
Responses were received from across Fife with the highest number from Northeast Fife. The locations of respondents are illustrated below:



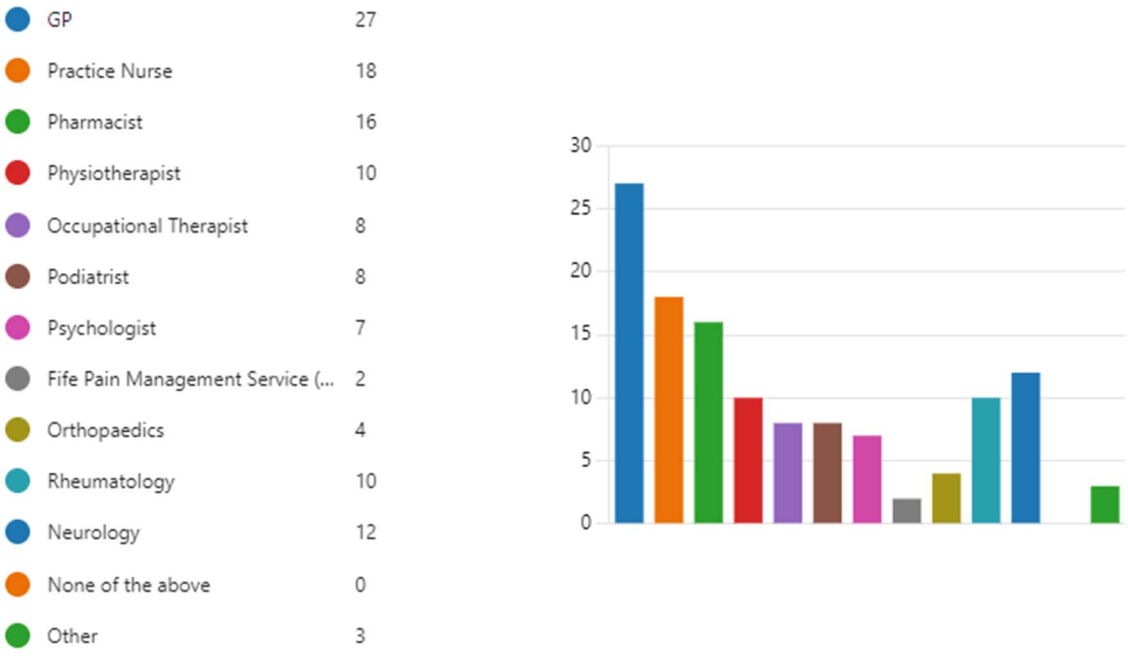


12 Carers had been supporting someone to manage their pain for more than 10 years. More than half of the people who responded were caring for a spouse or partner with 9 people caring for an adult child.

More than half of the people being cared for were over the age of 65.
People reported a range of activities that required daily support. Almost all were supporting with domestic activities, and more than half were assisting with mobility and personal care. Other support included emotional support and shopping. The below diagram provides a full breakdown:



26 people attend all healthcare appointments with the person they care for, 4 attend some appointments and 2 people do not attend appointments. The range of appointments attended is outlined below:



7 people reported that the person they cared for found living with unmanaged levels of pain the most challenging thing. 5 people answered limited mobility and 5 mentioned that a lack of support and understanding was challenging. Full details provided below:

5.2.2 Impact on The Person & Carer

40% of people described a poorer quality of life for the person they cared for with isolation, reduced social opportunities, loss of interest in hobbies and maintaining friendships all impacts of living with pain. 28% responded with comments around the mental health impact which ranged from feeling angry about life to feeling suicidal.

"Devastating. He rarely leaves the house now and needs to rest in the afternoons. He has flare ups which make everything worse. He has become more introverted and has lost self confidence. He suffers from depression - I took early retirement recently and that has helped."

"It has taken away his life".

"She has lost most friends, due to cancelling at last minute. She must sleep a lot and cannot exert herself too much. Often felt suicidal"

Half of the people who responded mentioned the emotional impact caring had on them. They reported finding it stressful seeing a loved one in pain, constantly worrying, and feeling distressed. Almost one quarter found it physically tiring and others mentioned the impact on their own mental health and poorer quality of life with little time to themselves.

Comments included:

"My heart breaks for him and the life we should have now. We can't go out as a couple very often and holidays are extremely rare. Intimacy is a thing of the past."

"Can be upsetting seeing them in so much pain, feel unable to do much other than care, feeling alone, emotionally and physically drained at times"

"It is very difficult. I am ill myself and exhausted all the time. I'm not able to support him emotionally as well as I used to. I no longer see my friends; I've lost touch with most of them. I don't go out anywhere".

5.2.3 What Helps & Hinders

A quarter of people felt that receiving support from family and friends helped them to continue in their caring role with almost a fifth saying that they did it because they loved the person, and it was their role to care. Others mentioned practical support and attending support groups helped them to manage. 2 people said that nothing helped, or they did not have enough support.

Comments included:

"Friends, family and loving him. Trying to stay positive and focus on the pros rather than the cons. I am part of an AS support group on Facebook. On a practical level, applying for and receiving Adult Disability Payment (for him), Carer's Allowance (for me) and his blue badge. The extra money means we are not struggling financially after my early retirement and when I do need to take him out in the car, the blue badge means I'm not stressed about finding a space near to our destination"

"My own health & relative fitness at 84 years of age - motivation and a measure of practical skills as I undertake all manner of domestic and personal tasks in support of my wife"

"My wife has various aids wheelchair, gutter frame, panic alarm, wet room, shower chair, grab rails, bed rail closomat toilet with aerolet and perching stools"

"Nothing- it's very lonely."

A quarter of people responded that the most challenging thing was feeling helpless when a loved one was suffering. Other challenging things mentioned included a lack of support and feeling they had to hide their own emotions. 3 people mentioned that the person they care for takes their frustration out on the Carer.

"To be there 24/7, and to see my wife in constant pain is very distressing".

"His constant pain is emotionally draining for us all."

"Most challenging is that she is still in. A lot of pain and I feel I just can't help her with the pain".

"The emotional side- that everything gets taken out on me."

5.2.4 What Support Would Help Carers

A quarter of people responded that they needed more support to help provide care, including things like respite from caring, the right care packages, financial help, and aids/adaptations. 5 people felt that having the right pain-relieving medication would help.

"GP or pain specialist who would actually prescribe medication with frequent review."

"Someone to come out to see my mum such as gp ect not just giving her medication all the time and not even see her."

"A wet room that he was promised from occupational therapy. And maybe another day centre day or a person in to see him for company"

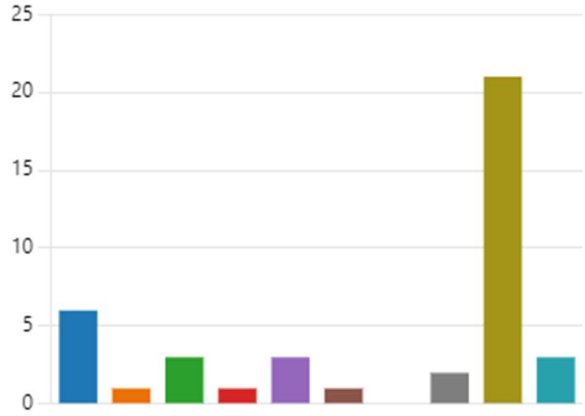
"Currently been awarded a care package but due to lack of staff no carers available to help"

5.2.5 Supported Self-Management

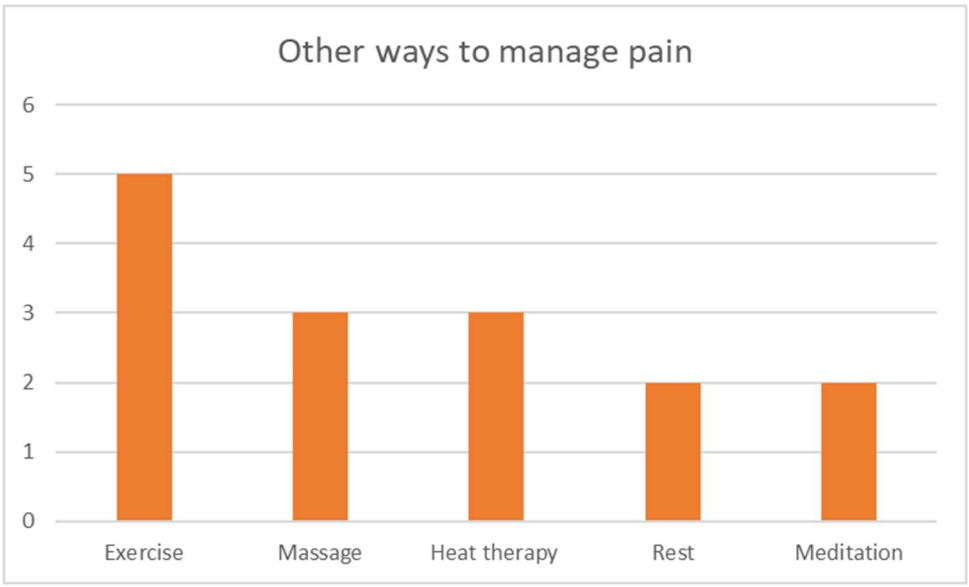
60% of the people who responded did not understand the term. Almost a third understood that it meant doing things to look after themselves with support from professionals.

21 people indicated that no-one on the list of professionals had spoken to them or the person they care for about supported self-management. 3 people had spoken to social care staff or family. Full details below:

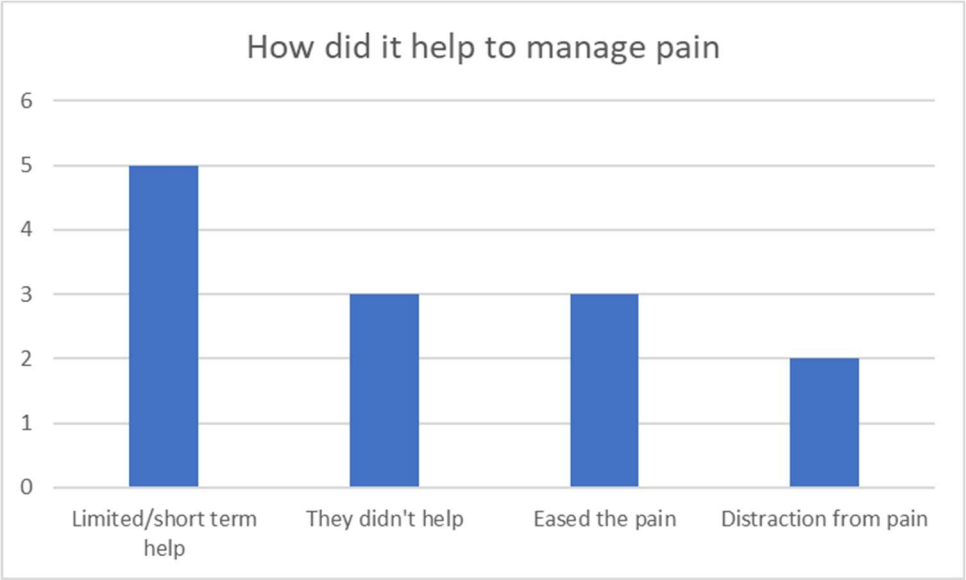
GP	6
Practice Nurse	1
Physiotherapist	3
Pharmacist	1
Occupational Therapist	3
Podiatrist	1
Psychologist	0
No one, I/ they found out myself	2
None of the above	21
Other	3



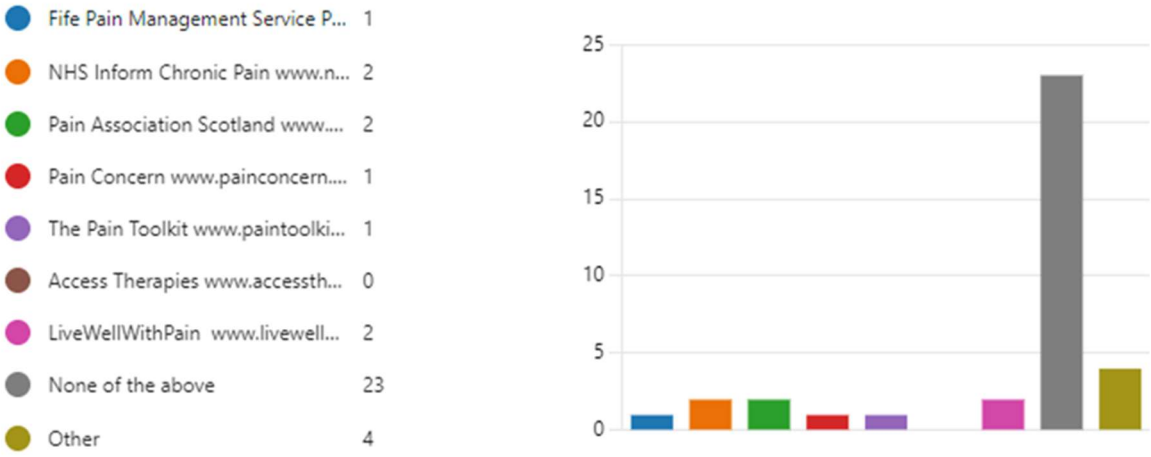
16 people indicated that other ways to manage pain had been used with 16 people saying that they hadn't. The below outlines these other methods:



Having tried other methods above, the below outlines how this helped:



23 people reported that neither they nor the person they care for had used or accessed any of the listed websites. 4 people selected other, but no other websites were listed in the responses. Low numbers of people selected some of the options listed.



25 people reported that the person they care for had not attended any groups. 3 people selected other but did not mention other groups and a low number of people attended some of the groups listed.

Comments from carers on supported self-management included:

"Being more active would be easier if he wasn't in so much pain all the time. He is never pain free and his default level of pain drains him completely, never mind when he has a flare up. I know painkillers can mask symptoms and that we need to feel pain to keep us safe, but surely there must be a better middle ground?"

"I believe supported self management would have to be well funded and staffed adequately, with a robust communication network to be effective"

"My partner suffers from M.E. And groups don't consider the requirements for someone with ME"

"Mum would never attend a group, and has little time for self management... Unless she came up with it herself"

5.2.6 Patient Overall Experience

When asked what one thing could have been done differently regards health care support of the person, almost one third of people mentioned that they would have liked more access to support. This included information on pain management, mental health support and respite care.

When asked what one thing could have been done differently to support the carer, one quarter of people would have liked more access to support. This included respite, equipment, and information about other services available.

When asked what matters most as a carer supporting someone with pain, more than half of the people responded was being able to access support for the person they were caring for. 4 people mentioned that having a good quality of life for themselves mattered so that they could continue in their caring role.

Additional carer comments, thoughts and ideas included:

"It would be good for people in the future if they were aware of what support is available"

"I do not presently have neither time nor inclination to "share" - I am living the nuts and bolts business of just coping and caring alone until any "cavalry" might come riding in form of Care Package or whatever"

"I know nhs is under an extreme amount of pressure and I greatly value all the work that staff put in. And how lucky we are to have an nhs."

5.2.7 Conclusions

The response to the surveys highlighted that carers were keen to engage with the Pain Medicines Patient Safety Programme and share their experiences. People responded from across Fife, and we have gathered a lot of quality data which will inform the work of the Programme as it moves into Year 2 and Year 3.

The key themes that emerged include:

- Many carers have their own physical or mental health issues and have been caring for someone for more than 10 years.
- The majority support with domestic tasks and more than half provide assistance with mobility issues and personal care.
- Reduced quality of life was reported both for the carer and for the person living with pain with limited social opportunities and mental health and emotional impacts for both.
- What mattered most to Carers was having better access to the support services and information that they needed to improve quality of life for both them and the person they care for.

5.3 Patient/Carer Stories

5.3.1 Background

In order to better inform the proposals for year 2 of the programme, it was important to enable patients to have 'a voice'. To provide this opportunity and gain valuable qualitative insights a "patient story" approach was adopted which is outlined in the diagram below:

Listening events were held across December 2022. Feedback from the events included involving more men in this work as they are often missed, use of language to help understanding (e.g., long-term pain rather than chronic pain) and making events/activities accessible to more people. This feedback helped to direct the approach taken to collecting and documenting the experiences of patients through patient stories.

Stories were gathered between January to March 2023 and the majority of these involve patients or those caring for people with complex needs. Initial interest came via Pain Association Scotland, local services, email, and word of mouth.

The first phase of story gathering involved 14 patients and 1 carer. Joe, Fiona, Charlie, Buck, Suzie, Lynne, Margaret, Pen, Sian, Selena, Fred, John, and Elle very kindly shared their stories (names have been changed to protect identities as requested). Joe is a carer and is also a patient himself therefore shared 2 stories from each perspective. There was also input from 2 other family members who are undertaking caring responsibilities, although did not identify themselves as carers. Patients and carers were asked a set of questions during their one-to-one sessions covering:

- pain conditions
- length of time managing pain
- what helps the pain/makes it worse
- support needs to help with daily tasks and who provides this
- involvement of Primary Care/referrals to specialist services
- prescribed medicines
- other ways of managing pain
- what matters most to everyone

5.3.2 Individual Situations & Conditions

People highlighted a range of situations through their stories including onset of long-term health conditions, accidents, and injuries. Long-term conditions included fibromyalgia, trigeminal neuralgia, osteoarthritis, greater trochanteric pain syndrome, functional neurological disorder, Scheuermann's Kyphosis, endometriosis, migraines, Crohn's Disease, hypermobility, lymphoedema, kidney disease, ulcerative colitis, COPD, shingles, long covid, diabetes resulting in neuropathy, charcot, sepsis, amputation as well as other conditions that have pain as a symptom. Most people sharing their

stories had experienced these conditions for anywhere between 10 to 30 years. Everyone highlighted they need help with doing daily tasks and receive this support from their partner/spouse or family members, although Joe as a carer and a patient himself had to put his wife's complex care needs before his own.

5.3.3 Pain Medicines

All 14 people were prescribed a variety pain of medicines and the majority take these on a regular basis. All individuals have had prolonged use of these medicines. That said, 5 people have significantly reduced medication, 2 people have stopped taking it all together and others use a minimal approach to medication taking only when needed alongside other methods of pain management.

5.3.4 Experience of Using Pain Medicines

Experiences included 6 patients having regular reviews, 3 people had no medicines review or follow up, 5 people made no reference to reviews or follow up and 9 people had adverse reactions to initial prescribed medicines or with other medication resulting in people stopping medicines themselves or with advice from a professional.

"I have been on the same medication for 15 years and it seems to work well for me, but I have never had it reviewed - something I hope to rectify soon." Lynne's story

"Originally, I was afraid of taking medicines as I prefer to keep a clear mind, although doctors and everyone were first class, so this helped me greatly." Charlie's story

"There was no medicine review until I asked for one as I was finding the 'painkillers' offered little relief and I didn't want to exacerbate any further issues with high blood pressure medication." John's story

5.3.5 Information About Medication

In relation to information provided about medication 12 out of 14 people received little or no information about their medicines, with 2 people reported receiving good information. Most people felt they had to find the information they needed themselves. Two people who accessed the Fife Pain Management Service had time with the pharmacist explaining medicines and how to take them. Another patient eventually received more information about his medicines which eventually benefitted him positively and enabled him to sleep. Joe (carer) highlighted how his GP takes a 'trial and error' approach with his wife's medicines due to the amount she needs/general complexity of her multiple conditions.

5.3.6 Referrals To/Involvement from Healthcare Professionals/Other Services

All participants had contact with their GP and physiotherapy in the first instance, with most people referred to specialist services such as neurology, occupational therapy and rheumatology, Fife Pain Management Service (FPMS)/pain clinic, Spinal Unit, Pain Association Scotland groups and acupuncture. Four people felt that the pain clinic/FPMS worked well for them, 3 people had good experience with physiotherapy, 3 people said that they benefit from the Pain Association Scotland groups and 3 people said occupational therapy was helpful. People stated the advice/guidance offered by health professionals that didn't work was mainly around level of support provided, lack of understanding and attitude.

"Everything the pain clinic did with me was great – lots of appointments, checks, explained everything well including medicines, diagnosis, it was all sorted out. I had acupuncture which I paid for privately and that helped with the pain. Things ran well, and nothing could have been done differently." Charlie story

"Advice from the surgeon at Western General was to lose weight and take up pilates – it did help a bit." John's story

"After I was diagnosed my GP referred me to a neurologist, but he didn't believe there was such a thing as fibromyalgia and advised me to take up yoga!" Lynne's story

5.3.7 Impact on Mental Health

Most people (12 out of 14) said that their pain experience or caring for someone impacted negatively on their mental health. The mental health impacts included feeling low, depression, anxiety, addiction, and non-accidental overdose.

"Before I was diagnosed, I had a nervous breakdown because I was in so much pain and couldn't sleep. I stopped eating for a while because I had no appetite and no desire to carry on." Lynne's story

"I was getting a lot of flare ups, and these could last up to 2-3 weeks, so I had to learn not to overdo it and stop hurting myself". Charlie's story

"There's a view that if you're given tablets – you're being 'dealt with'... no one asks, 'am I being 'dealt with' properly? or is this working for me?" John's story

5.3.8 What Helps/Worsens Pain

Most people indicated that overdoing things and stress made their conditions worse. Other examples included sitting or standing for too long, over-stimulation and lack of sleep.

Things that helped with pain included pacing self, exercise, rest and in some instances using a tens machine or heat products. Both patients and carers were keen to share this information as a guide/support to others experiencing similar situations.

5.3.9 Other Ways to Manage Pain

Most people (12 out of 14) use other ways of managing pain including exercise, heat therapy, pacing activities, rest, acupuncture, healthy eating, meditation, talking therapy, massage, complimentary therapies, support groups and arts and crafts.

"I realised after someone in the pain clinic said to me – it's about what you do and it's up to you now. It was like a wake-up call, and I realised I had to start thinking/doing things differently – they had arts, crafts, and other groups on – that is when I went to the art group. Thank goodness for the pain clinic – they had different projects for patients, and I used to draw so I decided to try the art. Pat was a great teacher and I'll never forget her – this was the start of my journey and I started to learn to live with the pain". Charlie's story

"Fibromyalgia affects everyone who has it differently and needs a more holistic approach. To be believed and to have emotional support is just as important as pain relief. It would have benefited me greatly in the early days to have had someone to talk to who lived with fibromyalgia." Lynne's story

"I often ask myself 'will I still be taking these drugs in 10 years time when I'm 71? Offering alternatives or 'assisted self-help' would be good and using a scale to measure pain levels as well as understanding psychological impacts of pain e.g., will it ever go away and changing health behaviours/perceptions around this." John's story

5.3.10 Other Ways to Manage Pain

There are several areas where people felt things could be improved including pain medicines, management, and interaction with services. A lack of understanding or attitude of staff was described as unhelpful by 6 people, they didn't feel listened to or believed. Six people felt that they had no-one to talk to and 2 felt medication was prescribed too readily. Improvement suggestions were around having support for carers, staff being better informed, receiving support and information on self-management.

5.3.11 Key Themes/Areas for Learning & Improvement

Over 50% of people described what matters most to them in relation to their experience including being treated as a whole person, being listened to, having an advocate/single point of contact, peer support, having somewhere to go and someone to talk to as highlighted in comments below.

"What matters most to me is about understanding what pain is e.g., short-term, long-term pain etc and its more about understanding the pain rather than just taking it away." John's story

"It there was one thing that could have been done differently regarding my experience of managing pain it would be for GPs to be better informed." Lynne's story

"I'm at a stage now where I know what I can or can't do and when to ask for help. It's important to accept the pain and make the best of how you are." Charlie's story

5.3.12 Patient Stories Conclusions

The quotes selected in this section of the report are from 3 patients broadly representative of the wider patient group. However, all the patient stories documented as part of the first phase of the programme are detailed and available in the separate report referenced in Appendix 1.

The below table summarises the key findings taken from the patient stories work as a whole:

Themes	Areas For Learning/Improvement
Lack of information provided about medicines	Spending time with patients & carers to understand pain medicines, how to take them effectively including side effects
Lack of medication reviews	Ensure reviews are booked as appropriate and particularly if medicines are being used for prolonged periods
Adverse interaction between medicines	Being aware of other conditions/issues/co-morbidities
Lack of communication across services/ healthcare professionals	Improved communication between healthcare professionals
Single Point of Contact/Coordinated Approach/Advocate	Coordinated approach to service delivery, particularly in relation to co-morbidities/multiple long-term conditions
Non-pharmacological solutions (other ways of managing pain)	Knowledge of wider pain management solutions/options. People having to learn to self manage.

	Knowing what's out there to help support/ manage pain.
Holistic approach to pain management	Being aware of and treating the 'whole person' Being aware of pain impact on mental health and providing support
Condition-Specific Peer Support	Use of a peer support network/group so once someone is diagnosed/or needs support related a particular condition they could be offered a peer support forum
Impact on Mental Health	Negative Impact of pain/pain medicines on mental health and overall wellbeing Diagnosis of mental health issues as a direct result of pain conditions
Good/Meaningful Conversations	Early meaningful conversations with Patients & Carers regarding other ways of managing pain Embedding key information as early as possible including a range of ways to manage pain effectively

6. What Do We Know About the Awareness and Experience Of Our Staff?

6.1 Primary Care Staff Awareness

6.1.1 Background

Survey work was undertaken with Primary Care staff to understand awareness, knowledge, skills, and attitudes regarding the use of HRPM in the management of pain conditions in Primary Care settings.

Four electronic surveys were designed using MS Forms and circulated electronically via Primary Care Managers, Professional leads and through Newsfeed on Stafflink. The focus of the surveys was Awareness, Knowledge/Skills/Attitudes, Awareness and Utilisation of Supported Self-Management Solutions and Prescribing & Guidance (Table 1).

The surveys used a combination of closed-option and open-ended responses to allow both quantitative analysis and context/thematic analysis to be undertaken.

The key findings from the Awareness, Knowledge/Skills/Attitudes and Awareness and Utilisation of Supported Self-Management Solutions surveys are described below. The key findings from the Prescribing & Guidance survey are described in Section 4.1.

Table 6a: Primary Care Surveys for HRPM Patient Safety Programme, Jan - April 2023

Survey Title	Survey Purpose	Target Audience	Dates	Responses
HRPM Awareness	What do you know of the programme and/or pain management?	General Practitioners (GPs) Practice Nurses (PN) District Nurses (DN) Allied Health Professionals (AHP) Primary Care Pharmacists (PCP) Primary Care Technicians (PCT) Community Pharmacists Physiotherapists Occupational Therapists (OT) Podiatrists	30 Jan – 12 Mar	72
Knowledge / Skills Attitudes	Existing knowledge and attitudes towards pain management		13 Feb – 18 Mar	42
Supported Self Management Solutions (SSMS)	Awareness and utilisation of supported self management solutions		27 Feb – 26 Mar	47
Prescribing & Guidance	What guidance do you access and how?		13 Mar – 9 Apr	51

6.1.2 Primary Care Staff Awareness of HRPM Patient Safety Programme & Pain Management

Of the 72 Primary Care staff who took part in the survey, one responded from a personal point of view i.e., as someone who suffers from chronic pain. As the survey was aimed at collecting views

from a staff perspective, this response was not included in any analysis. Thus, the total number of surveys used for analysis was 71.

The majority (29, 41%) of respondents were GPs, 16 (22%) were MSK Physiotherapists and 8 (11%) were GP Practice based Pharmacists.

The highest number of respondents worked in the North-East Fife area with the lowest number of respondents working in the Levenmouth and Lochgelly/Cowdenbeath areas.

When asked about awareness of the HRPM Patient Safety Programme, just over half (37, 52%) of respondents reported being aware.

Of those who were aware of the Programme, 18 (25%) reported seeing the Primary Care Newsletter, 10 (14%) had seen the Stafflink pages, 15 (21%) attended the August Primary Care lunchtimes sessions and 10 (14%) attended the November Primary Care lunchtime sessions. 7 (10%) of respondents attended both lunchtime sessions.

When asked about the challenges with supporting patients with pain conditions, several themes emerged: Time available for reviews, Patient expectations of pain medicine, Patient understanding of pain management, Patient acceptance of alternatives and accessing other services.

When asked about the challenges with supporting medication initiation and review in patients on HRPM pain medicines, several themes emerged: Lack of time, Patient reluctance, Accessing appropriate staff/services and Prescribing practices.

When asked about what would help to support patients to manage their pain better, the themes that emerged were: Access to services, Knowledge and access to alternatives to medication, Pharmacist support, Patient information/education and Staff education.

When looking at the survey responses, several key themes emerge: Time, accessing other services and Patient acceptance of alternatives or reluctance to change medication. These themes along with illustrative quotes are presented in Table 2 below. Further detailed analysis can be accessed (Appendix 1 has details).

Table 6b: Key themes, with illustrative quotes, from Primary Care Awareness Survey

Theme	Illustrative Quote
Time available for reviews	*"… there is simply no time or resources to tackle this neglected population." GP* *"Time constraints when consulting with patients regarding their pain/ pain medicines" Practice Pharmacist*
Lack of time	*"Time to explain what a complex area is - many people have no concept of the problems with long-term opioids for example." GP* *"Time and opportunity for longer consultations during a normal community pharmacy day" Community Pharmacist*
Access to services	*"Support from other agencies Eg Pain management services, physio and pharmacist support" GP* *"Easier access to pain clinic and pain management resources" ANP*
Accessing other services	*"Long waiting times in secondary care for painful conditions" GP* *"Lack of any pain service in fife, or one so geographically distant it is unusable for patients." GP*
Patient acceptance of alternatives	*"Getting them on-board with self-management strategies such as exercise" MSK Physio* *"Reluctance to accept psychological input can help." GP*
Patient reluctance	*"Patients often are reluctant to reduce doses or struggle when they do and ask to be put back up again." Practice Pharmacist* *"Resistance from patients to engage in dose reduction or medication change, even when medications are ineffective" Practice Pharmacist*

6.1.3 Primary Care Staff Knowledge, Skills & Attitudes

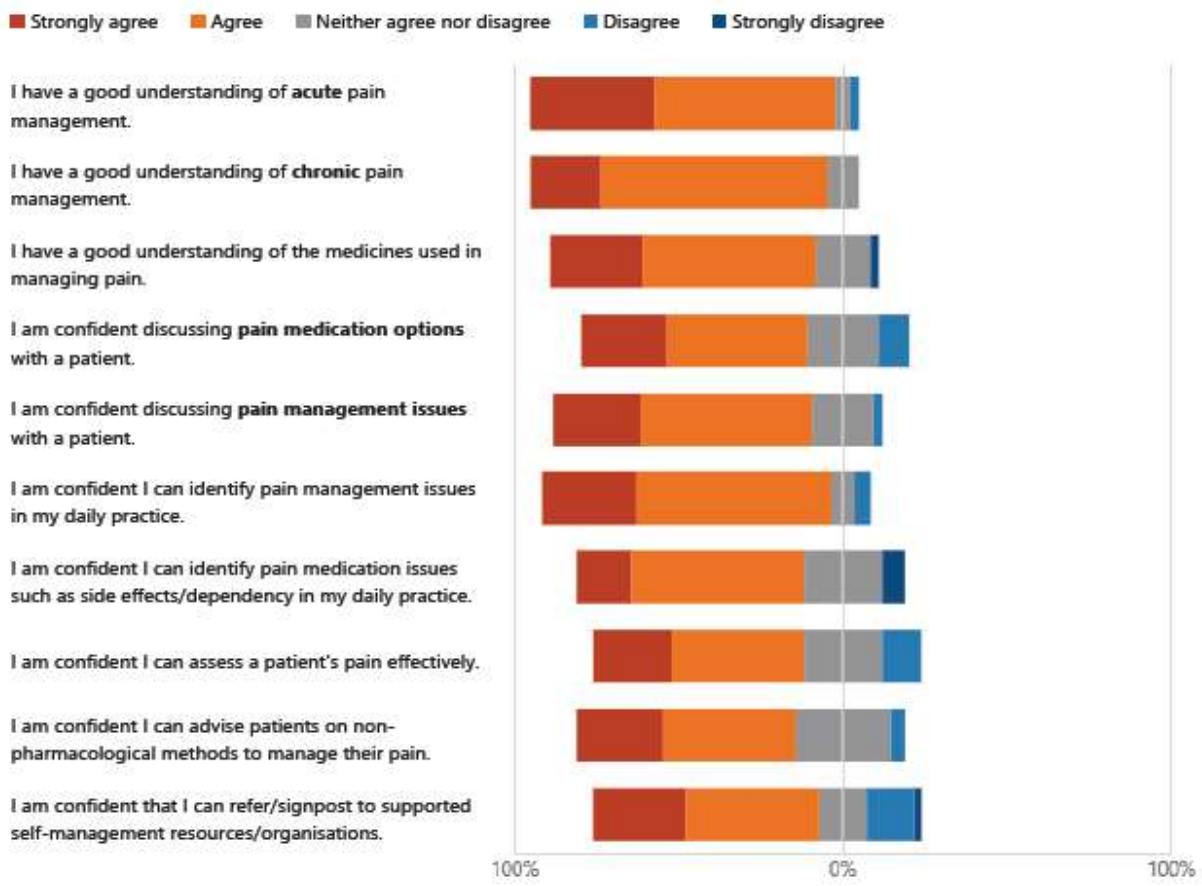
There was a total of 42 responses to the Primary Care Staff Knowledge, Skills, and Attitudes survey with 15 (36%) of responses being from GPs, 8 (19%) from First Contact Practitioner Physiotherapists, 6 (14%) from MSK Physiotherapists and 6 (14%) from GP Practice based Pharmacists.

Summary responses are provided here with full responses available from documents identified in Appendix 1).

The highest number of respondents worked in the Dunfermline, Kirkcaldy and Northeast Fife areas and the lowest number of respondents worked in the Lochgelly/Cowdenbeath area.

When asked about their knowledge, understanding and confidence regarding pain, respondents reported high levels across all areas listed – see Figure 6a.

Figure 6a: Primary Care Staff Knowledge, Understanding and Confidence regarding pain



When asked about awareness of pain assessment tools, 40 (95%) were aware of the Numerical Scale (1-10), 35 (83%) were aware of the Verbal Descriptor tool (Mild, moderate, severe), 18 (43%) were aware of the Patient Self-Efficacy Questionnaire, 16 (38%) were aware of the Activity Tolerance Tool and 11 (26%) were aware of the Wong-Baker Facial Grimace Scale.

When asked about the use of pain assessment tools, 38 (90%) reported using the Numerical Scale, 31 (74%) used the Verbal Descriptor, 13 (31%) used the Activity Tolerance tool and 13 (31%) reported using the Pain Self-efficacy Questionnaire.

When asked to rank what influenced prescribing practices, Guidelines/Protocols, WHO Pain Ladder, more senior/experienced staff and Secondary Care Specialist were the most common responses (Fig 6b).

When asked to rank what influenced prescribing of a particular pain medicine, On the formulary, Side effects and Drug interactions were the most common responses (Fig 6c).

When asked to rank what related to the patient influenced prescribing practice, Type of pain, Duration of pain and Previous medicines already tried were the most common responses (Fig 6d).

Fig 6b: Influences on prescribing practice

Fig 6c: Influences on prescribing a particular pain medicine

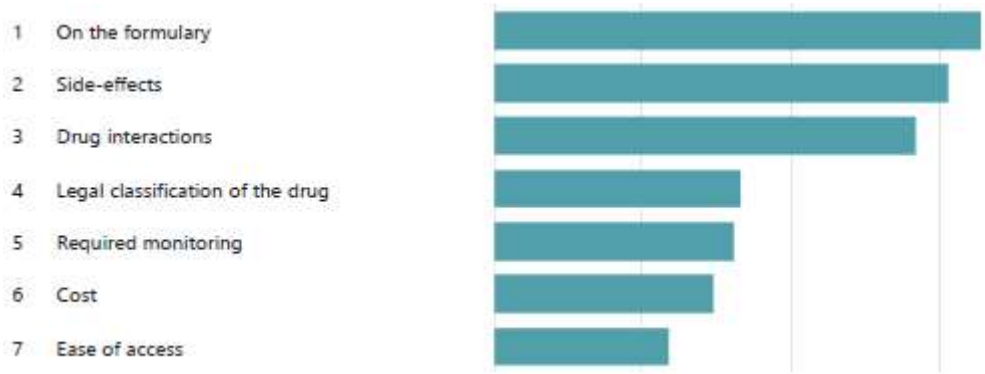
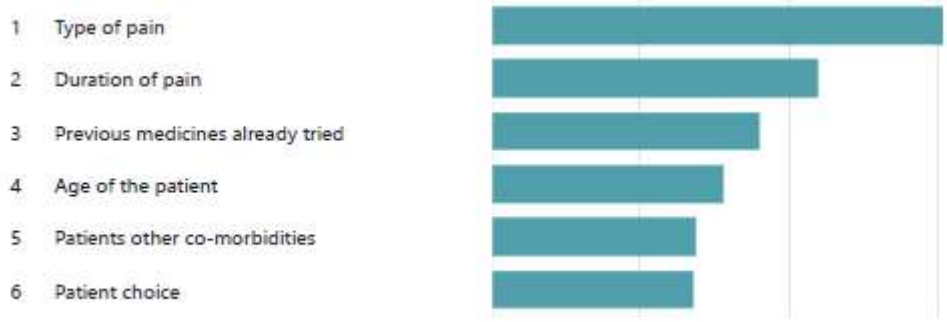


Fig 6d: Influences on prescribing practice related to the patient



6.1.4 Primary Care Staff Awareness and Utilisation of Supported Self-Management Solutions

A total of 47 people responded to the survey on awareness and utilisation of supported self-management solutions. Most responses were from GPs (24, 52%) followed by MSK Physiotherapists (8, 17%) and 5 (11%) of GP practice-based Pharmacists.

Many respondents worked in the Northeast Fife, Kirkcaldy and Dunfermline areas and the least responses were from staff working in the SW Fife, Lochgelly/Cowdenbeath and Levenmouth areas.

When asked about awareness of websites or resources to support patients with pain, most respondents (45, 96%) were aware of the Fife Moodcafe website, 34 (72%) were aware of the Pain Association Scotland website and 27 (57%) were aware of the Fife Pain Management Service website.

When asked about the frequency of referring or signposting patients to these websites or resources, fewer responded that they did this on a monthly, weekly, or daily basis and, where signposting did happen, the Fife Moodcafe website was most frequently signposted to (32, 68%) whilst 15 (32%) of respondents said they signposted or referred patients to the Fife Pain Management Service website.

When asked about awareness of services which could support people with pain, there were varying levels of awareness of the different services – 45 (96%) respondents were aware of the Fife Pain Management Service, 41 (87%) were aware of the MSK Physiotherapy Service, 38 (81%) were aware of the Weight Management Service and 34 (72%) were aware of the Fife Sport & Leisure Trust Active Options Programmes.

When asked about frequency of referring patients to these services, again fewer respondents referred to these services on a monthly, weekly, or daily basis. Where they did refer, 27 (58%) would refer to MSK Physiotherapy Service, 19 (41%) would refer to NHS Fife Silvercloud Programme, 15 (32%) would refer to First Contact Practitioner Physiotherapists and 18 (36%) would refer to Fife Pain Management Service.

When asked what would increase awareness of supported self-management resources to patients and clinicians, the themes that emerged were: Information in one place, Information for staff and Information for patients.

When asked what would increase ease of referral or signposting to supported self-management resources the themes that emerged were: Information in one place: Website, Information in one place: leaflet, Self-referral options and Information for staff.

When asked what other services or resources they would like to see to help support patients managing pain, the themes that emerged were psychological support and Information in one place. There were several other suggestions including “a “how to carry out a pain review” demonstration,” “Social spaces with drop-in clinics maybe run by patient champions who know what it feels like to have a good life despite pain” and “better education on opioids - not for chronic pain for patients and unfortunately staff colleagues too please”.

The themes from these open-ended questions, with illustrative quotes, are presented in Table 6b.

6.1.5 Primary Care Staff Conclusions

On the 17 April 2023, the key findings from all surveys were discussed as part of a dedicated workshop centred on agreeing our understandings from the staff perspective. The main conclusions taken from the survey findings included:

- Awareness raising of Programme needs to be ongoing, with focused messaging released often likely to be more effective than several topics infrequently.
- Solutions that support improvements to time and provide resources are identified as a benefit. One recurring theme as part of workshop discussion is the creation of some form of a 'resource hub.' It is thought this hub could help save time by acting as a 'single point of accesses for information on supported self-management and alternatives to prescribing. It could also offer resources to both patients and clinicians to support their pain management conversations and actions.

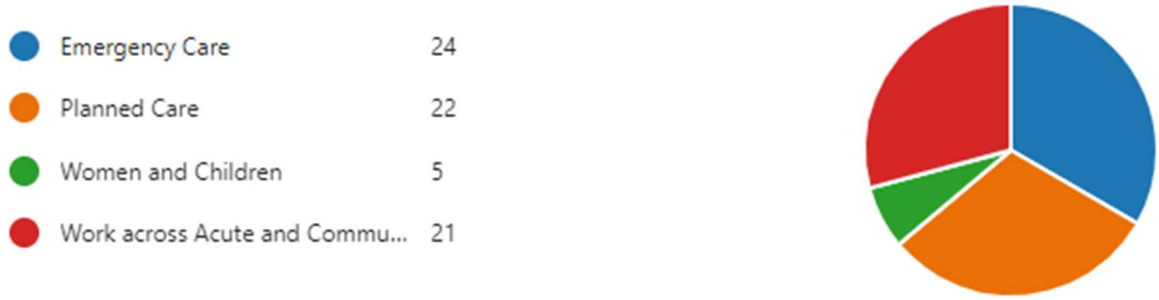
- The surveys indicate a strong confidence around pain management, but at the same time show via the prescribing and guidance survey that guidelines are mainly "never" or "rarely" used (less than once per month). This infers a risk that prescribers may not be aligned to the most up to date guidance. Section 4.2 of this report helps understand some of the reasoning behind this. Section 4.2 also identifies potential improvement areas for the existing guidance to focus on, to enable it to become more of a supporting tool. From the workshop discussion focused on the staff perspective, it was agreed there is likely a training response needed, to help raise awareness and embed desired ways of working.

6.2 Secondary Care Staff Awareness

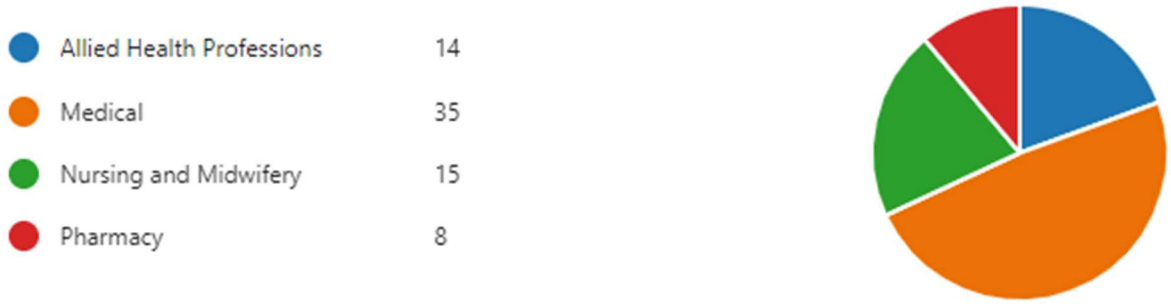
6.2.1 Background

Survey work was undertaken with Secondary Care staff to better understand awareness, knowledge, skills, and attitudes regarding the use of HRPM in the management of pain conditions.

A total of 72 secondary care staff responded. Across the following areas:

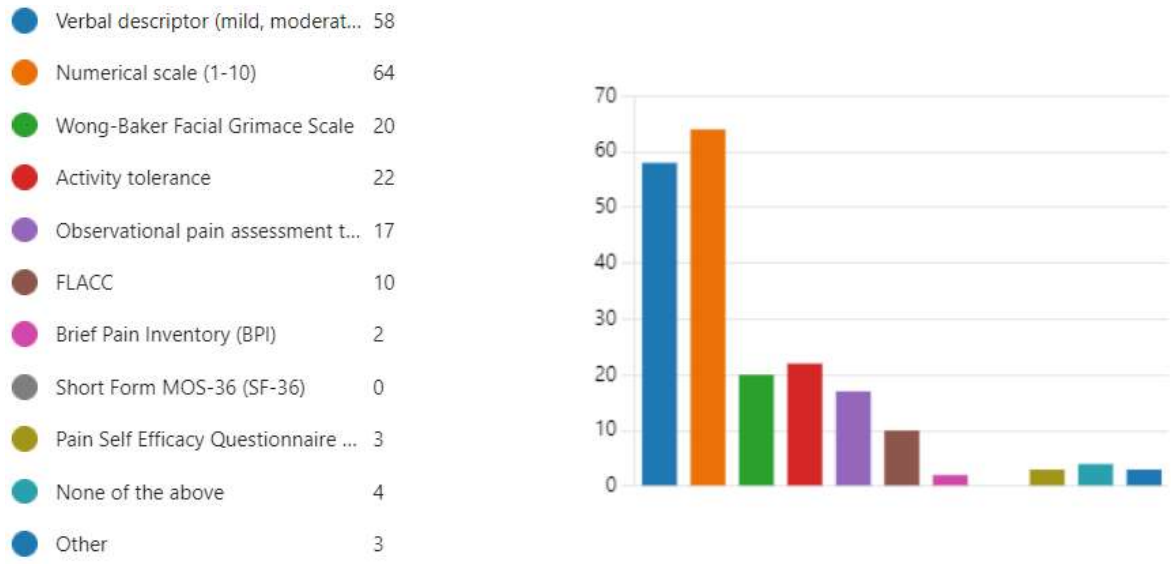


The roles covered included:



Allied Health Professions were mostly qualified physios, plus 4 from Occupational Therapy and Speech and Language Therapy, as well as 2 support workers. Medical was mainly consultants and 12 FYs. Nursing & Midwifery was mostly registered staff almost evenly split across staff/charge/senior charge/ advanced/ specialist and 2 Health Care Support Workers. For Pharmacy, 50% were clinical pharmacists.

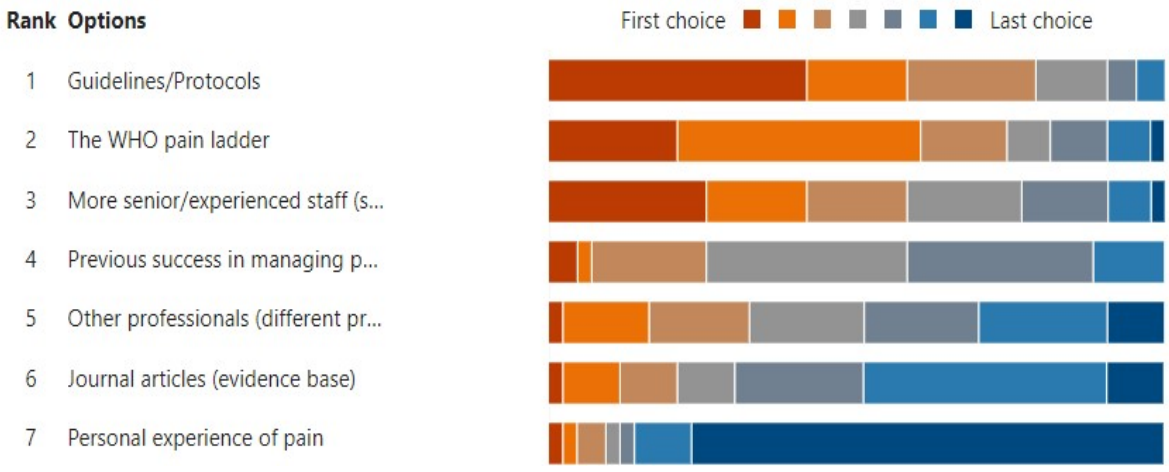
The following chart illustrates all the tools indicated as being used in pain assessment by Secondary Care staff:



The 4 who did not use any tool included 3 pharmacy staff (including 1 prescriber) and a Speech and Language Therapist.

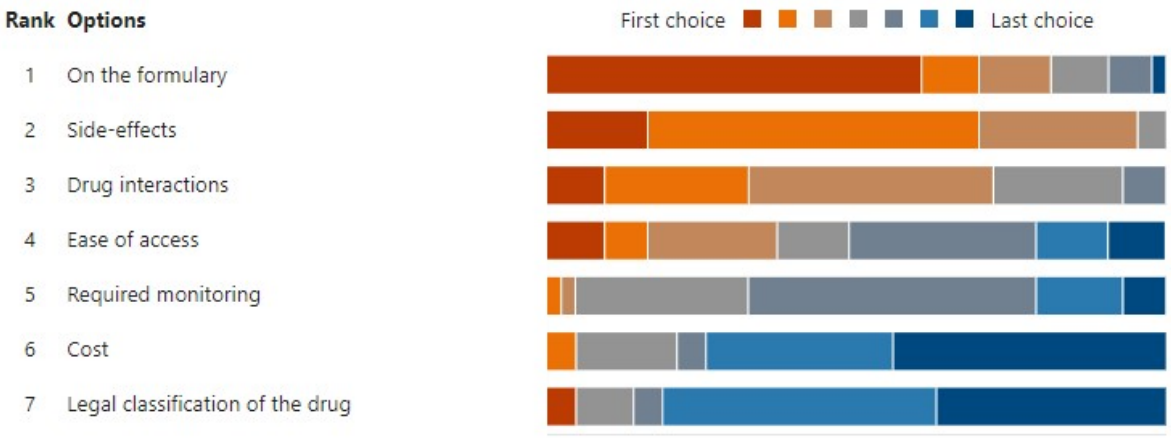
6.2.2 Prescribers

When asked what the influences were on prescribing practices in Secondary Care, the following were selected:

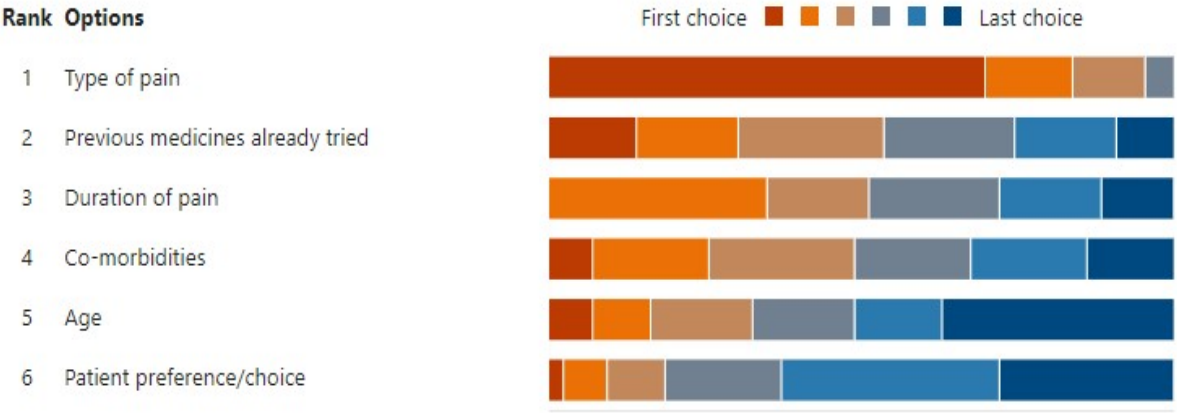


This was completed by mostly medical staff, only 4 NMPs (3 Nurses and 1 pharmacist) completed the survey.

The following outlines what is considered when prescribing a particular medicine:

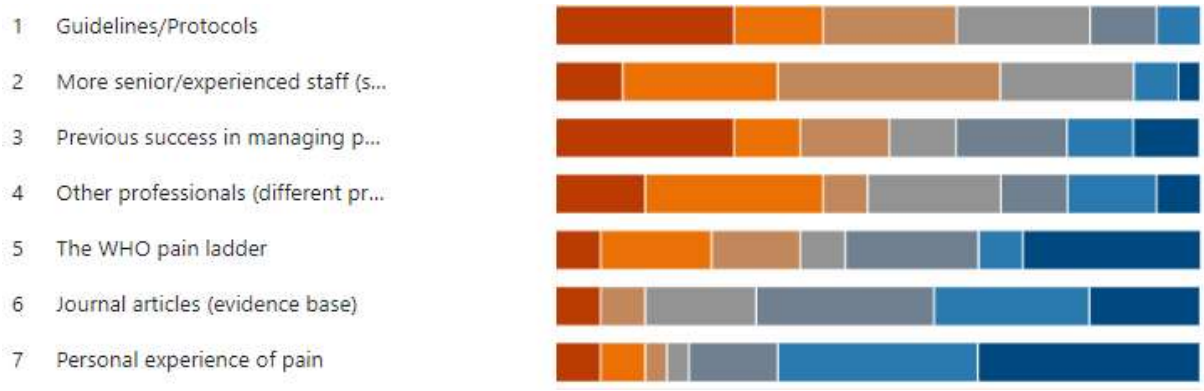


The following outlines what patient related factors are taken into consideration when prescribing a particular medicine:



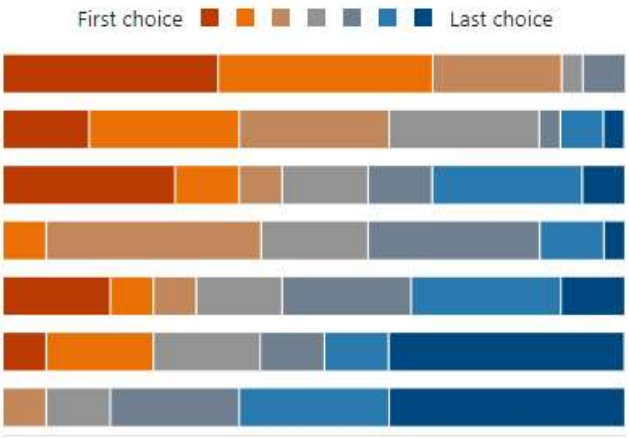
6.2.3 non-prescribers

The following indicates the main influences when considering pain management:



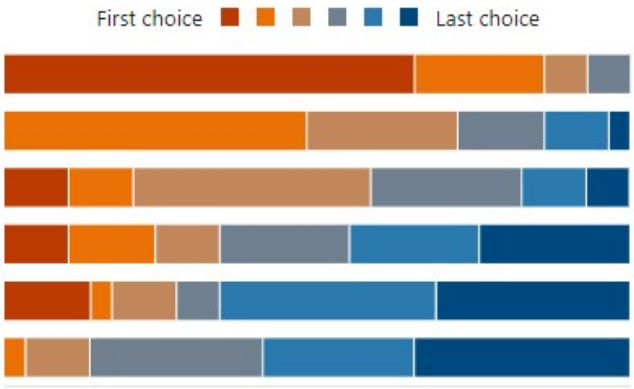
The following indicates the main influences on staff views of a particular medicine:

Rank	Options
1	Side-effects
2	Drug interactions
3	On the formulary
4	Required monitoring
5	Ease of access
6	Legal classification of the drug
7	Cost



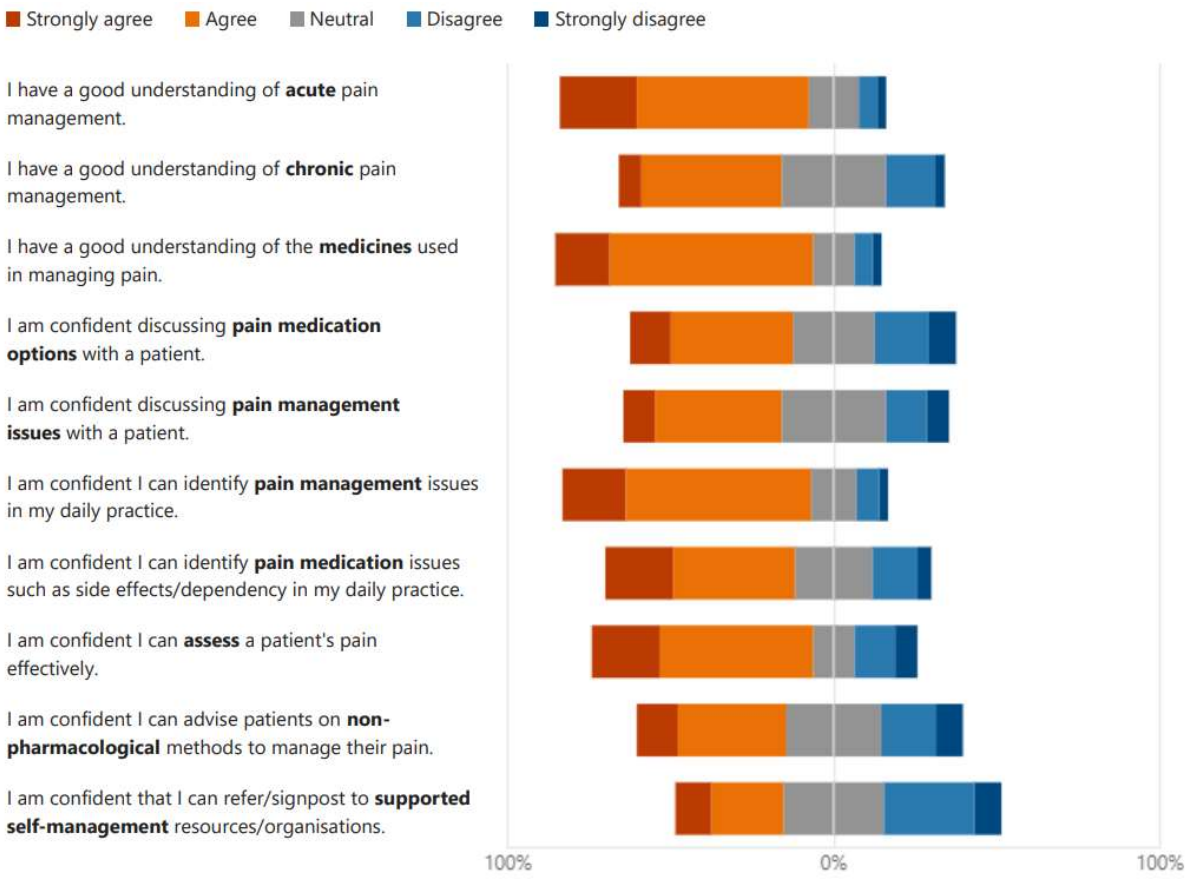
The following indicates the patient-related factors that influence opinion of a particular medicine.

Rank	Options
1	Type of pain
2	Duration of pain
3	Previous medicines already tried
4	Co-morbidities
5	Age
6	Patient preference/choice



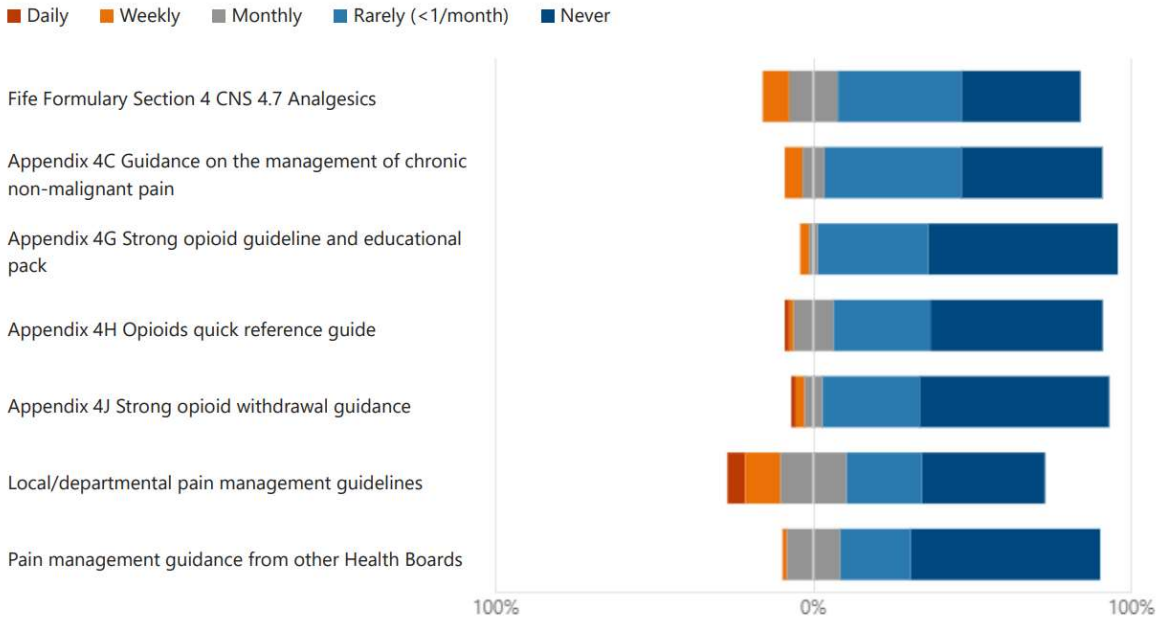
6.2.4 All Respondents: Pain Management Guidance

When asked to think about their knowledge, understanding and confidence regarding pain, the following shows the level of agreement with each of the statements:



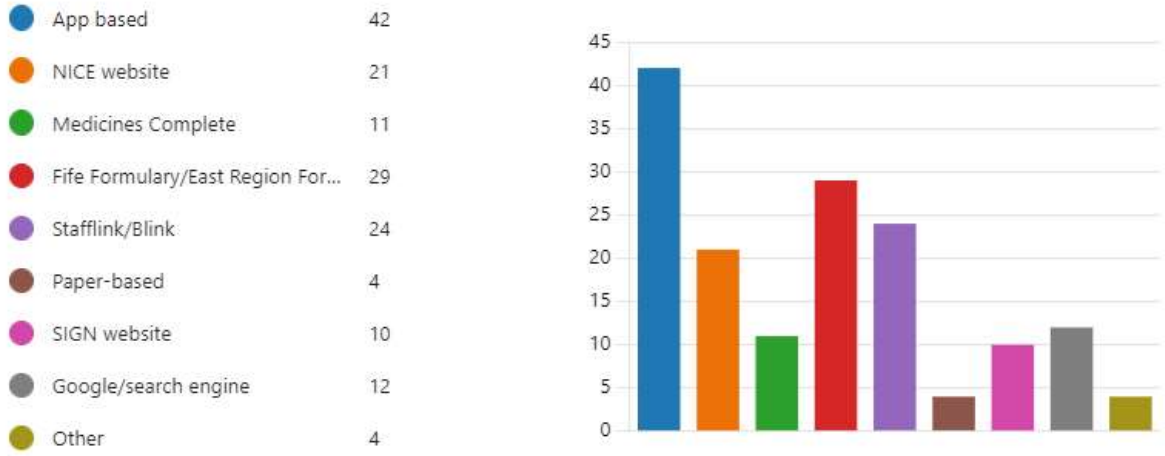
Overall, the diagram above suggests a very high level of confidence in the understanding of acute/chronic pain. There is also a very high level of confidence in the use of medicines in managing pain, discussing pain management issues, assessment of pain and the use of non-pharmacological/alternatives in supporting pain management.

In terms of accessing guidance, the following indicates how often this occurs across each component:



This shows a consistent pattern of mainly accessing guidance either “rarely” (less than once per month) or “never”.

When asked to indicate the preferred ways to access pain management guidance, the following were highlighted:



6.2.5 Secondary Care Staff Conclusions

As part of the end of year 1 programme phase and like the previous Primary Care staff section of this report, on the 17 April 2023 the key findings from all surveys were discussed as part of a dedicated workshop. This focused on agreeing our understandings from the staff perspective.

The main conclusions taken from the Secondary Care survey mirror that of the Primary Care staff. At the workshop there was a particularly noted consideration on the seemingly contrasting finding of a very strong confidence around all aspects of pain management. Yet at the same time guidance is being mainly “never” or “rarely” used. This infers a risk that pain management work is not aligned to the most up to date guidance. Section 4.2 of this report helps understand some of the reasoning behind this. Section 4.2 also identifies potential improvement areas for the existing guidance to focus on, to enable it to become more of a supporting tool. Like for Primary Care staff, from the staff perspective workshop it was agreed there is likely a training response needed to help raise awareness and embed desired ways of working.

7. What do our patient pathways tell us?

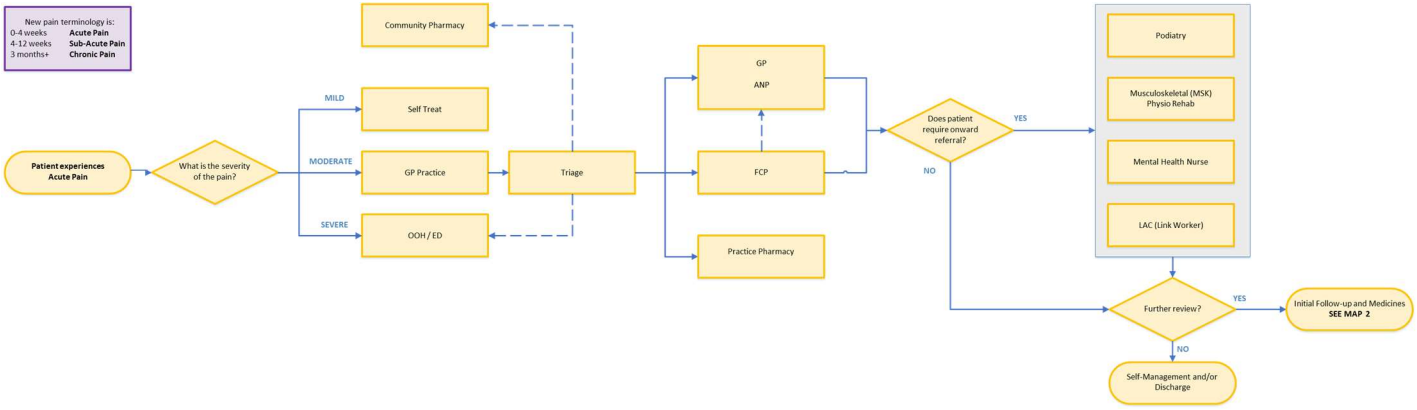
7.1 Primary Care Pathways

Over January/February 2023, 3 workshops were held to better understand our Primary Care Patient Pathways. The workshops firstly sought to identify the main activities that occur on the pathway and the sequence that these activities follow. The pathways have been looked at in 3 key time periods

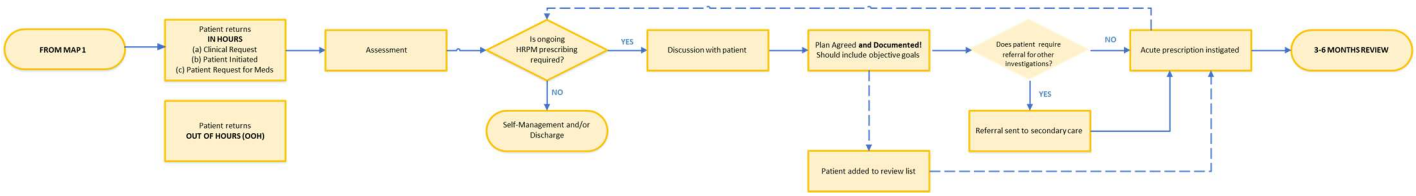
- Acute pain (duration less than 1 month)
- Subacute pain (duration of 1-3 months)
- Chronic pain (duration of more than 3 months)

This is illustrated in the below flow diagrams:

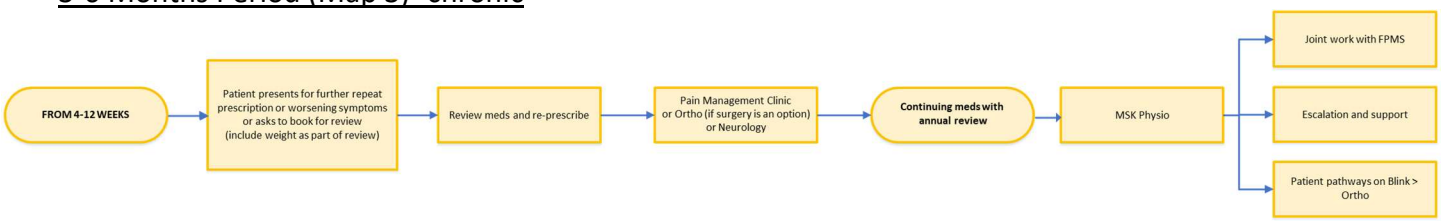
Initial Appointment (Map 1)- Acute pain



4-12 Week Period (Map 2)- Subacute pain



3-6 Months Period (Map 3)- chronic



The workshops then sought to identify areas of difficult and opportunity. This was taken into end of year 1 workshops with a wider set of stakeholders and discussed in April 2023, as part of refining the understanding of the problem.

These workshops sought to clarify and further develop the areas of opportunity to improve the existing pathways. The recurring themes of areas to focus improvement activity efforts on were:

- Improved communication especially at hand-off points in the system between Acute/Primary Care (one example being discharge letters covering intent/plan for the prescribing provided).

- At each patient contact point take the opportunity to educate/raise awareness of HRPM/pain management/alternatives e.g., the form this could take would vary based on the nature of appointments, but it could include full information leaflets/some discussion, to small reference cards linking to other resources.

- Better integrate the role of pharmacy in reviews (e.g., Medicines Management Support Workers may be able to support adding triggers for reviews from discharge letters).

- Have an acute limit on default tablet numbers for prescribers (not based on default pack sizes).

The above areas suggested, directly inform the programme candidate tests of change. It is also acknowledged that Secondary Care, and particularly out of hours may need to be explored further to ensure that tests of change initiated do cover the full system.

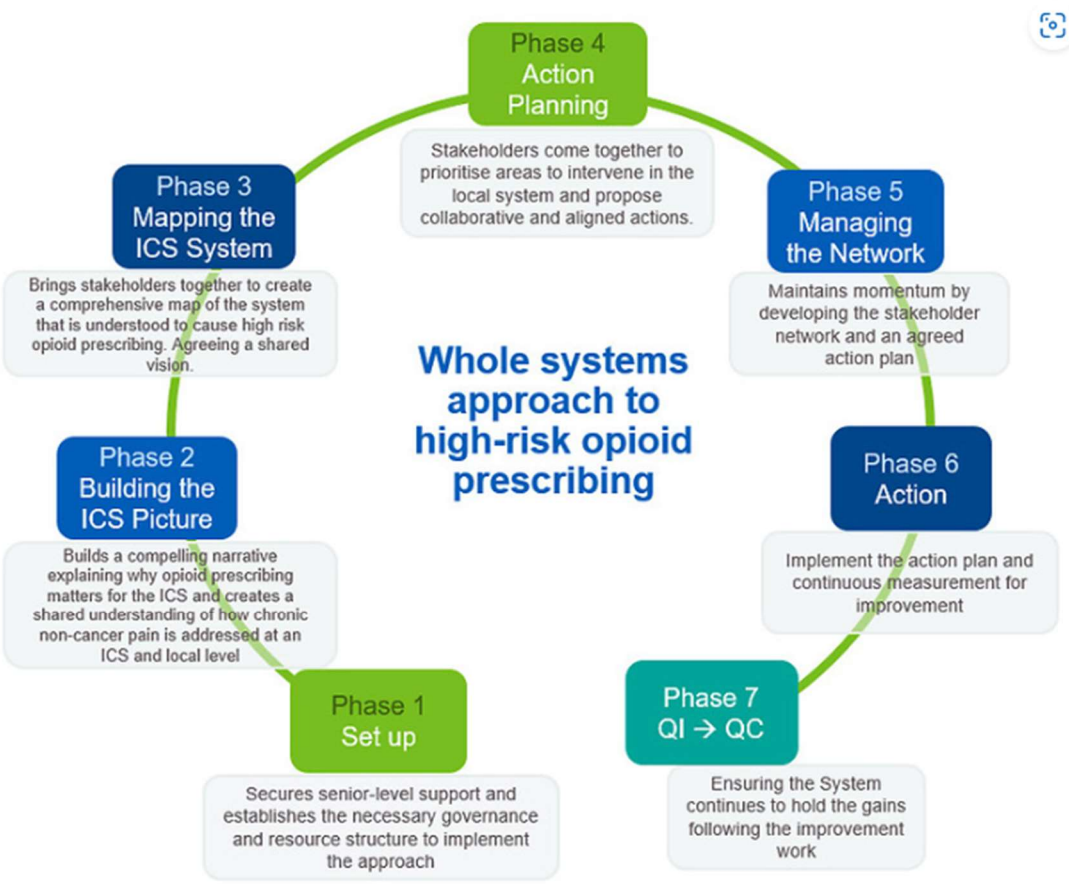
8. What Have We Learned from Elsewhere This Last Year?

8.1 Background

A substantial literature and desk-based search was undertaken with support from NHS Fife library services to identify key guidance and literature relating to analgesic stewardship. Many studies focussed on opioids alone, the challenges of system wide issues, lack of alternatives to prescribing.

The programme director linked with key stakeholders from a few organisations across the UK to understand how they were attempting to address this area, exploring what went well and what were the difficulties.

NHS England have taken a nationwide approach to addressing Opioid prescribing, developing a strand of their Medicines Safety Improvement Programme (MedSIP) to focus on Opioids. They designed an improvement programme intended to be delivered by Integrated Care Systems (ICS) which are like our health boards. It promotes a whole systems approach outline below:



The HRPM programme has followed a similar structure with Year 1 “Understanding the Problem” reflecting Phase 1-3 above. As we move into Year 2, we are considering phase 4-6 with Phase 7 in Year 3 and beyond.

Findings from other areas are noted over the tables below:

What	Focus/ What it is	How it was done or Recommendations	Possible/ Actual Benefits/ Risks

Painkillers Don’t Exist www.painkillersdontexist.com
 	
NE England
	Opioids & Public Health messaging	• Position Statement re high dose opioids
		• Public health campaign
		  • targeting long term or high dose
		  • Now focussing on 3-6 mths
		• Guidance pack to support structured medication review by GP & Practice Pharmacy team
		• Focus on patients wanting to reduce medicines
			4 years into programme:
			• 50% reduction strong opioid prescribing
			• 30% all opioid

Scottish Antimicrobial Prescribing Group (SAPG)- discussion with previous national lead pharmacist	Group developed to support the safe and effective use of antibiotics across hospital and community settings to tackle antimicrobial resistance	• National level with public health messaging • Multidisciplinary and multi sectorial • Developed clear and accessible guidance • Use of digital technology • Nominated leads at board level • Took time to take off and be recognised	• Joined up approach • “All in it together”
Campaign to Reduce Opioid Prescribing (CROP) Yorkshire and North East & Cumbria CROP NENC	Opioids (Yorkshire) Opioids & Gabapentinoids (NE & Cumbria)	• Practice data packs • Some targeted practice visits	• Yorkshire - Reduced opioid use • NENC – limited practice engagement and limited change

What	Focus/ What it is	How it was done or Recommendations	Possible/ Actual Benefits/ Risks
USA CDC Clinical Practice Guideline for prescribing opioids for pain 2016 implementation- Updated 2022	Guidance on Opioid Prescribing https://www.cdc.gov/opioids/healthcare-professionals/prescribing/guideline/at-a-glance.html	• National guidance • Revisited 2022 to highlight patient centred approach • "A clinical tool to improve communication between clinicians and patients and empower them to make informed, person-centred decisions related to pain care together"	• 2016 version poorly implemented in some areas with forced tapering or abrupt cessation of prescribing • "Prohibition" implementation led to other increased risk of harm including increased rates of opioid overdose, suicide, and mental health issues- MUST be patient centred
Local Medical Practice with positive NTI profile (Green in 7/8 indicators)	Practice Visit to discuss how practice treats HRPM	• HRPM on acute/ reduced quantity • Practice work as a team • Manage patient expectations of benefit • Nominated GP per Patient /Historically had pharmacist follow up	• Due to lack of patient public health messaging and understanding of chronic pain some negative patient feedback/ "Facebook flack" • Higher use of NSAIDs than Fife average bit may be appropriate if mitigating for risk as reflected in STU data
Ayrshire & Arran	Opioid Prescribing	• Analgesic subgroup of ADTC • Position statement & Medical Director wrote to outliers	• Reduction in prescribing
Swansea Bay Medicines Management team	Supporting analgesic stewardship	• Quick tips for stewardship strategies for GP practices • Community Pharmacy key messages & actions • Pharmacotherapy team targeted reviews	• Reduction in prescribing

What	Focus/ What it is	How it was done or Recommendations	Possible/ Actual Benefits/ Risks
Lanarkshire – Coatbridge Practice GP Veronica Rainey (Associate Medical Director)	Focus on Opioid prescribing	• Opioids on acute/ reduced quantity • Whole team involvement (incl admin) with Practice meetings & peer discussion • Patient Engagement • Focus on one drug group at a time e.g., co-codamol • Focus was not highest risk / most complex • Pharmacist & Technician follow up • Linked with Out of Hours to reduce what was issued there	• 70% reduction in opioid prescribing
Fife Pain Management Service	"Sore? Know More"- winter funding drop-in session pilot see	• Individualised patient education & signposting session based in leisure centres in Cowdenbeath & Levenmouth in Feb & Mar 22. • Patient booked for 20 min appointment with physio practitioner from FPMS and offered support re pain management and to access local services, two NHS rehabilitation support workers and a member of Fife Sports and leisure trusts were present and supported	• Patients felt informed, supported and more confident to use supported self-management resources • Risk- specialist resources required- can we make use of local area co-ordinators or lay people? • Opportunity to explore larger education session with follow up signposting?
OUCH Opioid Use Change Link to OUCH video	Educational video on opioid prescribing aimed at Secondary Care Clinicians	• Academic health services network Northeast & Cumbria funded project • Gliszczynski et al (2023) Online education for safer opioid prescribing in hospitals—lessons learnt from the Opioid Use Change (OUCh) project Post Graduate Medical Journal 1-5	• Educational opportunity to facilitate system wide responsibility for addressing opioid use

What	Focus/ What it is	How it was done or Recommendations	Possible/ Actual Benefits/ Risks

Centre for Sustainable Delivery- Modernising Patient Pain Pathways	Multiple pilots across Scotland- examples noted	• Calderside Lanarkshire- MDT Primary Care team (GP, AHP. Pharmacist, Link worker, 3rd sector)- created pain register reviewed patients.
		• Govanhill – Pharmacist led clinic linking with Advanced Practice Physiotherapist, Link Worker and Yoga Pain Specialist, and other members of the practice to deliver a more comprehensive pain service for patients encouraging and promoting self-management of pain as well as optimising pain medication, de prescribing and tackling addiction to prescription analgesics
		• Ayrshire- Pharmacist & nurse clinic-led to decreased GP appointments for pain conditions and improved patient reported outcome measures
			• Calderside
			  • 50% reduction in opioid and gabapentinoid prescribing
			  • Reduced GP consultation rate
			• Govanhill
			  • Reduction in opioids
			  • Reduced GP consultation rate
			• Ayrshire
			  • 49% reduction in Oral Morphine equivalence
			  • Improved patient confidence
			  • Reduced GP appointments

Right Decision Service- supported by Scottish Government	High Risk prescribing Decision support integrated with GP electronic health record systems – reflects STU indicators	• Piloted and now being rolled out in NHS Lothian & Tayside and being piloted in GGC • All participants wished to continue using platform after pilot • 88% planned to use it in long term conditions reviews, 82% in medicines reviews, 63% in routine consultations. • 88% confirmed that the system adds significant value over the inbuilt Vision and EMIS alerts.	• Improving patient safety and reducing avoidable emergency admissions • Available at no cost to the board • Supports beyond HRPM- needs advanced at board level

What	Focus/ What it is	How it was done or Recommendations	Possible/ Actual Benefits/ Risks

NHS England Framework March 2023
 	
Optimising personalised care for adults prescribed medicines associated with dependence or withdrawal symptoms: Framework for action for integrated care boards (ICBs) and primary care
	National framework to drive change for medicines associated with dependence which include opioids, gabapentinoids and benzodiazepines	• Action 1 – Personalised care and shared decision-making
		  • through dedicated clinics or using structured medication reviews (SMRs).
		  • openly discuss with the patient
		  • intended outcome from prescribing
		  • potential benefits, risk, and harm of the treatment
		  • decisions about whether to continue, stop or taper treatment.
		• Action 2 – Alternative interventions to medicines
		• Action 3 – Service specification and change management
		• Action 4 – Taking whole system approaches
		• Action 5 – Population health management
			• Promotes system wide approach

Scottish Government Pain management - service delivery framework 2022	National framework to reduce impact of chronic pain on quality of life and wellbeing	• Clear accessible information for patients • Patient & Carer engagement • Workforce development • Public health messaging planned	• In progress- public health messaging will not be early enough for programme but national supporting resources such as NHS inform update and ultimately TURAS staff development hub will support local work

What	Focus/ What it is	How it was done or Recommendations	Possible/ Actual Benefits/ Risks

NHS England Medicines Safety Improvement Programme (MedSIP) - to reduce harm from opioid medicines by reducing high dose prescribing (>120mg oral Morphine equivalent), for non-cancer pain by 50%, by March 2024	National programme taking whole system approach to Opioid prescribing- advises how to take local approach	• Framework and toolkit to support local integrated care systems (health boards) review causes of opioid prescribing and develop action plans
		• 5 targeted areas
		  • Prevent Initiation
		  • De-escalate doses early
		  • Find Chronic use
		  • Treat (Taper & Support)
		  • Sustain
		• Use of action learning sets
		• National dashboard supporting prescribing comparators
			• Outcomes ongoing- early analysis suggests saved 347 lives over last 2 years and 2,152 fewer cases of moderate harm
			• Helping 62 people to stop (or not start) opioids saves 1 life
			• Halve the risk of death by reducing from high dose to weak opioids

EMPOWER study- Professor Beth Darnall, University of Stanford	Ongoing research study (Effective Management of Pain and Opioid free ways to Enhance Relief)	• Focus on person and readiness to taper • Work with small decreases • Patient has ability to pause, stop or drop out of taper • Supported with education and access to supported self-management resources • Remember outliers- some WILL need prescription opioids with pain worsening on reduction- support use, review after fixed period and mitigate risk	• 50% reduction in opioid intake at 4 months and pain did not increase • 3 years later most continued decrease or stopped

9. What Does Good Look Like?

9.1 Programme Blueprint

The following section of this report attempts to outline what an improved system could look like by the end of year 3 of the programme. This is an aspirational direction that the projects of the programme should be providing outputs to help us move towards. It will often start vague but can be further refined and detailed as activity progresses and the impact of change work is evaluated.

Processes	**Organisation**
Seamless communication between services at pathway interface/hand-off points with clear plans related to prescribing intentions. Patients initiated on HRPM will have early review planned to assess efficacy and ongoing need. Patients continuing to need HRPM beyond 3 months will be identified to support transition to chronic pain management and role of supported self-management. Regular medication reviews (minimum annually) based on realistic medicine principles of shared decision making to inform any de-prescribing plan, ensuring this is comfortable, not daunting and patient feels supported. Medication reviews will be more proactively planned and highest risk groups targeted with a multidisciplinary approach maximising skills of non-medical prescribers (Community & Practice Pharmacy teams and Advanced Nurse Practitioners) Medication reviews follow a consistent framework and key criteria consultations should cover. Medication reviews will help set specific, measurable, aspirational but realistic objectives moving from focus on pain relief to function and quality of life (e.g., walk around the garden for 10 minutes 3 times a week). Patients will receive information regarding the impact of their medicines and the likely alternative options at key contact points. Post surgically patients will be weaned off opioids before discharge where possible Patients reporting clear benefits from HRPM use will be supported to continue appropriate use, mitigating for risk and with clear timelines for further review.	Wide organisational awareness of the differences between acute and chronic pain and the management strategies for both. Acceptance that pain management is everyone's problem and we all must influence the management of it where we have opportunity – there will be no new service that will do this for us. Fife Pain Management Service will support the most complex patients with most patients supported in the community. An established lived experience group and link with third sector organisations who can be approached for co-production and collaboration. We will have the workforce better trained around pain medicines and pain management and early identification of issues which will empower people to act on, or flag to, appropriate clinician to improve patient safety and experience We will have an Analgesic Stewardship group comprising key stakeholders across the organisation will monitor board prescribing, guidance, datix and impact and drive an ongoing communication strategy for HRPM Guidance will be regularly used to support prescribing to help ensure alignment to most current practice. We will have clear position statements on prescribing of HRPM to support clinician delivery Specialist pain service FPMS will have clear referral criteria and pathways, easily accessible to clinicians in all settings

Patients can self-refer or be referred by clinicians to community education sessions to support understanding of chronic pain and supported self-management	
Technology A new resource hub will make it easy for patients to access materials to understand their condition and to self-manage their pain condition. It will also provide a gateway to clinicians to access alternative services and support patient signposting and referrals. A new in-patient prescribing and administration solution will come to the organisation, which will support the information needs of the programme/wider system. A nationally supported electronic tool for GP prescribing systems will support clinicians identifying highest risk patients in real time to facilitate consultations and safety discussions. A MicroStrategy dashboard will support practice, cluster, and board level understanding of HRPM prescribing and can be used by practice teams to facilitate QI reflection. As part of public space refurbishment/face to face contact points with patients experiencing pain, our estate will consider distance to treatment rooms, the need for rest points etc.	**Information** Materials to support clinicians and patients understand conditions, guidance and supported self-management will be easily accessible through one central resource. Where HRPM are indicated, patients will be given information on benefits, risks and alternatives and clear plan for assessment of ongoing need before a shared decision to prescribe and will have the opportunity to further understanding or to ask questions in community pharmacy as part of supply route. Post-surgical patients discharged on opioids will be informed how to self-administer opioid medication safely, wean analgesics, how to dispose of unused analgesic medications safely and impact on driving. A leaflet will be provided to support the discussion. Discharge letters will contain a clear plan on why HRPM medicines were prescribed and the intent following discharge. Patient information on medicines and pain management will be accessible in digital and alternative formats. Patients transitioning from sub-acute (1-3 months) to chronic pain(>3months) will have information to support understanding of importance of non-pharmacological strategies and role of supported self-management Updates to guidance and safety messaging of HRPM will be actively disseminated through appropriate communication channels, targeting services and clinicians who regularly prescribe HRPM

9.2 What does a good patient journey look like?

HRPM initiated in community:
Acute (<1 month)

- Presentation at Community pharmacy
    - I explained what was wrong
    - The pharmacist asked some questions to clarify if it could be managed over the counter (OTC) or whether I needed to be seen by someone else
    - They checked my other medicines and conditions and then talked through the OTC medicine options with me and made a recommendation
    - I was given advice on what to take and when, they pointed outside effects to watch out for and flagged to me that these medicines are better for short term use only as there are risks with longer term use
    - They also gave me some useful tips on what I could do to help manage the pain just now using heat/cold, keeping the movement, when to rest and I was given a handy leaflet to back up the information they gave me
    - I was reassured that they advised me to contact the GP if things worsened and gave me a timescale to get back in touch if things weren't improving

- Presentation at GP practice
    - I explained what was wrong and the triage call identified whether I needed to be seen by GP or Advanced Physiotherapy Practitioner
    - I outlined the steps I'd taken on pharmacy advice so far and the clinician checked exactly how I had been taking my medicines
    - Pain assessed- physical and questions, was asked about
        - Pain what makes it worse/ better
        - Medicines benefits/ side effects
        - My sleep and mood
        - What I can do/ what my pain is stopping me doing
    - The clinician physically ruled out anything that required further investigation at this time
    - They discussed medicine options and we agreed for short term use of an opioid based medicine to compliment what I was taking, using on a when required basis.
    - It was highlighted how important it was for me to keep the joint active and I was shown how to do some gentle exercises, building up gradually to maintain strength whilst not overdoing it
    - Both the prescribing clinician and dispensing pharmacist repeated the short-term nature of use to avoid risk of dependency and checked I knew what side effects to expect, that it may make me drowsy and to avoid driving if impacted.
    - I was dispensed a small quantity of opioid, advised how to store it and to return any extra to the pharmacy if I no longer needed it.
    - I was advised to contact the GP surgery if things worsened or if I felt I needed further medicines
    - 2-3 weeks later I contacted the surgery, it was still troublesome but not any worse and I needed more medicines
    - I was booked for a call with the pharmacist who checked that things hadn't got any worse and asked about the benefit of the medicines I was taking. When I said I thought they were helping they also asked whether I had any side effects and

what else I was doing to help. They also checked if I was seeing the physiotherapist.
- I was issued with a further 2-3 weeks supply and asked to contact the GP surgery if things worsened or if I felt I needed further medicines

Sub-Acute (5-12 weeks)

- After the 3 weeks I requested more medicines and had a further conversation with the practice pharmacist- it was now approx. 7 weeks since the problem began
- The pharmacists again assessed the benefit of the medicines, checked for what they termed "red flag" symptoms and asked about my activity and what I was struggling with, what made my pain better/ worse. They said they didn't need to refer me to the GP or physio at that point. I got some good tips about when to take my medicines and some self-management ideas.
- I was issued with 1 months' worth of medicines and was advised to make a review appointment with the GP before they ran out if things were not improving, or earlier if there was a worsening of symptoms

Chronic Pain (>3months)

- **3-month review by GP**
  - My pain was re-assessed- physical and questions similarly to my first assessment
  - The benefit of my medicines was reviewed
  - I explained I was becoming less physically active, not able to do as much. I'd stopped my football and because of that was not seeing my friends as regularly. It was making my work harder and it was frustrating me. I was also worried that something was wrong and with being off work it was beginning to impact me financially.
  - The GP
    - Reassured me that there was nothing of concern at this time but that they recognised the impact it was having on me, and we needed to think slightly differently as surgery or medicines were not going to fix it at this time.
    - They explained medicines aren't always as effective in long term pain- they won't take it away completely and we needed to focus on non-medicine strategies too
    - They used the term supported self- management and we agreed a plan that would focus on keeping me doing the things I wanted to do and keep me active
    - We agreed some goals for me to aim for, like gradually building up to walking to shops or walking dog or doing some of my hobbies.
    - They showed me an online resource which would help my understanding and told me about a local education session and Pain Association Scotland groups
    - We agreed a medication plan and I was advised what do during a flare-up and how to reduce the medicines safely if things were improving
    - They said they would authorise my medicine to be repeated for the next 3-6 months and then I would be re-assessed to see if anything worsened, and I needed referral to orthopaedics
  - I could see on my prescription and medicine label when my next review was due but was able to order my medicine up to then

- **6-9 months of pain- review by GP or Other professional at the practice**
  - My pain was re-assessed- physical and questions similarly to my first couple of assessments but I was asked how I was pacing my activity and how I was getting on with my goals and how I was maintaining social contact.

- We made some adjustments to my medication after discussing options- I felt I had been able to contribute to the decision-making process and I know what to do during flare-up.
- My condition had deteriorated further, and the GP referred me to Orthopaedics for assessment. They explained it may be a wait before I was seen and that it was just as important to maintain my pain management strategies in the meantime.
- The GP was also realistic and highlighted that I may not be suitable for surgery, or it might not be indicated, re-enforcing the need for thinking to the future and maximising my ability to use alternatives to prescribing.
- I think this helped me understand that surgery and medicines might not be the answer but if it did progress to surgery I needed to be as fit as possible before hand- the GP called it "pre-hab".
- The GP checked whether I had accessed the resource hub or attended the local community education session- I hadn't yet but I resolved to book on.
- I was also referred to a local exercise class with Fife Sports and leisure trust- designed for those managing a long-term pain condition to help keep us active.
- I was referred for an x-ray of my joint
- My medication was then authorised for 12 months, but I knew I could contact the Practice Pharmacy team or the Community Pharmacist with any queries
- The community pharmacy team checked in with me now and again too to see if I was experiencing any side effects and how best to take my medicines

- **Prior to orthopaedics appointment**
  - I attended the community education session- it really resonated with me. They seemed to understand the impact it was having on me, my social and work life and even my finances. I was given lots of good advice on local resources that might help and put in contact with the local area co-ordinator and the Wells.
  - I had a follow up with the local area co-ordinator and found out how to access financial and occupational health advice- this was a weight lifted off my mind.
  - Everyone involved in my care seemed focussed on what mattered to me, and I felt supported and informed.

- **Orthopaedics and Peri-operatively**
  - I received a letter to let me know my referral had been accepted and I was on a waiting list
  - I was seen by the consultant within 12 weeks, and they discussed my x-ray, the impact of the pain on my life and what it stopped me doing
  - I was scheduled for an operation and given advice to manage pain and remain active in advance of the operation.
  - I had a pre-assessment appointment with a clinician in the 4 weeks before the operation. They reviewed what my current analgesic use was, discussed a plan for post operatively and checked to see I didn't need referred to the inpatient pain team as a high-risk candidate.
  - It was explained what would happen on the day and that I could expect some pain immediately afterwards, but it should be manageable, and they would work with me to get me as up and active as quick as possible
  - After the operation I was given some strong pain medicine to help for the first few days. I was given a plan how to gradually stop it which also included advice on how to reduce the pain medicines I was on prior to the operation if things kept improving. It was talked through with me, but it was also written down in a leaflet I was given

which explained how to store my medicines, what side effects to expect and how to manage and what to do with any extra I had left if I no longer needed them.

- I was given a clear exercise plan to build up my activity.
- An electronic letter outlining the plan was sent to my doctor and I was given a copy of the discharge letter too.
- I had a phonecall from the pharmacy team at the GP practice 2-3 days after my op to see how things were and to check I understood the plan for the medicines. They also checked to see if I needed any more or if I was managing how I could continue to reduce, including a plan for the pain medicines I was using pre-operatively. They said it was normal to be a bit sore after the operation and they would check in again in a fortnight but to get in touch if things were worsening
- I had a follow up call from the pharmacy team 2-3 weeks after the operation and they checked how I was getting on with the plan to gradually taper the medicine I was on before the operation- they discussed how I could use my medicine short term for a flare up if needed.
- As everything was going well and I had been able to reduce quite well they said they would put me on a 6-month pain medicine review but to get in touch if needed.
- They reminded me about local resources that would help and referred me to the local pain association Scotland Group

10. Exclusions/limitations

1. Although the surveys conducted have a high rate of return, these can only remain indicative. The findings reported here reflect the responses that were provided to the surveys and might not reflect the views of other Patients/Care/Primary and Secondary Care staff.
2. Audits were not undertaken in all key areas due to resource capacity so can only remain indicative of current practice in a particular prescribing setting. Some of the audits were undertaken in an Orthopaedics environment where there is slightly higher adherence to the recommendations from the Surgery and Opioids guidance.

Appendix 1: Supporting Documents

Below is a list of supporting documents that provide further detail/information on specific pieces of work that helped contribute to the overall findings detailed in this report.

Please contact fife.hrpm@nhs.scot for copies of any of these should you like to view any additional material.

- 1 Summary Service Descriptors
- 2 Geographic Mapping
- 3 HRPM SSMS Resource Mapping
- 4 Detailed Patient & Carer Stories
- 5 HRPM Carer Survey Evaluation
- 6 HRPM Patient Survey Evaluation
- 7 Staff Awareness Combined Summary
- 8 SMSS Combined Summary
- 9 Primary Care Knowledge Skills and Attitudes
- 10 Combined P&G Summary
- 11 Secondary Care Clinical Staff Summary

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.

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.EqualityandHumanRights@nhs.scot or phone 01592 729130

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Occupational Health and Wellbeing Service

Annual Report

2022 / 2023

Edition 01: 31 August 2023

Table of Contents

Introduction

The report describes the comprehensive Occupational Health and Wellbeing (OH) Service provided to NHS Fife and its employees.

Post Covid-19 pandemic, our Occupational Health Services have now reset to meet the demands and requirements of NHS Fife to provide robust mechanisms to support staff and organisational resilience as outlined in the Workforce Plan 2022-2025, Staff Health and Wellbeing Framework 2022-2025 and the Population Health and Wellbeing Strategy 2023-2028.

The Occupational Health and Wellbeing Service also delivers a range of services under Service Level or 'Consortium' Agreements, to employees in Fife General Practice (GPOH Service); Dental Practices; Fife based Independent Pharmacies; Scottish Ambulance Service employees, as well as external contractual agreements with St Andrews University and Fife College for medical and health care students.

Covid-19 activity continues; however this has reduced and is now incorporated into core Occupational Health functions. The service continues to provide advice and support to meet the needs and demands of the Board, focussing on quality of core services and service improvement.

This has been particularly key in the current circumstances of supporting the organisation through extreme staffing pressures. The service continues to develop integration of services with the organisation through attendance at key senior operational and strategic meetings, participating in mass nurse recruitment activities and exploring all options for staff returning to work at the earliest opportunity or being supported to remain at work.

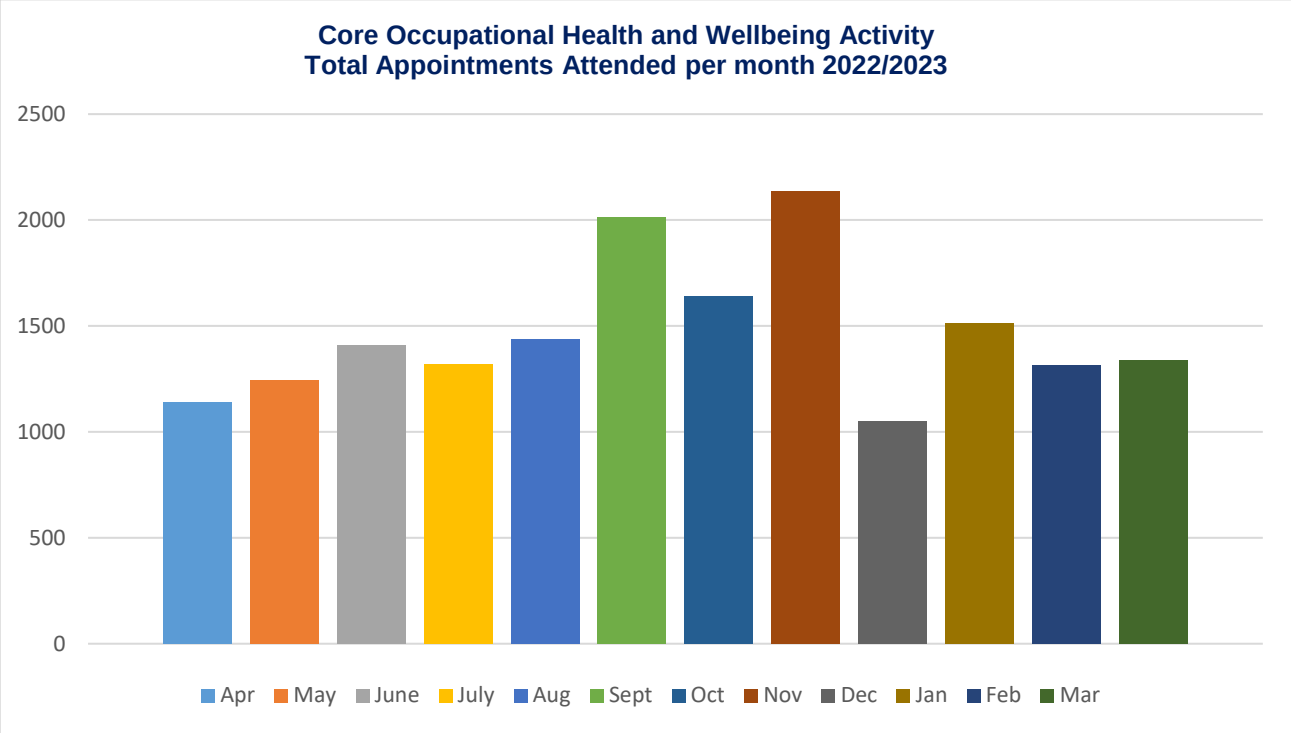
Appendix 1 provides further details of the full range of Services provided by the OH Service. The data presented within **Appendices 2 and 3** relate only to the Service delivered to NHS Fife employees, excluding the work / activity undertaken for the other organisations outlined above.

Appendix 4 details the activity data of all other organisations the Service delivers OH support to under agreed external contractual arrangements.

Occupational Health and Wellbeing Activity

The Service offers an average of 1,462 appointments per month with Management Referral, Pre-Placement and Communicable Disease Screening featuring as the main core activities. The levels of appointment attended activity for 2022/2023 has increased from that of the previous year (8,474 compared to 7,266 in 2021/2022, as detailed in Appendix 1) demonstrating an increase of 17% in overall activity with some monthly fluctuations, as detailed in the Graph 1 below:

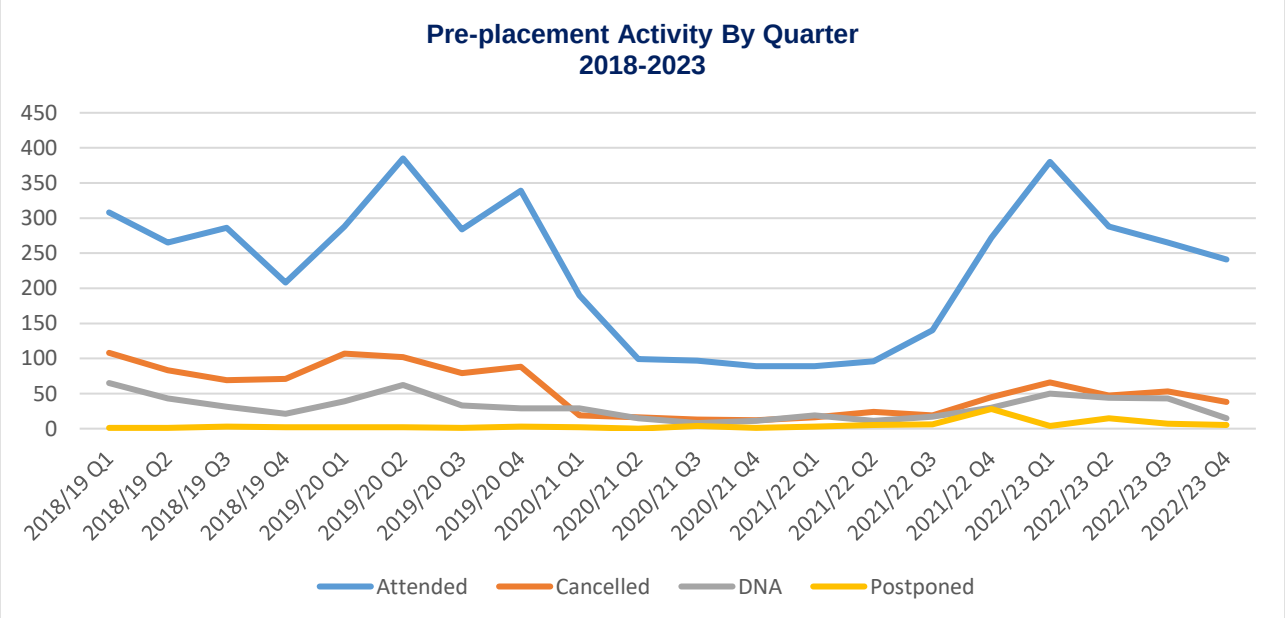
Graph 1: Core Occupational Health & Wellbeing Activity



Pre-placement Activity

The data highlights a spike in activity at the start of the pandemic which then plateaued during 2020/2021. However, this has risen sharply in Quarter 1 2022/2023 and is potentially a reflection on the organisational drive for recruitment. The volume of appointments attended during 2022/2023 via face to face, near me and telephone consultations has risen significantly by 97% (1,174 compared to 597 in 2021/2022) as detailed in Graph 2 below:

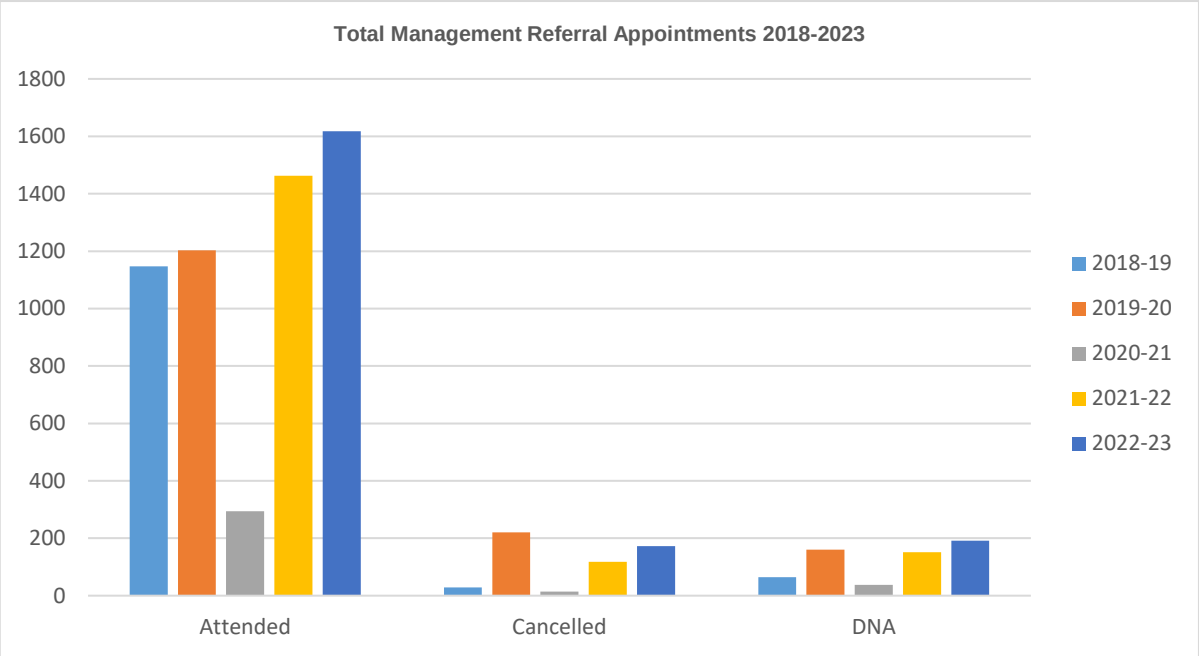
Graph 2: Pre-placement Activity 2018-2023 by Quarter



Management Referral / Staff Support

Management referral activity accounts for 15% of Occupational Health & Wellbeing activity. Referrals by month with annual year on year comparison shows that since last year there has been a 14% increase in management referrals with an overall 60% rise when compared to pre-pandemic figures in 2018-2019, which is perhaps reflective of the increased demands on the OH Service and increasing complexity of cases, as detailed within Graph 3 below:

Graph 3: Total Management Referral Appointments 2018-2023



Top Reasons for Referral

NHS Fife absence data highlights that long-term absence due to mental ill health accounted for 817 absence episodes (from a total of 1,603 absence episodes during 2022/2023) and combined reasons of musculoskeletal (MSK) complaints accounted for 493 absence episodes of long-term absence (from a total of 1,495 absence episodes). Analysis of management referrals for occupational health for the same period shows that 48% of management referrals are for mental ill-health and 28% are for MSK complaints.

It should be noted that mental health reasons have been combined to include mental psychosis, neurosis and dependency and musculoskeletal reasons to include back, neck, lower limb and upper limb complaints.

The anticipated demand for mental health supports post pandemic continues and the team has identified referral cases as more complex, requiring increased multidisciplinary approaches, utilising the skills and expertise of nursing, medical and allied health professionals to fully support staff and optimise outcomes. The demand for external independent counselling has exceeded capacity and is being addressed through expansion of the pool of available independent counsellors to increase availability.

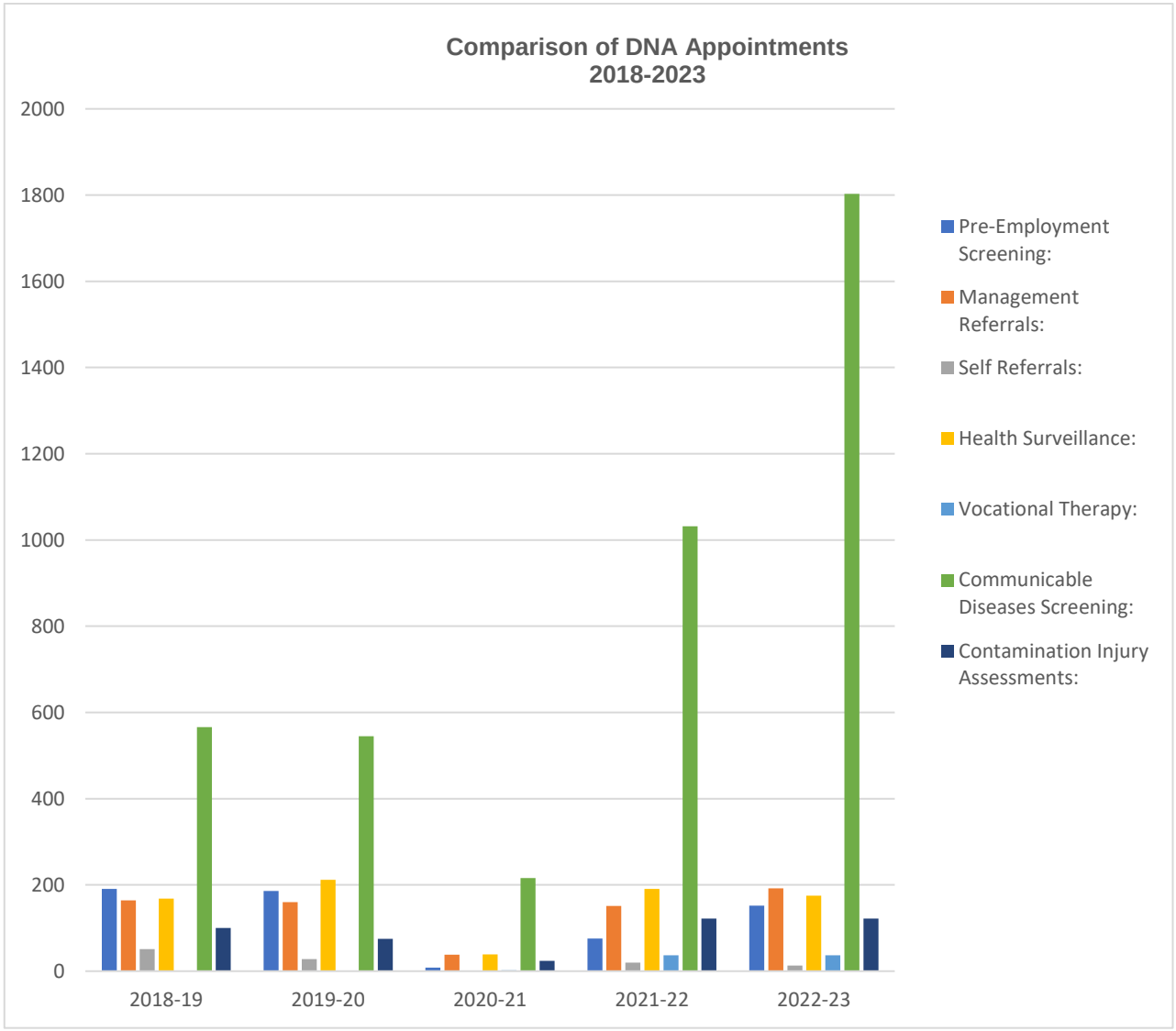
Cancellations / Did Not Attend (DNAs)

The year has been challenging with a significant rise in 'Did Not Attend' (DNAs) appointments compared to previous years. On analysis of total appointments attended by appointment type, management referral, vocational rehabilitation and pre-placement screening remain the best attended, with greater than 74% attendance.

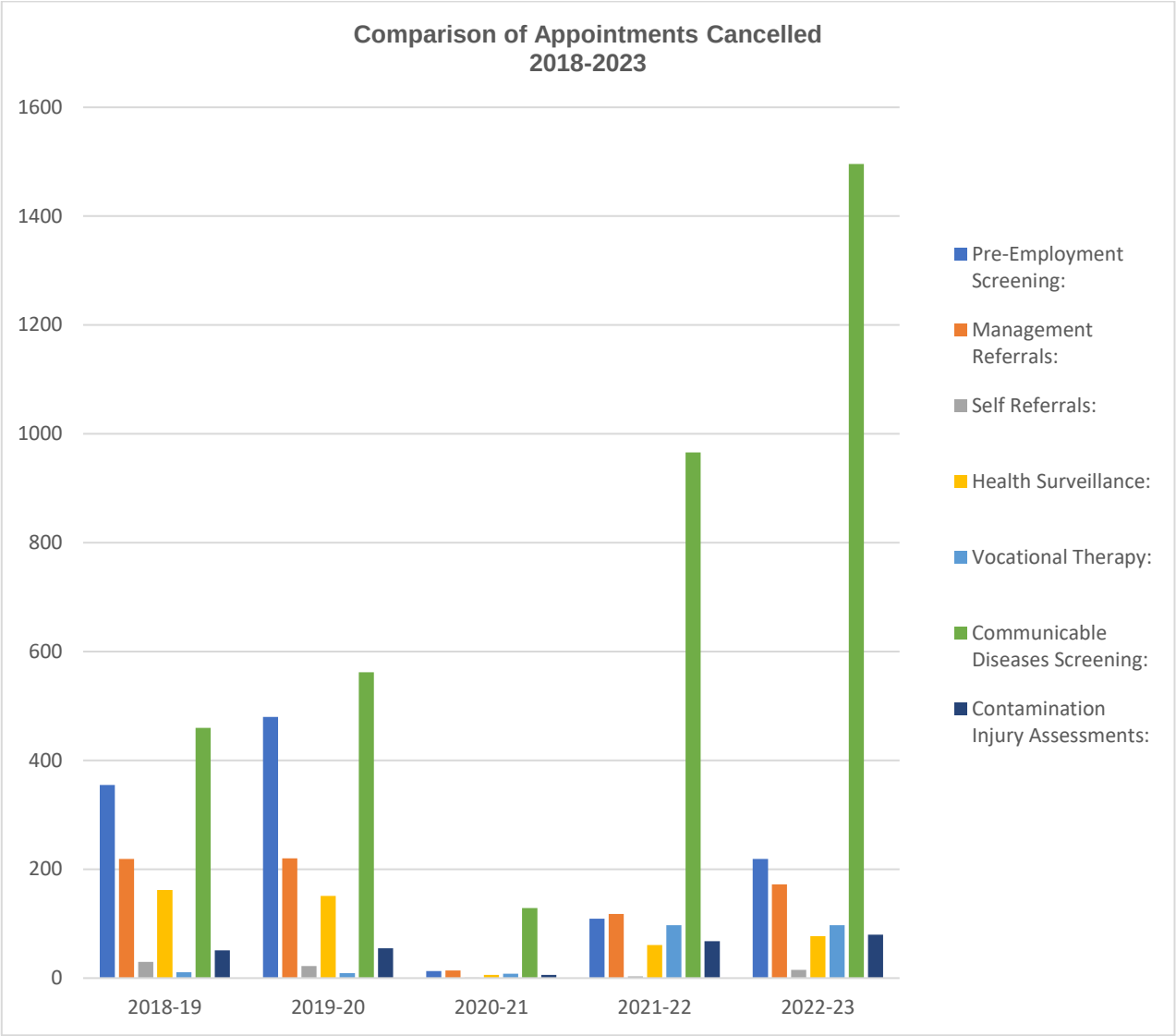
In comparison, Communicable Disease screening remains the highest appointment reason for DNA and cancellation rates; a trend that has remained consistent over the previous 5 years. However, during 2022/2023, there has been a 75% increase in DNA rates since last year and 220% since pre-pandemic, as detailed in Graph 4: Comparison of DNA Appointments 2018-2023 and Graph 5: Comparison of Cancelled Appointments 2018-2023 below.

The full reasons for this significant rise are not fully transparent and work is on-going to understand the root cause. Potential contributing factors are thought to be associated with staff pressures and difficulties in staff being released to attend appointments, increase in recall activity and accuracy of staff status as well as a change to communication of appointment via text messaging.

Graph 4: Comparison of DNA Appointments 2018-2023



Graph 5: Comparison of Appointments Cancelled 2018-2023



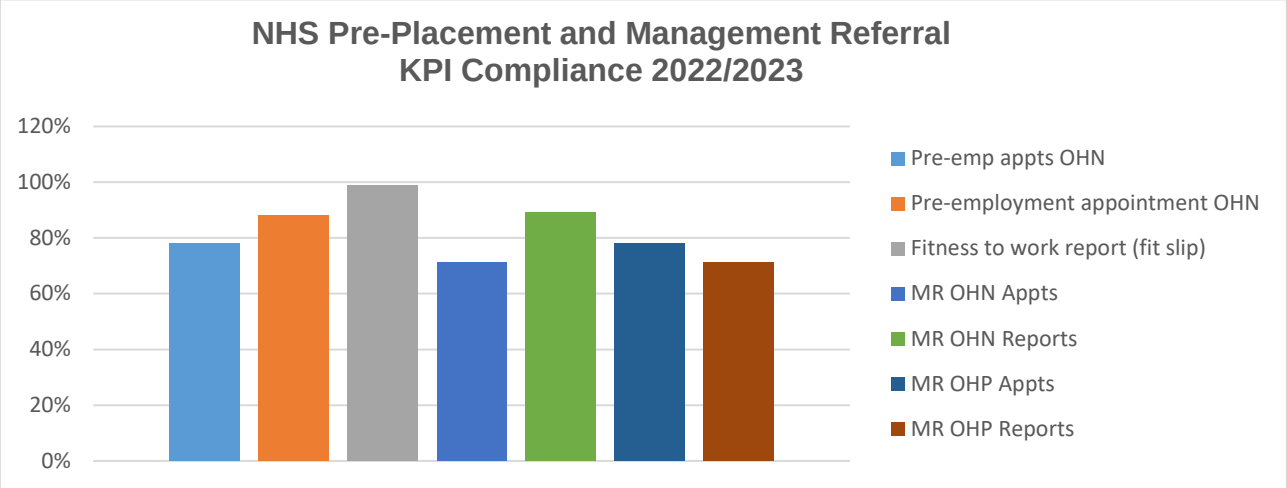
This is particularly significant in terms of lost clinic / clinician time of approximately 35 hours per week, as well as the additional administration resource required for rework. In financial terms, this equates to a loss of a Band 5 member of staff.

To address this, there has been a review of internal processes with the introduction of a new mode of SMS text service to allow reminders to be sent 24 to 48 hours in advance of appointments and the team continue to offer flexibility of times and locations of clinics, as well as increasing communications of the importance of vaccination as a tool against communicable disease, offering protection to the individual and importantly patients.

Performance Monitoring

The Service's performance against Key Performance Indicators (KPIs) is measured on a rolling quarterly basis and the current agreed historical KPI compliance rate is 95%. Performance is measured in terms of compliance with achieving 95% of management referral appointments offered within the agreed timeframes (10 days) and 95% of reports dispatched following appointments (within 5 days). Annual compliance is detailed within Graph 6 below and comparative data with previous year's activity has been included within the Appendix 2, for ease of reference.

Graph 6: NHS Pre-Placement and Management Referral KPI Compliance 2022/2023



KPI compliance has been affected during 2022/2023 by recruitment challenges, staff absence and resourcing issues, as well as the significant impact of increased cancellations and DNAs resulting in rescheduling and increased administration tasks.

The average total KPI for Management Referrals (referrals appointed within 10 days of receipt) has increased this year to 71% (from 57% in 2021/2022). Staff shortages and increased DNA rates have impacted on this area of activity with 'appointment within 3 days' most affected. Despite this, an average waiting time of 7 days has been maintained. Further details of the 2022/2023 KPI and activity information is attached at **Appendix 2**.

Service Developments / Innovation

Digital / Technological Improvements

Occupational Health and Wellbeing currently utilise an Occupational Health software database system, COHORT for all its functions and as the drive for increased recruitment continues across the service, OH have sought to make improvements for customers and service users involved in the pre-placement screening process via a new on-line employment module. This has now been successfully implemented and adopted by Recruitment Teams within the Board and facilitates greater transparency and streamlining of the process with a 'real-time' view of a candidate's progress. The Recruitment Teams can visually track progress, from issuing the pre-placement health questionnaire through to completion where opinion on fitness for role and any recommendations can be clearly seen. Full evaluation of this is yet to be undertaken, but to date is demonstrating positive benefits and a reduction in waiting times.

Mental Health Support to Staff Service

The Mental Health Support to Staff Service (MHSS) is now well established. Although the Mental Health Nurse has limited capacity, this service adds additional dimensions to offer mental health supports and complements other wellbeing and organisational development strategies offered across the organisation. As well as offering light touch goal setting sessions, there is increased partnership working with other key stakeholders to advise and develop tools to assist managers and individuals, i.e. Neurodiversity ability passport. However, a risk remans that service delivery is from a single mental health professional and resilience is needed to ensure delivery of service continuity.

Occupational Therapy Fatigue Management Service

Our Occupational Therapy Fatigue Management Service (OTFM) completes the complement of resource for the Vocational Rehabilitation Team within Occupational Health. This service was introduced mid Covid-19 pandemic to support staff experiencing Covid-19 related fatigue and has added tremendous value to individuals and the organisation by helping in the management of fatigue and associated mental ill health by advising on action wellness plans through to supportive return to work plans.

As numbers of Covid-19 related fatigue cases diminish, the team continue to seek new ways to utilise their skills and expertise to assist individuals and managers across the business, recognising that mental ill health (with associated fatigue) continues to be the highest reason for absences within NHS Fife.

There is a well-established process for referral to our Specialist Occupational Therapist, which currently focusses on musculoskeletal factors impacting on the individuals function at work. These evaluations are designed to:

- assess the individual's ability to perform a specific job;
- identify any workplace modifications to safely allow the individual to perform job role without aggravation of their condition; and
- establish skills for alternative work.

Work is in progress to follow the same model and adapt the framework to give advice, support and fitness opinions in relation to psychological health as well as physical health, further targeting support to individuals and managers where needed.

Clinical Governance Activity

Occupational Health Clinical Governance activities have been slow to be re-established, however, securing support for the Clinical Governance team via an additional 0.4 WTE non clinical resource has assisted with the progression of setting up a more robust Clinical Governance framework aligned to the Faculty of Occupational Medicine's quality standards: Safe and Effective, Quality Occupational Health Services (SEQOHS) Standards (2015). As noted in previous reports, the Occupational Health & Wellbeing Service is seeking to align all its work with these standards in preparation for future accreditation.

Occupational Health Workforce – Resourcing, Planning and Development

It is recognised that there have been national and local challenges to recruit to specialist roles in Occupational Health. Locally to the roles of Occupational Health Physician, Head of Occupational Health Service and Occupational Health Nurse (trained specialist nurse) have been difficult during 2022/2023. It has been necessary to utilise interim, locum and agency cover during 2022/2023. In January 2023, we successfully recruited to the Occupational Health Physician (Speciality Doctor) post, adding to the staffing complement. The orientation and induction period has impacted on skill mix and service delivery. The Head of Service role has now been filled, however, there remains a vacancy and succession planning gap in senior roles and within administrative posts, as well as challenges with the single point of service delivery for the Mental Health Nurse role.

Appendix 1: Occupational Health and Wellbeing Service Functions

The functions provided by Occupational Health and Wellbeing Service include a comprehensive service for all NHS Fife employees. The OH team also delivers the same comprehensive Service to Fife General Practitioners and their staff, General Dental Practitioners and their staff, and local Fife-based independent Pharmacies under other contractual agreements.

A defined Service is provided to Scottish Ambulance Service employees referred under an NHS Scotland Procurement 'Consortium' agreement and under agreed external contractual agreements with St Andrews University for their medical students and with Fife College for their nursing students.

The activities covered are:

- Health Surveillance and Health Assessments complying with Control of Substances Hazardous to Health Regulations 2002 (COSHH) and 'fitness to work' (such as for occupational drivers, Exposure Prone Procedure Workers (EPP) and those entering confined spaces).

- Pre-placement screening to national standards and complying with Equality Act 2010 and Health and Safety at Work etc. Act 1974.

- Communicable diseases screening complying with the 'Green Book', and HPS guidance.

- Contamination incident risk assessment and follow up complying with national guidance.

- Management referral appointments complying with GMC recommendations on transparency, confidentiality and consent, Faculty of Occupational Medicine 'Good Occupational Medicine Practice' and Ethics guidance.

- Expert OH Occupational Therapy assessments to support an employee in performing their work duties with a reduced risk for aggravating their existing medical condition. i.e., DSE; Workability or Job Evaluation assessments.

- Workplace based assessments / visits.

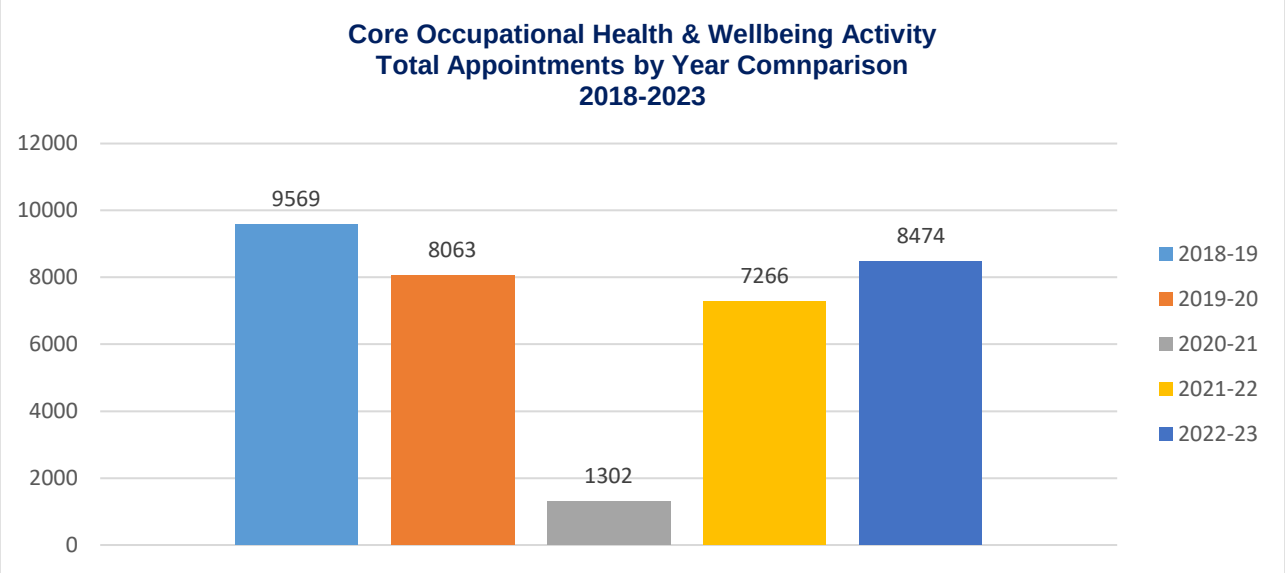
- Support from Mental Health practitioner to support employees in managing their mental health.

- Problem Assessment Groups and Incident Management Teams for infectious diseases outbreak scenario. Risk assessment of staff and related follow up.

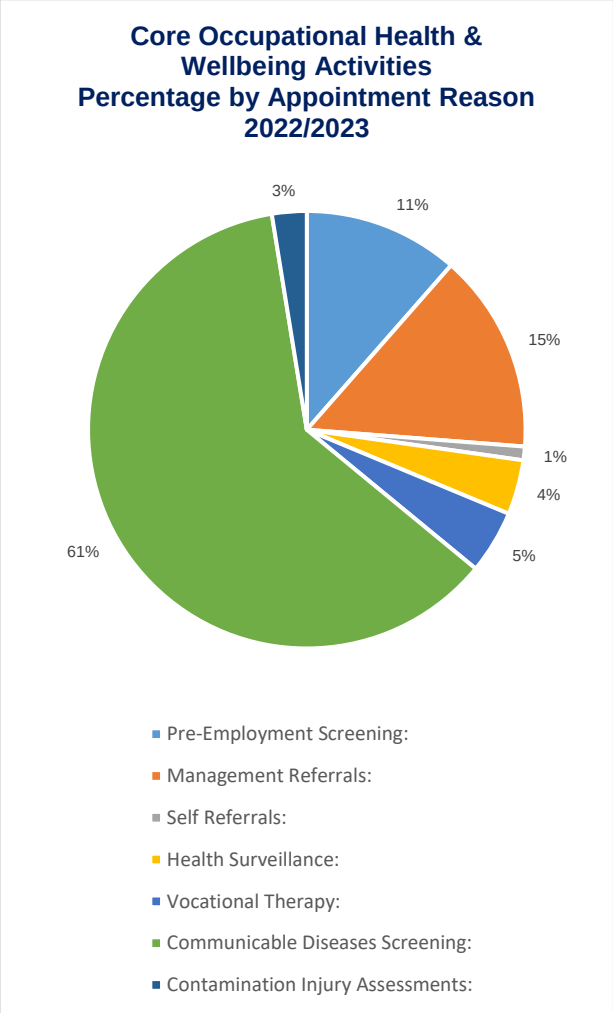
- Occupational Physiotherapy assessment and treatment.

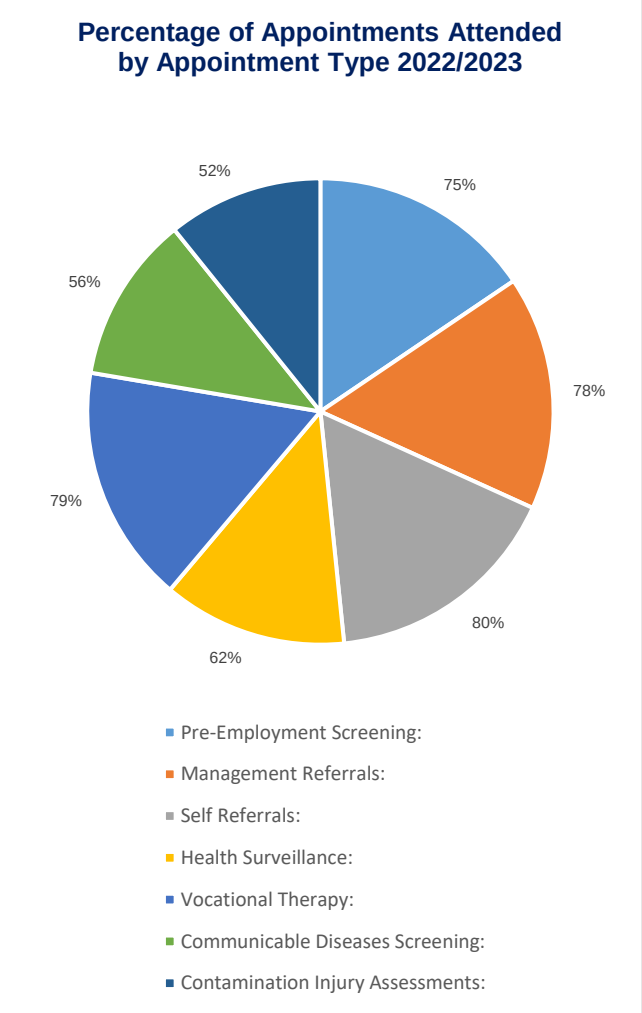
- Staff Counselling Service provided by BACP accredited counsellors.

Graph 7: Core Occupational Health & Wellbeing Activity –Total Appointments by Year Comparison 2018-2023



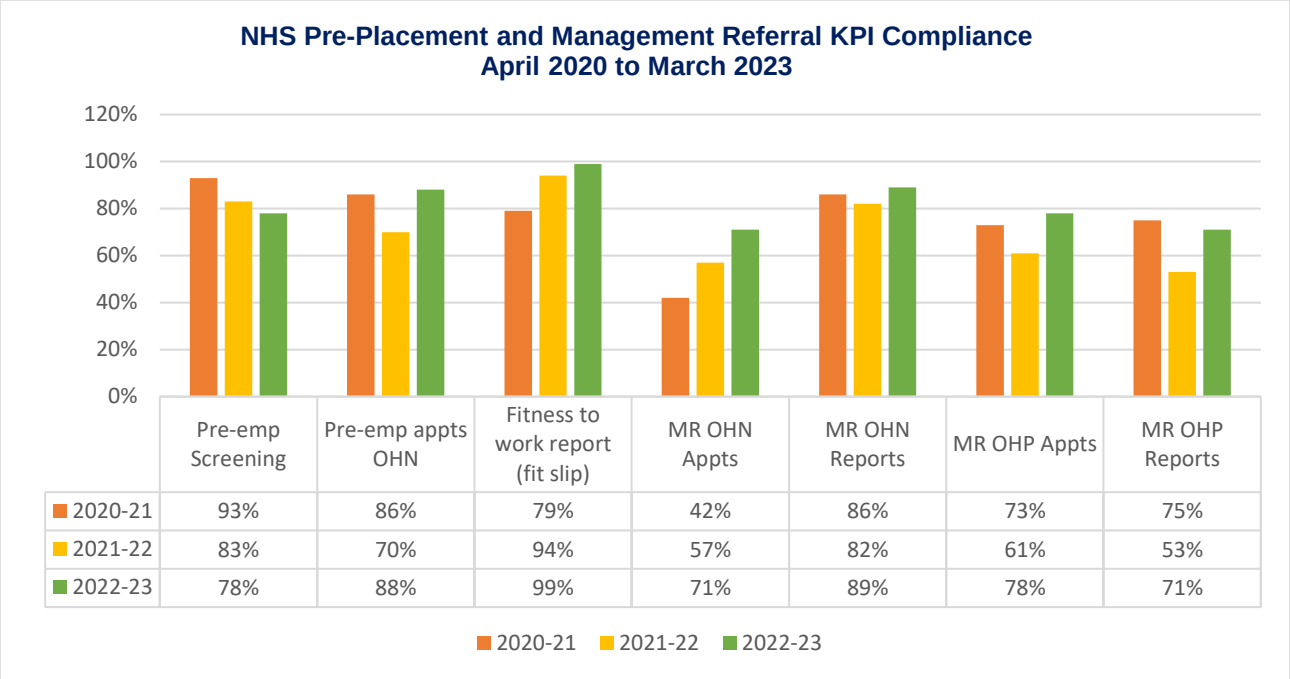
Graphs 8 and 9: Core Occupational Health & Wellbeing Activity – Percentage by Appointment Reason and Appointments Attended by Appointment Type 2022/2023





Appendix 2: Occupational Health and Wellbeing Service Pre-Employment and Management Referral KPI Compliance 2022/2023

Graph 10: Pre-Employment and Management Referral KPI Compliance



NHS Pre-Placement and Management Referral KPI Compliance 2022/2023

Pre-Placement Health Assessment Key Performance Indicators have been established, with the initial response required within 3 working days and issue of appointment within 10 working days following completion of the 3 day initial paper screening. For Exposure Prone Procedures (EPP), this is increased to 21 working days from appointment to report to include allowances for any indeterminate results which require analysis by the reference lab.

First appointments for management referrals with OH clinicians are scheduled for 10 working days and reports on fitness for work and management referrals are issued within 5 working days.

Table 1: NHS Pre-Placement and Management Referral KPI Compliance 2022/2023

Description	KPI Target (within working days)	Average Days	Processed/ Attended	Nos. within KPI	KPI Compliance
Pre-Employments					
Pre-employment screening OHN	3	3	1,429	1,114	78%
Pre-employment appointment OHN	13	8	1,533	1,348	88%
Fitness to work report (fit slip)	21	4	1,132	1,120	99%
Management Referrals					
MR OHN Appointments	10	7	846	602	71%
MR OHN Reports	5	3	935	832	89%
MR OHP Appointments	10	7	536	419	78%
MR OHP Reports	5	6	391	278	71%

Combined Doctor / Nurse Management Referrals					
OH Nurse & Dr Appointments	10	7	1,382	1,021	74%
OH Nurse & Dr Reports	5	4	1,326	1,110	84%

Table 2: Occupational Health and Wellbeing NHS Fife Activity Report 2022/2023

Appointment Reason	Attended	Cancelled	DNA	Postponed by OH	TOTAL
Pre-Employment Screening:	1,164	219	152	21	1,556
Management Referrals:	1,618	172	192	86	2,068
Self Referrals:	119	15	13	2	149
Health Surveillance:	525	77	175	27	853
Vocational Therapy:	558	97	37	10	702
Communicable Diseases Screening:	4,226	1,496	1,803	65	7,590
Contamination Injury Assessments:	222	80	122	4	428
Total	**8,432**	**2,156**	**2,494**	**225**	**13,307**

Table 3: Physio / Counselling Self Referral

Appointment Reason	Attended	
Physio Referral Sessions Via Discharge	892	Including DNA/ cancelled
Caps Referral Sessions Via Discharge	821	Including DNA/ cancelled

Table 4: Occupational Health Therapist Self Referral

	Referred	Jobsite Evaluations	Computer Workstation Assessments	Work Ability Evaluations	Career Search Evaluations	Cancelled Appointments
OH Occupational Therapist	176	47	100	24	5	30

Table 5: Occupational Therapy Fatigue Management Service

	Referred	Discharged	In Progress
OT Fatigue Management	58	63	18

Occupational Health and Wellbeing Core Activities Comparison 2018-2023

Table 6: Appointments Attended

Appointment Reason	2018-2019	2019-2020	2020-2021	2021-2022	2022-2023
Pre-Employment Screening:	1,109	1,507	97	596	1,164
Management Referrals:	1,147	1,203	294	1,463	1,619
Self Referrals:	504	502	44	131	119
Health Surveillance:	419	551	227	585	566
Vocational Therapy	102	110	54	558	558
Communicable Diseases Screening:	6,044	3,996	538	3,748	4,226
Contamination Injury Assessments:	244	194	48	185	222
Total	**9,569**	**8,063**	**1,302**	**7,266**	**8,474**

Table 7: Appointments Cancelled

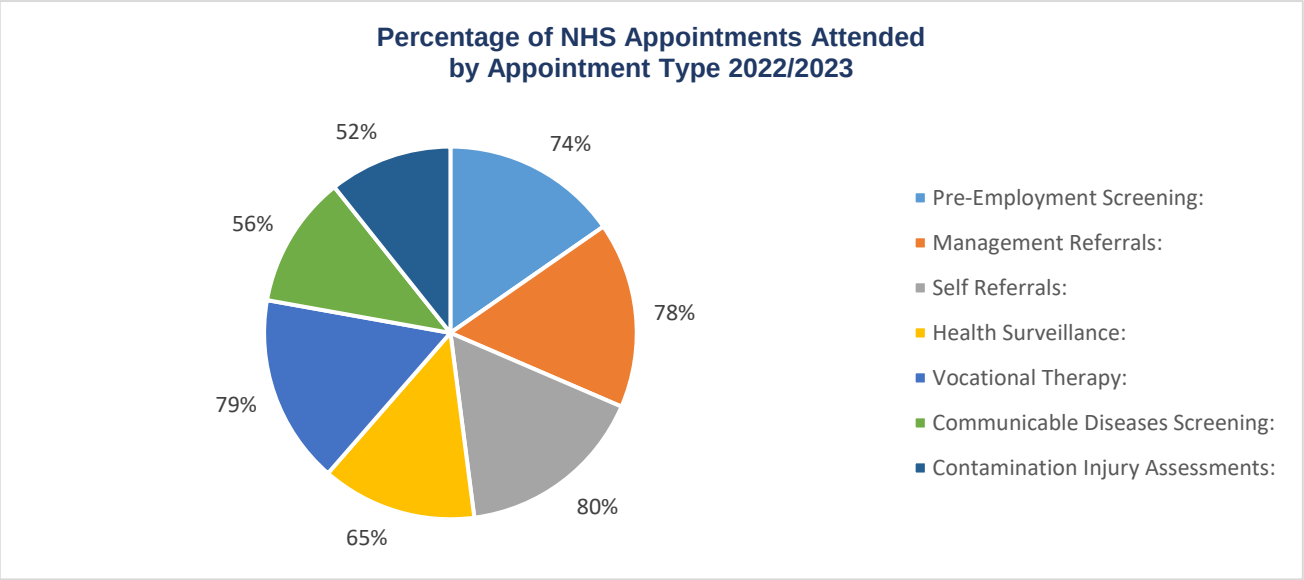
Appointment Reason	2018-2019	2019-2020	2020-2021	2021-2022	2022-2023
Pre-Employment Screening:	355	480	13	109	219
Management Referrals:	219	220	14	118	172
Self Referrals:	30	22	1	3	15
Health Surveillance:	162	151	6	61	77
Vocational Therapy:	11	9	8	97	97
Communicable Diseases Screening:	460	562	129	966	1496
Contamination Injury Assessments:	51	55	6	68	80
Total	**1,288**	**1,499**	**177**	**1,422**	**2,156**

Table 8: Appointment DNAs

Appointment Reason	2018-2019	2019-2020	2020-2021	2021-2022	2022-2023
Pre-Employment Screening:	191	186	8	76	152
Management Referrals:	164	160	38	151	192
Self Referrals:	51	28	1	20	13
Health Surveillance:	168	212	39	191	175
Vocational Therapy:	1	1	2	37	37
Communicable Diseases Screening:	566	545	216	1032	1803
Contamination Injury Assessments:	100	75	24	122	122
Total	**1241**	**1207**	**328**	**1629**	**2494**

Appendix 3: NHS Occupational Health and Wellbeing Service Appointment Attendance

Graph 11: Percentage of NHS Appointments Attended by Appointment Type 2022/2023



Graph 12: Percentage of NHS Appointments Offered Attended 2022/2023

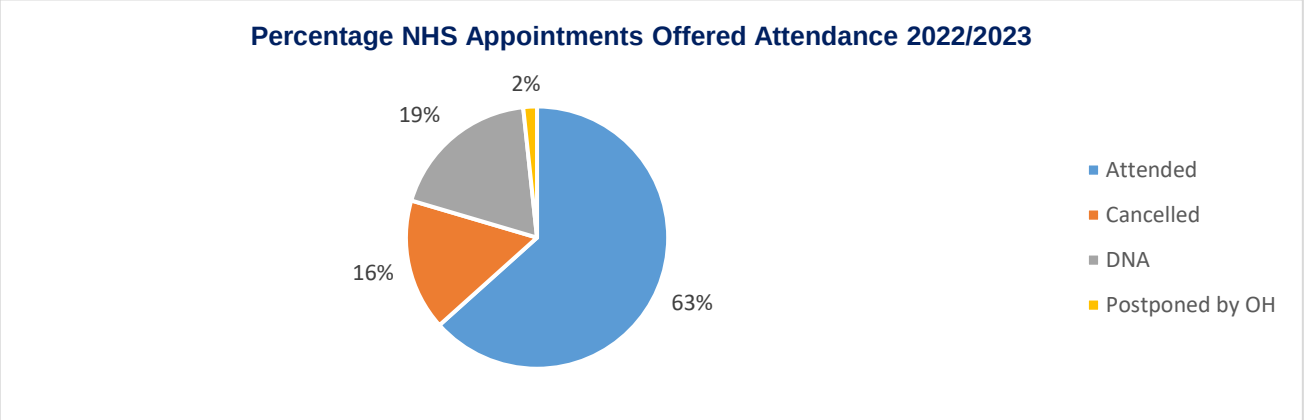


Table 9: NHS Appointments Offered Appointments by Appointment Type

Appointment Reason	Attended	Total Cancelled	DNA	Postponed by OH	TOTAL	% of Appts attended	% of Appts cancelled	% of Appts DNA	% of Appts Postponed
Pre-Employment Screening:	1,164	219	152	31	1,566	74%	14%	10%	2%
Management Referrals:	1,619	172	192	86	2,069	78%	8%	9%	4%
Self Referrals:	119	15	13	2	149	80%	10%	9%	1%
Health Surveillance:	525	77	175	27	804	65%	10%	22%	3%
Vocational Therapy:	558	97	37	10	702	79%	14%	5%	1%
Communicable Diseases Screening:	4,226	1,496	1,803	65	7,590	56%	20%	24%	1%
Contamination Injury Assessments:	222	80	122	4	428	52%	19%	29%	1%
TOTAL	8,433	2,156	2,494	225	13,308	63%	16%	19%	3%
Percentage of total appts	**63%**	**16%**	**19%**	**2%**	**100%**	**63%**	**16%**	**19%**	**3%**

NHS Appointment Attendance Percentage of Offered Appointments by Division 2022/2023

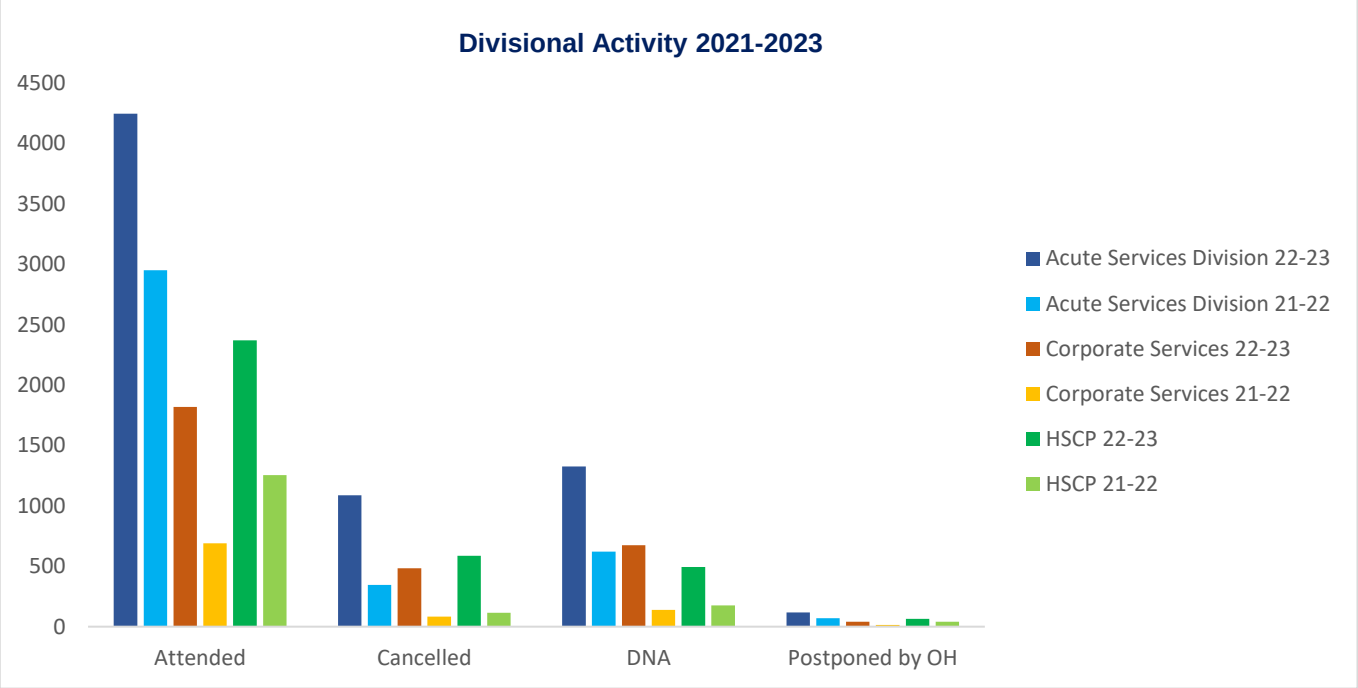
Table 10: Divisional Activity 2022/2023

	Attended	Cancelled	DNA	Postponed by OH	TOTAL	% of Appts Attended	% of Appts Cancelled	% of Appts DNA	% of Appts Postponed
Acute Services Division	4,245	1,087	1,325	119	6,776	63%	16%	20%	2%
Corporate Services	1,818	483	675	41	3,017	60%	16%	22%	1%
HSCP	2,369	586	494	65	3,514	67%	17%	14%	2%
TOTAL	**8,432**	**2,156**	**2,494**	**225**	**13,307**	**63%**	**16%**	**19%**	**2%**

Table 11: Divisional Activity 2021/2022 (For Comparison)

	Attended	Cancelled	DNA	Postponed by OH	TOTAL	% of Appts Attended	% of Appts Cancelled	% of Appts DNA	% of Appts Postponed
Acute Services Division	2,949	346	622	70	6,776	44%	5%	9%	1%
Corporate Services	690	82	140	15	3,017	23%	3%	5%	0%
HSCP	1,254	114	176	42	3,514	36%	3%	5%	1%
TOTAL	**4,892**	**543**	**939**	**127**	**13,307**	**37%**	**4%**	**7%**	**1%**

Graph 13: Divisional Activity 2021-2023



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AREA CLINICAL FORUM

(Meeting on 3 August 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 3 AUGUST 2023 AT 2PM VIA MS TEAMS

Present:
Aileen Lawrie, Chair
Jackie Fearn, Consultant Clinical Psychologist
Donna Galloway, Women Children & Clinical Services General Manager
Robyn Gunn, Head of Laboratory Services
Janette Keenan, Director of Nursing
Ailie Mackay, Speech and Language Therapy SLT Operational Lead
Nicola Robertson, Associate Director of Nursing
Amanda Wong, Director of Allied Health Professions

In Attendance:
Isla Bumba, Equality & Human Rights Lead Officer *(item 5.1 only)*
Sally Tyson, Head of Pharmacy *(deputising for Ben Hannan)*
Hazel Thomson, Board Committee Support Officer (Minutes)

1. Apologies for Absence

The Chair welcomed everyone to the meeting.

Apologies were received from Ben Hannan (Director of Pharmacy & Medicines), Chris McKenna (Medical Director), Susannah Mitchell (General Practitioner) and Emma O'Keefe (Consultant in Dental Public Health).

2. Declarations of Members Interests

There were no declarations of interest from those present.

3. Minutes of the Previous Meeting held on 8 June 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.

Item 4: Reporting Line

The Chair advised that an Annual Assurance Statement will be presented to the NHS Fife Board, along with regular updates at each Board meeting. The Chair also advised that she is meeting with the Board Chair to discuss ways of raising the profile of the Forum.

5. PRESENTATION

5.1 Equality & Human Rights

The Equality & Human Rights Lead Officer gave a presentation on Equality & Human Rights in NHS Fife.

The equality outcomes & mainstreaming report was explained, and suggestions were welcomed around planning and evidencing equality outcomes. Discussion took place around the issue around identifying wide ranging symptoms in neonates and mothers who are not of white ethnicities, and also the difficulties for clinicians to record skin problems for non-white patients, such as jaundice. It was suggested to gather information on sensitive issues, to identify and measure staff confidence, with a view to empowering staff and subsequently improving patient outcome and experience.

It was noted that the new international recruits, who have recently joined NHS Fife, bring a wealth of experience. Suggestion was made to promote the work of interpreters, with it noted that medical terms can often be difficult for family members to interpretate.

The technology issues within laboratories, in terms of specific reference ranges for different races/ethnicities/and sexes was raised as challenging, and it was noted that there is no government guidance available. The Equality & Human Rights Lead Officer advised an NHS Fife Trans policy is in development.

The Director of Nursing advised that protective characteristics and promoting equality & human rights is being considered at Executive level.

Discussion took place on potential staff networks that could be established to support equality outcomes, once they have been identified and developed, and it was noted that smaller projects could be carried out in the interim.

A summarised version of the presentation will be circulated to the Committee.

Action: Board Committee Support Officer

6. QUALITY / PERFORMANCE

6.1 Quality and Improvement Faculty Updates

The Director of Nursing reported that Marcia Simpson joins the Spiritual Care Team in September 2023 as a Healthcare Chaplain.

There was no further update available.

6.2 Winter System Review Update

The Director of Nursing reported that she led a Winter Review Group the previous year, and that work is being taken forward operationally. It was noted that the improvement work at the front door has been positive. It was also reported a national led Winter Summit Event will take place on Thursday 22 August 2023.

7. GOVERNANCE MATTERS

7.1 Delivery of Annual Workplan 2023/24

The Forum **noted** the tracked workplan.

8. UPDATE FROM EXTERNAL GROUPS

8.1 Area Clinical Forum Chairs Group for Scotland Update

An update will be provided at the next meeting.

9. LINKED MINUTES

9.1 Allied Health Professions Clinical Advisory Forum dated 7 June 2023 (unconfirmed)

9.2 GP Subcommittee dated 21 February 2023 (confirmed), 21 March 2023 (confirmed), 18 April 2023 (confirmed) & 16 May 2023 (confirmed)

9.3 Area Medical Committee dated 2 May 2023 (confirmed) & 27 June 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

There was no other business.

12. DATE OF NEXT MEETING

The next meeting will take place on Thursday 5 October 2023 at 2pm via MS Teams.

Area Medical Committee

AREA MEDICAL COMMITTEE

(Meeting on 27 June 2023)

No issues were raised for escalation to the Clinical Governance Committee.

CONFIRMED NOTES OF THE AREA MEDICAL COMMITTEE (AMC) HELD ON TUESDAY 27 JUNE 2023 VIA MS TEAMS

Present:

Chris McKenna (Chair)	Medical Director
Fiona Henderson	Fife LMC Honorary Secretary
Glyn McCrickard	Fife LMC Representative
Ian Fairbairn (from 14.36)	Clinical Director Emergency Care
Iain MacLeod	Deputy Medical Director, ASD
Sally McCormack (from 14.21)_	Associate Medical Director, Emergency Care & Planned Care
In Attendance:	
Deborah (Debs) Steven	Lead Pharmacist, Fife Pain Management Service and Programme Director, High Risk Pain Medicines (HRPM) Patient Safety Programme, NHS Fife
Catriona Dziech (Notes)	Executive Assistant to Medical Director

Dr McKenna welcomed Debs Steven to the meeting who had been invited to give the Committee an update on the High Risk Pain Medicine work.

Debs gave a presentation through a series of slides setting out the background and work of the High-Risk Pain Medicines Safety Programme. A 99 page report is available which sets out the work over the past year.

In closing the Committee was asked to:

1 Acknowledge the problem and support the findings from Year 1.
2 Advocate for the programme and action across peers and teams
3 Facilitate and prioritise support for delivery of Tests of Change in Year 2
4 Support with leadership in the change we all need to make.

In taking questions it was noted:

Within the next 12 to 18 months there should be public health messaging centrally from Scottish Government to change the thinking around how to manage long term pain and the role of high-risk pain medicines.

A joined-up approach between primary and secondary care would be helpful in identifying and supporting patients with high-risk pain medicine / substance misuse who are admitted to hospital. This could be highlighted at the point of discharge and explored further.

As part of the National Programme and chronic pain implementation framework an education hub is being developed which will be an informed, skilled, enhanced at specialist level.

In closing Dr McKenna thanked Debs for attending and taking the Committee through the presentation and giving them an opportunity to hear about this important work and confirmed the Committee's support.

1 APOLOGIES FOR ABSENCE

Joy Tomlinson

2 DECLARATIONS OF MEMBERS' INTERESTS

There were no declarations of interest.

3 MINUTES OF PREVIOUS MEETING HELD ON 02 MAY 2023

The notes of the meeting held on 02 May 2023 were approved.

4 MATTERS ARISING

i) Update from Realistic Medicine Team

(will attend a future meeting to provide update)

5 STANDING ITEMS

i) Financial Position

Dr McKenna advised the financial position improved significantly for the organisation by the addition of £8m plus to our NRAC share. This uplift brings the Board closer to parity. There are no plans yet on how this will be managed but to make good use of the money savings will still need to be achieved.

ii) Adverse Events Update – considered at the Clinical Governance Oversight Group

Dr McKenna advised from the most recent meeting it was noted the number of cardiac arrests was falling in the organisation as compared to a peak in the challenging winter periods. All the good work in this area needs to be acknowledged.

iii) Medical Staff Committee

Nil to report.

iv) Update from GP Sub Committee

Dr Henderson advised there was nothing specific to report other than GPs continue to be busy seeing patients.

Following discussion at the last meeting Drs Henderson and McCormack have discussed DNACPR and communications. Dr McCormack acknowledged DNACPR is not undertaken perfectly and there are issues with documentation. Currently we are behind many other health boards of moving towards an electronic patient record. As part of this our MOE

department is going to be scanned. MOE is one of the departments that has the biggest number of DNACPR due to the type of patients they have, and work is ongoing behind the scenes to get these on to an electronic patient record. Within Acute it is hoped to start a trial in the MOE wards at the end of July.

Dr McCormack also highlighted there will be an audit around DNACPR which will hopefully raise awareness and education to try and address some of the issues.

Ward 6, which frequently has Locums, will also be looked at and taken forward.

The next phase will be uploading community DNACPR.

v) Realistic Medicine

Nil to report.

vi) Medical Workforce

Dr McKenna highlighted significant work is ongoing to secure appropriate replacement cover for the Junior Doctor Industrial Action on 12 July 2023 for 72 hours.

Communication will be issued to General Practice in due course setting out any significant changes which will impact GPs.

vii) Education & Training

Dr McKenna advised he is attending a meeting at St Andrews University with NES and Forth Valley which is likely to be a springboard for ScotCOM progressing for 2025 entries.

6 STRATEGIC ITEMS

i) GMS Implementation

Fiona Henderson advised GMS implementation remains problematic. It is now five years into a new contract in 2018, which has still never been delivered. Last March, there was an agreement that vaccinations would transfer from GPs, but unfortunately Practices are still having to code childhood vaccinations after their deliver by the immunisation team. At the end of this March, there was a second memorandum of understanding whereby all pharmacotherapy work would be put in along with care and treatment room services. Despite best efforts full recruitment has been unsuccessful. Many practices across Fife, do not have full implementation of service, which is obviously causing additional pressures.

Due to lack of funding from SGHD GP Practices have neither money nor workforce. Numbers continue to deplete in terms of people retiring or leaving the profession.

On a National level, there has been discussion around Industrial Action. As GPs are independent contractors, it is much harder to have any sort of industrial action because they would be in breach of contract. There is talk of what can be done to reflect the fact that SGHD are currently in breach of contract.

Currently there are negotiations with Health Board representatives to try and come to some sort of transitionary agreement with the end aim of hopefully full implementation of the contract.

ii) **Transferring Care Safely to General Practice**
Dr McKenna highlighted that he felt it would be beneficial if this document was jointly produced with primary and secondary care to set out the standards, we collectively hold ourselves to. It was suggested Sally McCormack lead from secondary care.

This document has been used by other health boards and changed locally to fit with Fife.

Dr McKenna reiterated he felt there was always real success with this sort of document when it is produced jointly. There is a lot of detail within the one document which might best be broken down into a couple of documents.

Dr MacLeod agreed we need to build conversations and work together. This could be through a working group with a small group of people from across general practice and secondary care.

It was agreed Sally McCormack along with Morwenna Wood and John Morrice to cover acute secondary care along with Fiona Henderson and any other LMC representatives would consider the document collectively and decide what needs unpicking, what is relevant to junior doctors and what sits elsewhere. It was agreed this could be done out with the AMC.

Action: SMcC,MW, FH, JM

7 ITEMS FOR INFORMATION

i) Notes of the GP Sub Committee:
17 January 2023, 21 February, 21 March and 18 April 2023
Noted.

ii) Notes of the Clinical Governance Oversight Group:
20 December 2022 & 14 February & 18 April 2023
Noted.

iii) Notes of NHS Fife Area Drugs & Therapeutics Committee:
08 February 2023
Noted.

8 AOCB

i) **Annual Organisational Duty of Candour Report 2021-2022 (as discussed at NHS Fife Clinical Governance Committee on 03 March 2023)**
Noted.

9 DATE OF NEXT MEETING
Tuesday 08 August 2023 at 2pm via MS Teams - *Maxine Michie invited to attend to provide a Finance Update*

NHS FIFE CLINICAL GOVERNANCE OVERSIGHT GROUP (Meeting on 20 June 2023)
No issues were raised for escalation to the Clinical Governance Committee.

NHS Fife Clinical Governance Oversight Group

Date: 22/06/2023
Enquiries to: April Robertson
Telephone Ext: Microsoft Teams

UNCONFIRMED MEETING NOTE OF THE NHS FIFE CLINICAL GOVERNANCE OVERSIGHT GROUP HELD ON TUESDAY 20 JUNE 2023 via MICROSOFT TEAMS

Attendees

Lynn Barker (LB)	Associate Director of Nursing, HSCP
Norma Beveridge (NB)	Interim Associate Director of Nursing, Acute
Claire Fulton (CF)	Lead for Adverse Events
Janette Keenan (JK)	Director of Nursing
Aileen Lawrie (AL)	Associate Director of Midwifery
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
Shirley-Anne Savage (SAS)	Associate Director of Quality & Clinical Governance
Geraldine Smith (GS)	Lead Pharmacist, Medicines Governance
Amanda Wong (AW)	Director of Allied Health Professions
Prof Morwenna Wood (MW)	Consultant Nephrologist – Renal Medicine

In attendance

Nicola Harkins (NH)	Acting Senior Manager, Learning Disabilities, HSCP
Heather Bett (HB)	Senior Manager, Children Services Projects, HSCP
Rebecca Hands (RH)	(minute taker) Clinical Governance Administrator

Apologies

Dr Sue Blair (SB)	Consultant in Occupational Medicine
Pauline Cumming (PC)	Risk Manager
Fiona Forrest (FF)	Deputy Director of Pharmacy & Medicines
Catherine Gilvear (CG)	Fife HSCP Quality, Clinical Care & Governance Lead
Dr Helen Hellewell (HH)	Associate Medical Director, HSCP
Nicola Robertson (NR)	Associate Director of Nursing, Corporate Division
Dr Sally McCormack (SMcC)	Associate Medical Director for Emergency & Planned Care
Dr Iain MacLeod (IM)	Deputy Medical Director, Acute Care

	Items	Action
1	**Apologies for Absence**	
	Apologies for absence were noted from the above members.	
2	**Minutes of the last meeting held on 18th April 2023**	
	The Group confirmed that the note from the meeting held on the 18th of April 2023, was a true reflection of what was discussed.	
3	**Matters Arising/Action List**	
3.1	Deteriorating Patients **(CMcK/NB)**	
	SAS & EM assured the group that project management support was now in place. CMcK informed the group that with regard to the cost of Welch Allyn devices, this was now sitting with Senior Leadership Team.	

	NB informed the group that the test of change report will be taken back to senior leadership team, and the request was with the Capital Equipment Fund group. CMcK was supportive of the Test of Change being completed; we could include the Research and Development Team to assist with the analysis. NB will speak to IM to take the proposal back to SLT in a shortened version.	NB
4	**PATIENT EXPERIENCE**	
4.1	Patient Experience Flash Card **(JK/SM)**	
	SM shared the Patient Experience Flash Card with the group stating that last year we had a total of 538 stage one complaints and 387 stage 2 complaints. April to June so far we have received 155 enquiries, 102 concerns, 127 stage one and 58 stage 2 complaints. The themes have remained consistent, with the main issues of complaint being, disagreement with treatment, co-ordination of treatment and staff attitude. SM told the group she is currently working with Digital & Information Services to create a comprehensive dashboard that could be accessed, meaning weekly reports would no longer be sent out, this would refresh every morning at 5am. The patient experience team would access a separate dashboard which would allow them to access their own compliance data and easily see all cases the handlers had and at what stage they were at. The patient relation team are trying to encourage care opinion feedback, looking at how different areas promote this. The team are currently assisting Health & Social Care Partnership with ways to promote care opinion. The team have appointed a part-time bank member who visits Health & Social Care Partnership sites to talk to patients and catch the stories from people who are elderly or don't have IT access / skills. There will also be a care opinion dashboard which will allow areas to look at the stories from their patients, allowing them so see themes and responses. SM explained she was looking at ways to collate, evidence of learning from complaints and how to share the learning. Some areas used their own forms for feedback, whilst this was good to get the feedback it made it very difficult to report nationally. A staff questionnaire had been sent to consultants on patient feedback, there has so far been 41 responses with very helpful detailed information on how they feel about complaints and what the barriers were. A standard operating procedure is being compiled which will assist on showing which complaints were being delayed and how these should be escalated to help expedite the complaint. CMcK responded that this was all very helpful good work. LB wondered if the way to share learning around Patient Feedback was through the Organisational Learning Group. CMcK stated that the complainant was rarely content with the response received. Would a workshop be a good way to assist with responses, JK agreed this would be a good idea.	

	CF advised the group that one of the biggest projects in adverse events this year was looking at a refresh of the actions module. This tied in with what SM was describing and she would share her ideas of how to look at this as an organisation. AL told the group she felt one of the things which added to complainant's discontent is the length of time taken to apologise. The workshop would be a good idea; an apology could be given early without being an admission of wrong doing. CMcK added he thought an apology was given at a local level; it was an organisational apology that was missing. CMcK asked SM and CF if a workshop could be set up this year. CF wondered if the patient information leaflet might be useful, there is currently a leaflet for SAER's but this could be adapted. It states "we are sorry that you have experienced and adverse event while in our care" it lays out, what will happen next and gives key contacts for the service. SM suggested if a complaint is complex or moderately difficult, should we set our own response instead of letting a complainant think we can response within 20 days when we know this is impossible. We should get this expectation correct from the beginning. CMcK concluded that we should be mindful that there is a lot of good work going on in NHS Fife, from all the feedback, these complaints were a very small proportion and the rest of the feedback was positive.	**SM/CF**
5	**Adverse Events & Duty of Candour Status Update**	
5.1	NHS Fife Adverse Events KPI's **(CF)**	
	CF raised 2 points from the report; • Proposed change in KPI 5, Current measure - SBAR received within 5 days. This measure is no longer accurate since the change to review commissioned process. Proposal to change KPI 5 to; Review commissioned within 10 working days of event, within is in keeping with national guideline. No opposition to the proposal was made. • KPI 7 closure of actions from SAER/LAER on time 27% at end of April. Actions to address this KPI will be further discuss in agenda item 5.5	
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 increased from a monthly average of 41 per month in 2022 to 44 per month in 2023 so far. Two themes of major / extreme events were identified from the themes analysis • Missing person events reported have increased from an average of 2.5 incidents per month to 8 incidents reported in May. A verbal update to provide assurance was given by HSCP, Director of Nursing that this increasing trend had been recognised locally and work was underway to identify any learning.	

	• Cardiac arrest events reported have reduced from a 12 month average of 6.8 incidents per month to 4 reports in April and 1 in May. It is thought this reduction could be attributed to the commencement of the focused improvement work on the deteriorating patient work stream. Overall the types of adverse events that received the greatest number of reports is consistent, with the top 4 categories of events accounting for over 50% of all reported events (table 3). The same approach to identifying themes from all level of reported events was applied to ensure no opportunities were missed in identifying lower level of harm events that had potential to lead on to major/extreme levels of harm if learning was not identified and managed. An increased trend in blood transfusion reported events was identified. In particular there was 20 events reported in April, this was the only month in a 12 month period where the number of reported events have reach the 20's with a monthly average of 8 events reported per month. The data was shared with the blood transfusion team who met with the Adverse Event Lead to interrogate the data and ensure all opportunities to learn had been identified. Findings – Of the 20 incidents, 9 were wastages of frozen products during activation of Major Haemorrhage Protocol. Individually the events have been reviewed and closed as unavoidable. Conclusion - an increase in the number of major haemorrhage protocol activations resulting in loss of fresh frozen plasma (FFP) accounted for a large number of the additional Blood Transfusion incidents for the month of April. Although FFP not used is potentially unavoidable the blood transfusion team will review whether it is being requested at correct trigger point and implement any improvement actions identified. At service level the team were aware of the increase in wasted product events, however collectively this had not been identified as an increasing trend. This new approach to working collaboratively with services when a trend has been identified has created an opportunity for learning that otherwise would have been missed. It was agreed at that this had been a beneficial addition to the adverse events updates that are provided at each meeting and should become a standing agenda item.	
5.3	Staff Support following an Adverse Event **(CF)**	
	CF gave an update on the progress of the Short Life Working Group led by the Adverse Event Lead and supported through the Staff Health and Wellbeing group. A staff support following an adverse event resource pack is in early draft stages. The key elements of the pack are; • Guidance on the purpose of staff support, when and how it should be offered • Staff leaflet on managing stress following an adverse event • Hot debrief tool and guidance document • Bite size education sessions by the peer support service on how to facilitate a debrief • Cold debrief sessions when required facilitated by peer support / spiritual care service • Management flowchart	

	• Signposting A further update will be presented following review of the resource pack at the Staff Health and Wellbeing group meeting in August.	
5.4	Adverse Events Process – Key Changes **(CF)**	
	CF provided an overview of the key changes to the Adverse Events Process and advised that Blink has been updated and provides a useful resource for managing adverse events; • Updated Adverse Events policy published May 2023 • E-learning module on TURAS launched Nov 2022 • Updated process for commissioning and approval of major adverse events • Introduction of SAER panel sign off process • Update to templates including introduction of Complex Care Review	
5.5	Adverse Events Improvement Plan update **(CF)**	
	CF updated the group on the next steps for the adverse events improvement journey; Move to electronic SBAR for all types of events, Cardiac arrest SBAR as first step expected to commence August 2023. Complete and publish Adverse Events Management Resource Pack. A lot of the information is already on Blink as an independent folder. The pack requires bringing together all the sections in 1 place as a complete resource for managing an adverse event. Launch and embed staff support, further update to following after review at Staff Health and Wellbeing group. Develop virtual Adverse Events local network The largest focus of the improvement plan is on the actions associated with adverse events. Currently actions module on Datix is predominantly used for actions resulting from SAER / LAER, however, compliance with closure of actions on time is poor at 27% with a target of 70%. Short and long term plans to address this were discussed; Short Term; • Reduce KPI from 70% of actions closed on time to more achievable goal of 50% to be achieved by March 2024. • Communications published on Blink to raise awareness and offer support with managing actions in Datix. • Report on all open actions to be sent to service senior leadership team. Long Term; • It was proposed by CF that this improvement work is considered as a project by the Organisation Leading Group.	

	• Actions module is utilised for adverse events, complaints, claims and risk. Better use of actions module across all areas will provide the organisation with the evidence and assurance that where needed, action has been taken and lessons learnt. • Engagement with services and key stakeholders to refresh Datix action module. • Addition of level of action required to be able to identify actions for organisation learning group. • Anticipated start date for commencement of work August 2023	
6	**GOVERNANCE**	
6.1	NHS Fife Health & Social Care Partnership Clinical Governance Assurance Update **(LB)**	
	LB presented the update noting this was the first time this had been presented to this group for assurance, from the meeting held on 21st April 2023. The purpose of Quality Matters Assurance Group (QMAG) is to provide assurance that clinical and care governance is discharged effectively within Fife HSCP whilst meeting the statutory duty for the quality of care delivered specifically in relation to patient/client safety, clinical effectiveness and patient/ client experience using a person centred, rights based approach and which can be evidenced using Integration Governance Principles: "How Do You Know"? LB explained they are looking bring a synopsis and summary of what was discussed at QMAG to provide assurance or reassurance to each CGOG meeting. The group noted the report.	
6.2	NHS Fife Health & Social Care Partnership Inspection Update **(NH)**	
	NH spoke to the group to provide assurance with regard to the Mental Welfare Commissions Inspections. The reports being presented provide an update regarding the visits to a number of inpatient areas and provide a commentary as to any similarities or differences to the visits over the last 12 months. The report was presented for information and assurance regarding work in progress to improve service delivery and patient experience. The statutory function of the Mental Welfare Commission (MWC) includes, monitoring the care and wellbeing of people subject to mental health legislation, and ensuring they are receiving the treatment they need. One of the ways in which the MWC fulfils this function is through visits, including visits to hospitals. The overviews of the themes from inspections are; Elmview (older adult area at Stratheden) has no recommendations made around ward and were extremely satisfied. However, the patients did recognise how stretched the staff were, meaning they were not always able to interact with them.	

	Some of the less positive feedback was around some of the older units, where the environment was very poor, and in some areas there is a lack of outdoor space, which can be challenging. Other key points highlighted by NH are; • Managers should ensure that current patients on a ward who require a T2 or T3 certificate have one in place, should arrange for a copy to be held with the drug Kardex and should ensure all psychotropic medication is legally authorised. • Managers should consider opportunities to provide an activities co-ordinator from within their staff establishment. • Managers should carry out an audit of the nursing care plan reviews to ensure they fully reflect the patients' progress towards stated care goals and that recording of reviews are consistent across all care plans. NH assured the group that each ward has an action plan which is updated on a monthly basis and there is an overall service action plan which is reviewed each quarter. There has been a short life working group to take forward actions re T2, T3 forms where training has been put in place for all staff including medics and the Senior Charge nurse audits this on a monthly basis. Positives need to be utilised around care planning and provide more detail around activity outcomes especially in adults with learning disabilities. CMcK informed the group that this report would need to be taken to NHS Fife Clinical Governance Committee and asked NH if the action plans were available. He will speak to JK out with this meeting to discuss what format should be taken to committee.	**CM/JK**
6.3	Adult Support Protection / Child Protection Risk Report **(LB/Heather Bett)**	
	LB presented the papers on Adult Support Protection explaining that Internal Audit had reviewed recently and were seeking assurance on how they managed, collated and reacted to identification of adult support and protection, including the governance and assurance routes within that. The Integration Joint Board (IJB) holds a strategic risk regarding Adult and Child Protection which is monitored by the Quality and Communities Committee Care Governance Committee twice per annum. The risk register report contains details of the Adult and Child Protection risk held on the IJB Strategic Risk Register. The risk was most recently reviewed by risk owners in February 2023. The risk is currently scoring 10, a moderate risk. Changes to the risk since the last review include two additional internal controls as follows: • Regular reporting of ASP activity, practice issues and assurance into QMAG on a quarterly basis. • Enhanced working with Executive Director of Nursing/NHS Fife in relation to the imminent NHS Public Protection Framework, which will deliver positive impacts for Multi-agency working In addition to this strategic level risk, further operational risks around adult and child protection are held by the partner bodies. These are regularly monitored by the Quality Matters Assurance Group. Any risks that are of concern at the operational level would be escalated to the Senior Leadership Team and to the appropriate strategic level if necessary.	

	CMcK asked that further update be brought to this group. JK advised that a group had been set up to look at the public protection assurance framework and a GAP analysis was completed, they are pending the self evaluation toolkit coming out. This has previously been presented at the last Clinical Governance meeting where it was shown that adult protection was under resourced, where NHS Fife have 0.6 of a Band 6, other boards have lead nurses in adult protection and heads of public protection. HB presented the paper on Child Protection Risk Report; The purpose of this paper was to provide assurance to Health & Social Care Partnership Quality Matters Assurance Group of the measures in place to address Integration Joint Board risk 10. There is a risk that the Integration Joint Board does not receive sufficient assurance to enable it to fulfil its statutory duty for Adult and Child protection, leading to negative impacts for individuals and for multi-agency working and damage to the reputation of the partner organisations and the Integration Joint Board." Following April 2023 Health & Social Care Partnership Quality Matters Assurance Group of the measures in place to address Integration Joint Board risk 10 and recent discussions at SLTAG, it was agreed that further detail and assurance was sought around Integration Joint Board Risk 10, relating to Adult and Child Protection; the paper should reference the detail within the risk and incorporate timeous processes and systems that are in place to provide robust assurance governance within the Health & Social Care Partnership and describe the responsibilities and accountabilities for adult protection and child protection. The request re IJB Risk 10 originated from Internal Audit, with a further Internal Control Evaluation (ICE) update to be reported through Clinical Governance Oversight Group (CGOG), which provides assurance to the Clinical Governance Committee (CGC). The group noted the structures and reporting arrangements in place which provide assurance that the Integration Joint Board can discharge its responsibility for child protection CMcK stated the group could take assurance from the comprehensive report	LB
6.4	NHS Fife Health & Social Care Partnership Missing Persons Update **(LB)**	
	LB informed the group that at the fortnightly Quality Matters Assurance huddle a spike was noticed in missing persons at the end of last year, mainly mental health patients absconding from clinical and mental health settings. This had then reduced however in February to May this year it had again spiked. A short life working group has been commissioned, this should give assurance to the group that H&SCP are aware of the significant rise in missing persons. There is an action plan in place which LB would be happy to bring to a future meeting. CMcK would be happy for the action plan to be brought to the next meeting.	LB AR

6.5	Drug & Alcohol Death Cluster Review Process Paper **(Dr Susanna Galea Singer)** c/f to future meeting	
	This item has been moved to August meeting.	
6.6	Clinical Governance Strategic Framework Annual Delivery Plan 2023/2024 **(SAS)**	
	SAS spoke to the updated delivery plan for this year, looking for any comments or updates to be sent to her before she takes it to NHS Fife Clinical Governance Committee on 7th July 2023.	ALL
6.7	NHS Fife Clinical Governance Oversight Group Terms of Reference **(SAS)**	
	SAS informed the group the terms of reference was at the meeting for its annual review. These were agreed by the group.	
6.8	NHS Fife Clinical Policy & Procedure Update **(EM)**	
	EM advised at their April meeting, the NHS Fife Clinical Policy & Procedure Co-ordination & Authorisation Group that there were no new policies or procedures approved. There are **five** Fife wide procedures and **two** acute services division procedures past their review date. The group were given assurance that they have a 92.5% compliance rate for all clinical policies and procedures for NHS Fife.	
6.9	NHS Fife Activity Tracker **(EM)**	
	EM shared with the group that there was; One new publication which was - New Quality Framework for community engagement published in April. One standard was published which was the Bairns' Hoose standards published on 31st May 2023	
6.10	Fatal Accident Enquiry **(SAS)**	
	SAS noted that the findings of the Fatal Accident Inquiry (FAI) is in the public domain, and the importance of acknowledging NHS Fife's response to the FAI was highlighted. The SBAR presented outlines the main findings of the enquiry and the recommendations. A small group was formed to look at the recommendations. SAS informed the group that there is still some work to be done around the action plan however this will now be going to Executive Directors Group and NHS Fife Clinical Governance Committee for transparency. CMcK informed the group that the submission was accepted by the Sherriff with no return to us.	
6.11	NHS Fife Corporate Risk Register **(SAS)**	

	SAS spoke around the Register to inform the group that there were a couple of additional mitigations added. The main change was that the target risk and level rating would no longer be set at the end of the year; it would be now up to each individual risk owner to set their target date. SAS & CMcK have an offline discussion with regard to which risks would be most beneficial to come to the meetings.	SAS/ CMcK
6.12	SBAR Corporate Risks Aligned to Clinical Governance Committee Deep Dive - Quality and Safety **(SAS)**	
	CMcK noted the Deep Dive and invited any comments out with the meeting. This will be going to Executive Directors Group and NHS Fife Clinical Governance Committee.	
7	**STRATEGY & PLANNING**	
7.1	NEWS2 **(SAS)**	
	SAS had no update on NEWS2 and will bring this to the next meeting. JK informed the group that they had recently appointed to the band 7 Deteriorating Patient Lead within practice development and that she will be the nursing support for the roll out of NEWS2.	SAS
8	**QUALITY/PERFORMANCE**	
8.1	NHS Fife Integrated Performance & Quality Report May 2023 **(CMcK)**	
	The report was noted by the Group.	
9	**LINKED COMMITTEE MINUTES**	
9.1	NHS Fife Clinical Policy & Procedure Co-ordination & Authorisation Group 24^{4h} April 2023 **(EM)**	
	The minutes of the meeting were noted by the group and no escalation is needed.	
9.2	NHS Fife In Patient Falls Steering Group 10th May 2023 **(NB)**	
	This meeting was cancelled, next meeting 9th August 2023	
9.3	NHS Fife Tissue Viability Working Group 25th May 2023 **(LB)**	
	This meeting was cancelled, next meeting 6th July 2023	
9.4	NHS Fife Resuscitation Committee - 24th May 2023 **(JK)**	
	This meeting minute was carried forward to August meeting	
9.5	NHS Fife Health & Social Care Partnership Quality Matters Assurance Group - 21st April 2023 **(LB)** Unconfirmed minute.	
	The minutes of the meeting were noted by the group and no escalation is needed.	
9.6	NHS Fife Organisational Learning Group – no meeting date	

9.7	Acute Services Division Clinical Governance Committee – 22nd March 2023	
	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 **(SAS)**	
	SAS had nothing to highlight from the Workplan.	
11	**ISSUES TO BE ESCALTED**	
	Claire Fulton's presentation on Adverse Events should be taken to Clinical Governance. Health & Social Care Partnership Inspection reports should also be escalated; CMcK and JK will discuss the correct format to be taken to the CGC.	CMcK/JK
12	**ANY OTHER BUSINESS**	
	No Other Competent Business.	
	Date of Next Meeting 22nd August 2023 09:30 via Microsoft Teams	

DIGITAL AND INFORMATION BOARD (Meeting 19 July 2023)
No issues were raised for escalation to the Clinical Governance Committee.

Digital and Information Board

Fife NHS Board
UNCONFIRMED

MINUTE OF THE DIGITAL AND INFORMATION BOARD HELD ON WEDNESDAY 19TH JULY 2023, 0900, VIA MS TEAMS

Present:

Chair - Dr Chris McKenna	Medical Director
Alistair Graham	Associate Director, Digital & Information
Claire Dobson	Director of Acute Services
Janette Keenan	Director of Nursing
Margo McGurk	Director of Finance & Strategy
David Miller	Director of Workforce
Joy Tomlinson	Director of Public Health
Sally Tyson	Head of Pharmacy, Development, and Innovation on behalf of Director of Pharmacy & Medicines
Audrey Valente	Chief Finance Officer on behalf of Director Health & Social Care

In Attendance:

Andy Brown	Principal Auditor
Helen Hellewell	Associate Medical Director
Marie Richmond	Head of Digital Strategic Delivery, Digital & Information
Matt Valenti	Partnership Representative
Amanda Wong	Director, AHPs
Allan Young	Head of Digital Operations, Digital & Information
Claire Neal	(Minute) PA to Associate Director, Digital & Information

Apologies:

Charlie Anderson	Head of ICT, Fife Council
Lynn Barker	Director of Nursing
John Chalmers	Clinical Lead, Digital & Information
Margaret Guthrie	Head of Information Governance & Security / DPO
Sharon Mullan	General Practitioner
Torfinn Thorbjornsen	Head of Information Services, Digital & Information

1 Welcome and Apologies

Dr McKenna welcomed everyone to the meeting and apologies were noted to the Board.

2 Minute and Actions of Meeting Held – 19/04/23

Minutes were reviewed and agreed. Updates were provided for completed action.

3 Matters Arising

3.1 Use of Personal Devices

A Graham advised this item has been brought to Board for assurance.

The paper included a recommendation from the M365 Programme Board relating to the adoption of the security and data protections solutions available as part of M365. This paper outlines the rapid implementation of M365 during the pandemic, but with limited opportunity to implement the associated security products. The recommendation allows the introduction of controls that allow us

to prevent the opportunity for unintentional data loss when a staff member is accessing M365 products on a personal device. There will be no change to corporate devices. A Graham provided a summary of paper, noting the implementation of the controls will prevent a staff member downloading items from Outlook or Teams onto a personal device. The items will still be able to viewed and edited (if required) just not able to be stored on a personal device.

J Tomlinson noted this is a positive move but would this create any challenges sharing between Boards. A Graham replied no, these items are seen as prerequisites for further adoption of items such as SharePoint.

C McKenna queried if we have reviewed the consequences for the staff who access on their personal devices as not everyone has a works device. A Graham confirmed experiences from other Boards have been taken into consideration e.g., NHS Lothian. A Graham noted that a phase implementation will help to assess the impact and ensure any impact is understood.

Further discussions were held with concerns raised on how this will impact and to fully understand what this means. Query was raised on what could be seen and could a screen shot be taken instead. A Graham advised the item could be viewed just not downloaded.

It was noted that further impact assessment would be made as part of the implementation.

Action – AG and AY to investigate. **AG/AY**

Items to be reviewed and further information provided at next meeting.

3.2 Back to Referrer Issue – Update

M Richmond noted this item has been brought back to Board to provide a verbal update on the Back to Refer issue which was presented at April's meeting.

M Richmond thanked all staff who have been reviewing this issue. We are nearly complete and have supported all actions. The monitoring of this item continues and since the initial item was highlighted a further 108 back to referral items needed consideration. S McCormack has taken an action regarding and will take this to Clinical Leads.

We will continue to monitor until there is a fix in place and will continue to update the D&I Board.

No comments were raised.

3.3 Digital Maturity Assessment Results

A presentation was delivered by M Richmond to provide an update to the Digital Maturity Assessment. A brief overview was provided noting this was conducted between May and June. A range of questions were asked relating to several areas. Invites were sent to a few departments e.g., Information Governance, Mental Health, Primary Care, and all GP's, which was a significant undertaking. We engaged with our Social Care colleagues also, but they felt the questions were not relevant to them, this has been fed back to Scottish Government.

M Richmond explained the Digital Maturity Assessment structure.

A summary of the results was provided by theme, noting some examples below:

- Readiness – this equates to 6 areas the majority of which were scored higher than the National average except Information Governance and Skills & Competencies.
- Capabilities – are the next 10 areas and NHS Fife were below the National average with the exception of Medicines Optimisation, and a few others. We were surprised we scored high as we don't have

HEPMA. This was queried with Scottish Government, and they confirmed this is correct due to scores in Primary Care.

- Infrastructure – A few new sections were added. We scored above the National average.

A full report will be issued from Scottish Government, but it has been noted that NHS Fife will be a significant outlier. Upon this report, actions will then be taken which will inform the next Digital Strategy and the next rounds of Delivery Plans.

The Staff survey that was undertaken went well, with 745 responses received. M Richmond provided a summary of these results. Full report to follow.

A brief conversation was undertaken regarding the initial feedback from Scottish Government and surprised with this result. M Richmond noted they had queried with Scottish Government, but no comments were received. It was suggested when the full report is available for this to be added to next meeting spending some time of the findings.

No other comments were made.

4 Risk Management

4.1 Risk Management Report

A Graham highlighted there is no change with the Risk Management update. A report will be issued later with the opportunity for comment.

Action – AG to forward Risk Management Report. **AG**
Action - for all to provide any comments. **ALL**

No comments were made.

4.2 NIS Update

A Young delivered a presentation and provided an overview, noting this has been brought to Board for an update to the NIS Audit.

A new auditing contractor was awarded for 2023 so a full reset will take place with this audit. Our last level of compliance was 78%.

NHS Fife initial assessment took place on 11th May. We submitted all evidence on 3rd July, we believe our evidence is strong. On 8th August we will be able to provide further clarification, with further assessment. An interim report will then be received on 14th August and final report is expected 28th August.

C Mckenna thanked for the update and queried when the report will be presented to the Board. A Young confirmed this will be presented for the October's meeting.

A Graham noted this audit is more extensive than those conducted through the pandemic and includes site visits, interviews and formal feedback discussion. The action plan will be presented to D&I Board and the IG&S Steering Group.

No further comments were made.

5 Performance

5.1 D&I Performance Summary

A Young presented D&I Performance Summary from the last quarter, noting the below:

- Great progress continues to be made with majority of KPI's being met.

- Steady progress with the 2008 and 2012 servers. It is hoped more will removed by end of financial year.
- Maintaining good Cyber exposure score.

A Young noted noting to alert within the performance summary.

C McKenna thanked for all the hard work and good to see so many greens within summary. A query was raised for two items highlighted in yellow within the report. A Young advised there have been changes with reporting, due to moving over to eRostering but will be available at next meeting.

No further comments were made.

5.2 Cyber Update

A Young noted item brought to Board to provide an update to our Cyber Security position.

A summary was presented noting the below:

- NCSC threat statue remains high.
- Averaging 25 Cyber incidents/alerts per month.
- Averaging 10 new vulnerabilities per month.

A penetration test will be taking place on 31st July, which will last three weeks. An anonymous person will arrive and try to attack our servers. Feedback from this test will be provided.

No further comments were made.

6 Strategy and Programmes / Project

6.1 Strategic Delivery Update

M Richmond introduced item and provided an update to some of the items within the project update. A brief update is noted below:

- National Programmes led by NSS continue to have issues and delays. Concerns have been raised and discussion continue with these delays. Programmes are constantly moving on delivery timescales.
- Digital Pathology now amber.
- eRostering remains amber, we hope this will improve to green with an updated timeline of 2025 to completion. A paper will be issued to EDG for a decision on a BAU team.
- Morse moving to phase 2.
- Digital Medicines. HEPMA contract not signed. Meeting later today in hope to an agreement with CMM.
- Pharmacy Stock Control is linked to HEPMA so once progressed with HEPMA can progress.
- LIMS has a new plan in development, that is likely to stretch the system adoption into 2024. Ongoing discussion within the LIMS Programme Board. This is disappointing but holding supplier to account.

M Richmond provided a highlight to other items in delivery update.

C McKenna thanked for the report and raised concerns each time we extend this is costing money and we need to progress.

No other comments were made.

6.2 Delivery Plan

M Richmond provided an overview to item noting the delivery plan for the next 2 years. With strategic and operational delivery now combined. There is a significant level or work to be undertaken but we will need review and reprioritise as project needs.

C McKenna noted the amount of work required which is why it would be good to have communications issued to the organisation on the amount of work that is already being undertaken and unable to absorb anymore.

No further comments were made.

6.3 Digital Enablement Framework

A presentation was delivered by M Richmond and a summary was provided noting the below:

- A Digital Enablement Team has been established and they are all about embracing the change and embedding into practice.
- A Gap analysis was conducted, and a few examples of the findings were provided, out of date, key personnel missed, lack of standardisation.
- Within 23/24 we are looking to build on standards.
- Move to accreditation on key cornerstone systems.
- Standardise training, with users prompted to check they understand, and this will be fed to Manager.
- If there was ever another pandemic, we will know where staff can be placed to work.
- Results of Digital Maturity, listen and change.

M Richmond confirmed this is a brief overview and document will follow at next Board.

J Tomlinson thanked and supported the change to empowerment and the engagement. Thinking of barriers and mindful of all disabilities.

A brief discussion was undertaken, and it was noted this should continue to be driven with SLT.

No other comments were made.

6.3 a Update on Senior Clinical Engagement

M Richmond provided an overview to the work undertaken to prepare for the possible Junior Doctors strike.

7 Strategy

7.1. Strategy Development 2024 – 2030

M Richmond shared a presentation and advised we are due to undertake the next strategy from 2024 – 2030.

M Richmond provided an overview of presentation noting a few of the below:

- Establish a clear and specific goal.
- Commit to meaningful milestones.
- Build organisational ownership linking to relevant strategies e.g., Population Health and Wellbeing and HSCP Digital Strategy.
- Support realistic planning.

We are creating a road map to understand immediate issues and longer-term goals. We want to understand team ownership and engage with all teams and other strategies and delivery plans. It is important there is accountability, this is not a D&I Strategy this is an NHS Fife Strategy. It will advise on the volume of work and the timescales involved.

M Richmond provided background on the timescales and how this is going to be achieved.

Dr McKenna highlighted the Population and Wellbeing Strategy, and the opportunity for direct links to the digital strategy work. We need to be considerate on the list of projects and huge workplan that you mentioned in earlier item, which is a challenge to deliver.

A brief discussion was undertaken, and comments provided on the other strategies within NHS Fife & HSCP. How these links in with these and where we are? Can the definition of these strategies help to make the task of the revised digital strategy more simple.

A Graham noted comments and advised will review other strategies mentioned and look to align to these programmes.

A query was raised on the timescale for strategy and how quickly things can change. M Richmond advised it takes time to deliver on this objective. This will continue to be reviewed.

Further discussions were held, and it was agreed an offline conversation would continue. The Digital Strategy would become a standing item on the agenda to support and provide comments.

No other comments were made.

7.2 AI – Position Statement

A Graham advised item presented to Board to provide an update to AI and automation.

A Graham delivered a presentation and provided an overview noting the below:

- There is currently an AI Strategy for Scotland. We are aware how this can help Healthcare.
- We need to mindful on autonomous AI, e.g., Chat GPT. This can develop its own capability and can be unpredictable.

A Graham noted some bad examples of autonomous AI. However, where Applied AI can assist currently in e.g., Breast Screening and Cancer detection.

Regional and National support is being developed for AI Governance.

A brief discussion was held, and it was noted if conversation could continue offline where there could possibly assist with cost savings.

Item for **noting** only.

No other comments were made.

8 Business Cases / Proposals

8.1 GP Initial Agreement

M Richmond noted this paper is presented to Board for the initial agreement for GPIT and Order Comms.

A background was provided to paper noting we need consider this on a going basis. We were hoping to go to tender, but we unfortunately have one option as there is now only one provider.

A lengthy discussion was held on paper and a query was raised if this decision is with D&I Board. M Richmond noted this to be discussed within this Board and will then be taken to GP Sub Committee.

It was agreed this should be taken offline and further discussions with M Richmond and H Hellewell. This item should then be brought back to the next D&I Board.

Action – Add to next meeting as an agenda item. **CN**

9 Escalation to Clinical Governance Committee

A Graham noted the Back to Referrer update and the possible outcome to HEPMA.

Updates to the Digital Strategy provided to Clinical Governance Committee in the future.

No further comments were made. No requirement for escalation at this time to CGC.

10 AOCB

No other items were noted. Dr McKenna thanked all for their continuing good work and thanked all for attending.

11 Date of next meeting

Wednesday 18th October 2023,0900 via MS Teams

AREA DRUG & THERAPEUTICS COMMITTEE (Meeting on 21 June 2023)
No issues were raised for escalation to the Clinical Governance Committee.

Area Drug & Therapeutics Committee

CONFIRMED

MINUTES OF THE MEETING OF THE FIFE DRUGS AND THERAPEUTICS COMMITTEE HELD ON WEDNESDAY 21 JUNE 2023 AT 2.00PM VIA MICROSOFT TEAMS

Present:
Mr Ben Hannan (Chair)
Dr David Griffith
Ms Claire Fernie
Mr Fraser Notman
Ms Olivia Robertson
Ms Geraldine Smith
Ms Amanda Wong
Ms Doreen Young

In attendance:
Mr John Brown (item 7.4)
Ms Deborah Steven (item 7.6)
Mr Grant Syme (item 6.3)
Mr Duncan Wilson (item 11)
Ms Sandra MacDonald, Administration Officer (minutes)

ACTION

1 WELCOME AND APOLOGIES FOR ABSENCE

Mr Hannan welcomed everyone to the June meeting of the ADTC.

Apologies for absence were noted for Shona Davidson, Claire Dobson, Dr Iain Gourley, Dr Helen Hellewell, Dr Sally McCormack, Maxine Michie, Dr John Morris, Nicola Robertson, Rose Robertson, Andrea Smith, Satheesh Yalamarthi.

It was noted that the meeting was not quorate. It was agreed to progress with the meeting and circulate the minutes and decisions to members for ratification.

2 MINUTES OF PREVIOUS MEETING ON 26 APRIL 2023

The minutes of the meeting held on 26 April 2023 were accepted as a true record subject to ratification by the quorate Committee.

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 to liaise with the new professional secretary for the MSDTC to produce an action plan going forward. A one-page plan of action to include the timeframe for progressing this work to be brought to the ADTC meeting in August. **FN/AM**

Mr Notman also briefed the ADTC on progress with the transfer of information/guidelines previously held on the ADTC website onto Blink/Stafflink (ADTC and Medicines Information section).

East Region Formulary (ERF) - Transition to Website
Mr Notman advised that a guide on accessing the information on the ERF website is being produced by the ERF Team. This will be added to the ADTC and Medicines Information section on Blink/Stafflink and circulated to all stakeholders. Desk-top communication with links to the information is also proposed. The timescale for completion of this work is mid-July 2023. **FN**

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 provided a verbal update from the East Region Formulary (ERF) Committee and highlighted key points.

All adult chapters of the ERF have been reviewed. Review of the paediatric chapters is progressing (the Cardiovascular paediatric chapter has been finalised and approved by the ERFC; the Gastrointestinal and Respiratory paediatric chapters are being finalised for submission to the next ERFC for approval). The next paediatric chapter scheduled for review is the Central Nervous System. There has been good input from Clinicians and Pharmacists across the three Boards. It is anticipated that the review process will be finalised within the next 6-9 months.

The ADTC noted the update from the ERF Committee and the good progress made.

6.2 MSDTC

Written update from the MSDTC deferred to the August ADTC meeting. **SMcC/ AM**

6.3 Non-Medical Prescribing Oversight Group

Mr Grant Syme, Consultant Physiotherapist introduced the update report on behalf of the NHS Fife Non-Medical Prescribing (NMP) Oversight Group and highlighted key points.

The report outlined the background to the establishment of the NHS Fife NMP Oversight Group and development of the revised NMP Policy which was approved by the ADTC in February 2023. In order to assess the impact of introduction of the revised NMP Policy, a baseline assessment of the current NMP infrastructure and governance was undertaken. The ADTC noted the results of the baseline assessment. Areas for improvement have been identified and a 12 month delivery plan for taking forward key actions produced.

The ADTC noted the update report on behalf of the NMP Oversight Group. The ADTC was assured by the results of the baseline evaluation of the NMP Policy and was supportive of the ongoing work of the NMP Oversight Group.

7 SBARs/Updates

7.1 Medicines Governance Structure

Mr Notman introduced the SBAR Review of Medicines Governance Structure and took the ADTC through the proposed revisions.

The ADTC noted the revisions to the medicines governance structure including the addition of links to the Peer Approved Clinical System Tier 2 (PACS2) Panel, Shared Care Group and Fife Prescribing Forum.

The ADTC approved the revised medicines governance structure. Mr Notman to take forward communication/education around the medicines governance structure and process. **FN**

7.2 Valproate Audit and Improvement Plan

Mr Notman introduced the report - Valproate - Medicines Safety Programme and briefed the ADTC on the background to this.

The ADTC discussed the results of the re-audit undertaken in March 2023 and the proposed actions going forward including implementation of individual action plans where required and re-establishment of a multi-disciplinary Valproate group which will report to the Safe and Secure Use of Medicines Group.

The ADTC was assured by the actions being taken forward. It was agreed that a risk should be developed for inclusion on the ADTC risk register. To be brought back to the August ADTC meeting for discussion and consideration of next steps. **FN**

7.3 Melatonin Prescribing Update

Mr Notman provided a verbal update on melatonin prescribing. It was noted that an SBAR is currently being developed and will be brought to the ADTC for discussion at the August meeting.

The ADCT noted that the latest 12 month data available demonstrates that NHS Fife remains the third highest user of melatonin within NHS Scotland. The ADTC noted the update on progress with plans to review the initiation and ongoing prescribing of melatonin. The ADTC also noted the work ongoing in conjunction with Primary Care and Mental Health teams to implement a switch to a more cost effective generic melatonin product.

The ADTC noted the verbal update on melatonin prescribing. An SBAR to be brought to the August ADTC meeting with a clear timeline and implementation plan. **FN**

7.4 Progress in NHS Fife against SGHD/CMO(2019)4 National Guidance for Monitoring Lithium

Mr Brown provided an update on progress in NHS Fife against SGHD/CMO(2019)4 National Guidance for Monitoring Lithium.

The ADTC noted the proposals for a revision to the re-audit process to ensure that the highest risk patient group is captured in the first instance. Pharmacy teams are currently in discussion with locality General Practice teams to run a test of change and following this proposals for a Fife-wide audit will be submitted to LMC.

The ADTC noted the update on progress in NHS Fife against SGHD/CMO(2019)4 National Guidance for Monitoring Lithium. An SBAR with action tracker to be brought to the August ADTC meeting. **JB**

7.5 Prescribing in Renal Impairment (DOACS)

Mr Notman provided a verbal update on progress with establishment of safe systems for prescribing, review and monitoring of high risk medicines including Direct Acting Oral Anticoagulants (DOACs) in patients with renal impairment.

The ADTC noted the ongoing work in Primary Care to review patients who are on a DOAC medicine. The initial focus has been the review of patients with chronic kidney disease to ensure that they are on the appropriate dose of DOAC.

The ADTC noted the verbal update. An SBAR to be brought to the ADTC meeting in August. **FF**

7.6 High Risk Pain Medicines Guidelines Updates

Ms Steven introduced the SBAR High Risk Pain Medicines (HRPM) Guidelines Updates and briefed the ADTC on the background to HRPM programme and the process for development/refresh of HRPM guidelines.

The guidelines were developed in consultation with all relevant stakeholders who initiate and review HRPM within Fife to support practitioners to reduce inappropriate prescribing of long term pain relief medicines and potentially increase patient safety. The guidelines update and replace current Formulary guidelines and several additional quick reference guides have also been produced. Statements of practice have been developed based on the current evidence base and these set out a strong position statement from NHS Fife.

The ADTC noted the intention is to develop an over-arching guidance and agreed that it would be helpful to see this guidance in its final form. The ADTC also noted the requirement for standardised formatting of the guidance with the addition of appropriate review dates. The ADTC suggested that further consultation on ease of use of the guidance would also be helpful. The final version to be uploaded to the ADTC and Medicine Information section on Stafflink.

There was a discussion around the gabapentin and opioid patient information leaflets and it was suggested that consideration be given to strengthening of wording around limitations/patient expectations.

Following discussion the ADTC supported the recommendations outlined in the SBAR in principle and supported the proposals to progress as a test of change. The over-arching full guidance to be brought back to the ADTC in its proposed final format for noting. A separate SBAR relating to the HRPM statements of practice including evidence in support of the proposed approach to be brought to the August ADTC meeting for consideration. **DS**

7.7 Controlled Drugs Accountable Officer Annual Report

Ms G Smith introduced the Controlled Drugs Accountable Officer Annual Report and briefed the ADTC on the background to this.

The report was produced to provide an update on the work ongoing to ensure the safe and effective use of controlled drugs (CD's) within Fife and give assurance with regard to operation of responsibilities of the Controlled Drugs Accountable Officer.

Ms Smith took the ADTC through key aspects of the report including results from the annual ward audit which is undertaken jointly by a member of the nursing team and a pharmacy professional to assess compliance against procedural requirements for CDs; destruction of CDs; monitoring of CD prescribing across Fife; reporting and learning around CD related incidents reported via Datix; and updates from the Controlled Drug Local Intelligence Network and the East Region Controlled Drug Intelligence Network.

The ADTC noted the Controlled Drugs Accountable Officer Workplan priorities for the next 12 months including review of the inspection model for GP practices and re-commencement of inspections; development of additional tools to support staff; and the launch of medicines safety workshops, the first of which will be an oxycodone/morphine video. The ADTC also noted the update to the previous workplan developed in October 22.

Amendments to the report were noted to update reference to the Portfolio Board which is no longer operational. A revision to the formatting/readability of the action plan to also be considered.

The ADTC noted the Controlled Drugs Accountable Officer Annual Report May 2023, the workplan for the next 12 months and the update from previous workplan developed in October 22. The updated report to be submitted to the Executive Directors Group, Clinical Governance Committee and Area Pharmaceutical Committee in due course.

7.8 Adult Primary Care Antibiotic Guidance

Dr Griffith introduced the Adult Primary Care Antibiotic Guidance and highlighted the changes made including adjustments to dosages. The updated Guidance has been discussed and agreed by the Antimicrobial Management Team.

The ADTC approved the updated Adult Primary Care Antibiotic Guidance.

8 Risk Register

Mr Notman highlighted the revised template for presenting risks and took the ADTC through the risks scheduled for review.

Risk 1504 - Lack of a Central IT Location to Store Guidance Documents
Discussed under agenda item 3. The ADTC was content with the actions and agreed that the current RAG status should remain.

Risk 1621 - Medicines Shortages
The ADTC was content with the actions and agreed that the current RAG status should remain.

Risk 2304 - East Region Formulary
Discussed under agenda item 6.1. The ADTC noted the actions taken to transfer guidelines previously hosted on the ADTC website onto Stafflink and the proposals for hosting public facing information on the NHS Fife website. A recovery plan to be brought to the August ADTC meeting. **FN**

Risk owner to be updated to Mr Hannan for all ADTC risks. Actions by ADTC to be described and RAG status to be used in terms of likelihood, probability and target. **FN**

9 ADTC-COLLABORATIVE/SCOTTISH GOVERNMENT COMMUNICATION

9.1 Cancer Medicines Outcome Programme (CMOP) End of Phase 2 Progress Report

The ADTC noted the CMOP End of Phase 2 Progress Report.

10 EFFECTIVE PRESCRIBING

10.1 National Cancer Medicines Advisory Group (NCMAG) Programme Overview

The ADTC noted the NCMAG Overview of Programme and Summary of Published Outputs.

10.2 NCMAG 108 Vinorelbine

The ADTC noted the NCMAG 108 Vinorelbine Advice Document.

11 HEPMA Update

Mr Wilson provided a verbal update on the current contractual position and progress with electronic prescribing and the implementation of HEPMA.

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 to the Clinical Governance Committee.

14 ANY OTHER COMPETENT BUSINESS

There was no other business.

Other Information

a **Minutes of Diabetes MCN Prescribing Group** 13 June **2023**. Not available.

b **Minutes of Heart Disease MCN Prescribing Sub-Group 20 April 2023.** For information.

c **Minutes of Respiratory MCN Prescribing Sub-Group 18 April 2023**. For information.

d **Date of Next Meeting**
The next meeting is to be held on **Wednesday 16 August 2023 at 2.00pm via MS Teams**. Papers for next meeting/apologies for absence to be submitted by 2 August.

QUALITY & COMMUNITIES COMMITTEE

Meeting on 3 May 2023

No issues were raised for escalation to the Clinical Governance Committee.

Quality & Communities Committee

Fife Health & Social Care Partnership

Supporting the people of Fife together

CONFIRMED MINUTE OF THE QUALITY & COMMUNITIES COMMITTEE
WEDNESDAY 03 MAY 2023, 1000hrs - MS TEAMS

Present:	Sinead Braiden, NHS Board Member (Chair) (SB) Councillor Rosemary Liewald Councillor Graeme Downie Councillor Lynn Mowatt Ian Dall, Service User Rep, Chair of the PEN (ID) Morna Fleming, Carer's Representative (MF) Paul Dundas, Independent Sector Lead (PD) Kenny Murphy, Third Sector Representative (KM)
Attending:	Dr Helen Hellewell, Deputy Medical Director (HH) Nicky Connor, Director of Health & Social Care (NC) Lynn Barker, Director of Nursing (LB) Fiona McKay, Head of Strategic Planning, Performance & Commissioning (FMcK) Lynne Garvey, Head of Community Care Services (LG) Lisa Cooper, Head of Primary Care and Preventative Care Services (LC) Catherine Gilvear, Quality Clinical & Care Governance Lead (CG) Simon Fevre, Staff Side Representative (SF) Nicola Harkins, Acting Snr Manager, Clinical Learning Disabilities (NH) Vanessa Salmond, Head of Corporate Services (VS) Jo Bowden, Consultant Palliative Care (JB)
In Attendance:	Jennifer Cushnie, PA to Deputy Medical Director (Minutes)
Apologies for Absence:	Councillor Sam Steele Councillor Margaret Kennedy Dr Chris McKenna, Medical Director Ben Hannan, Director of Pharmacy and Medicines Roy Lawrence, Principal Lead for Organisational Development & Culture Rona Laskowski, Head of Complex and Critical Care Services Christine Moir, Head of Education and Children's Services (Children and Families/CJSW and CSWO)

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 18 JANUARY 2023 AND 10 MARCH 2023** SB advised, there are two sets of minutes for approval - the Minutes of the meetings held on **18 January and 10 March 2023.** As the meeting on 10 March was not quorate, the minutes from 18 January 2023 could not be approved. It was noted, however, no changes were requested at the meeting. The previous minutes from the Q&CC meeting on 10 March 2023 were reviewed and no alternations or corrections were requested. Both sets of minutes were taken as an accurate record of the meetings.	
5	**ACTION LOG** NT gave an update relating to the MH Services report specifically looking at benchmarking. She explained, this is an exercise involving all NHS Boards in Scotland, through the MH Leads Network. Potentially helpful models have been identified. She also advised of a HSCP benchmarking family which has been identified with a wider partnership, including several regions. Aim is to provide a report to Committee. Cllr Liewald queried if there was an update re Cllr Steele's query re men who had not completed the Calendonian Programme. SB will follow up with HB for an update.	**S Braiden**
6	**GOVERNANCE**	
	6.1 Palliative Care Transformation The report is presented by Lynne Garvey who is joined by Dr Jo Bowden and Karen Wright to support. The paper is brought to Committee for **Discussion and Agreement.** The Committee are asked to consider and discuss the proposal and take assurance that the model supports quality clinical care in a local setting and has been informed through performance and	

	engagement with staff, people and families in palliative care and the wider public. LG advised of the route to the meeting the paper had taken - SLT, Executive Directors Group and IJB Development Session. She wanted to give some facts around Palliative care. Currently 80% of Fife Specialist Palliative Care Service budget is allocated to specialist in-patient palliative care, just 4% of Fife population die there. She advised HSCP wanted to look at the Service and commissioned an independent evaluation of palliative care which was prompted by new national and local strategic focus, focusing on palliative care to all, understanding care delivery was inequitable with significant unmet need. LG stated, in April 2020, Fife Palliative Care Collaborative was established with an integrated forum with representation across all sectors. The main focus was to lead improvement work in response to the independent review. LG advised, the paper will describe how the clinical service model of palliative care is being delivered in response to local and national recommendations. Also, supports a decision being made to address the permanent re-provision of palliative care in Fife and to enable the IJB to reach a decision so services can continue to deliver high quality, person centred, best value care to the people in Fife. LG referred to the impact of Covid where resources had to be reconfigured very quickly – a prof-prof line was offered, and the public expressing a preference for home-based, rather than the in-patient care, which resulted in a very underutilised hospice. From a strategic perspective, the new model is closely aligned to the Health & Wellbeing Strategy, the Carer's Strategy, Scottish Government Palliative and End of Life Strategy, currently in development. LG felt it was important to state, having had the chance to deliver the enhanced model for the past 3 years, she was bringing it today with confidence and evidence it is absolutely the correct thing to do for the people of Fife. LG highlighted several key facts and figures from the paper, including hospice beds not being utilised, fewer admissions to hospital and significantly fewer days in hospital beds, where treatments are being delivered at home. LG read out positive quotes from carers and patients, however, assured the service is clinically led and referred to assurance from Executive Directors of Medicine and Nursing, also the Director of Psychology. In terms of workforce, there has been Staff-Side support introducing the new way of working. Financially, best-value is evidenced, as well as better quality of care. Patient choice and the various options made available to the people of Fife with specialist support was outlined. LG stated it is not financially sustainable to delivery both models of palliative care and	

	it is evidenced, if there were two hospices, there would be many empty beds. LG referred to the EQIA, robust communication, engagement and consultation and feedback indicating the new model is wanted by the people of Fife. She stated, with every change of delivery comes a degree of risk, however, she felt the model offers high assurance the model is right and referred to evidence within the paper. Dr Bowden added, figures this week indicate, non-cancer support is one in three, a year-on-year increase which is important when talking about equity. Questions were invited. Cllr Liewald fully supported the work and felt it was impressive the degree of research and engagement with the community. She was very pleased to see the Service is being delivered across the whole of Fife and told of feedback she has personally received from community members. Cllr Downie thanked LG for the presentation, he voiced concerns and did not feel assured by the quotes referred to. He stated his biggest concern with the paper was too many times he was hearing, "early stages, things will be worked up by the time they go to IJB, we are waiting on Scottish Government Strategy, assuming we will be in line with that, it's not about money" he did not feel assured in a number of ways. He agreed choice should be offered to people to die closer to home. He felt the model is not quite ready to go to IJB, a lot of work and consultation still to be done. He advised he will attend one of the Q&A drop-in sessions which have been arranged. S Fevre commented on the robust staff engagement with the workforce, he stated the number of people coming to the staff engagement events is becoming less and less which he felt indicates there are less and less issues and questions from the workforce. He queried Appendix 1, where there are 'dedicated general palliative care beds' in St Andrews and the Adamson, however, they are not described the same in other hospital, he queried the difference in terminology. Ian Dall was very supportive. Morna Fleming was also supportive and very impressed by what has been taking place and was reassured it was a test of change involving the whole system. She was concerned the removal of the hospice is seen as a negative rather than this is replacing a hospital situation to an at home situation. She advised there is a huge communication job to be carried out with the public as, she felt, they will only see the hospice is closing. Paul Dundas gave his support for the paper and the team. He was keen to keep the role and purpose of care homes alive in thought, in terms of what HSCP will be looking to do for those living in a care home at such a time.	

		Nicky Connor acknowledged the different perspectives being heard, the support and the concerns, as outlined by Cllr Downie. She recognised Cllr Downie would be attending an IJB drop-in Q&A session which will be used to go into further detail. She advised there was no financial saving being made with the model and stated the paper will also go to the Finance, Performance & Scrutiny Committee. Balance of the resource has been looked at and noted, the vast majority goes to in-patient settings where only 4% of people die. She referred to the model being clinically led and championing by senior clinical staff advising the service needs to change. NC advised she is on the National Group re the Palliative Care National Strategy. She answered the reference to a positive slant being placed on feedback – lots and lots of questions have been asked over a prolonged length of time. NC referred to ambulance and volunteers and gave assurance transport is available and will be enhanced further. She felt through listening to feedback, the Service can be made even better. Re Communication, there is close work with the comms team around press releases and the website people are being directed to. NC stated, in different hospitals in different parts of Fife, HSCP deliver services for the whole of Fife, addressing concerns the hospice in Kirkcaldy will be for the whole of Fife, this is the case for specialist services which are delivered in different hospitals within different part of Fife. She was very happy to answer any other questions. Dr Bowden was grateful for all the supportive comments but also acknowledged there were concerns. She advised she knew 18 months ago there would need to be wide canvassing for feedback, all district nurses and GPs in the Fife were surveyed and very useful feedback was received. Equity of delivery was demonstrated, working with PH List analysists to look at objective data which demonstrate this. She referred to research involving families dealing with bereavement and felt it was incredibly important to let public into decision making, all about caring for the population. She told of members of public who have come to Q&A sessions with real concerns which have been satisfied and stated there has been overwhelming support. SB asked Cllr Downie if he was reassured at all. Cllr Downie appreciated all the work which has gone into the model, he was concerned around the process which brought us to this point, he queried the consultation and engagement, could not get to a place he was comfortable. He will attend a Q&A drop in session. Ian Dall told of a personal experience where close friends had died during the past 18 months and benefitted from the new model of care. He advised the families of the people who died, had given very positive feedback. He hoped his story would alleviate some of Cllr Downie's concerns.	

	Cllr Downie thanked Ian for sharing his experience and spoke of the subject of choice and the possibility of people changing their preferences. Dr Bowden responded to Cllr Downie's concerns regarding people changing their preferences as their illness progresses, she advised rolling conversations take place to understand what is important for the patient. She advised it is very common for a patient's preference to evolve/change in late stages. LG wanted to add she was happy Cllr Downie would be attending a Drop-In session as concerns can be fully addressed there. She answered SF's query re names on Appex 1, NE Fife beds are GP beds, not part of a community hospital MOE based model, however, both same quality of service. SF queried how this is operationalised and accessibility. Dr Bowden advised there is now great clarity around who looks after which beds and explained fully. SB rounded off by saying she felt it was an excellent example of transformational change, person centred and tailored to meet the people of Fife. She stated the Committee, as a whole, were happy to recommend the paper to the IJB, noting the concerns of Cllr Downie which have been minuted. She asked if the Committee were happy with this proposal, it was agreed they were.	
	6.2 HSCP Locality Planning 2022/23 FMcK was very pleased to introduce the report on the Locality progress which she felt is close to people's hearts working in the community and she stated, the SLT have embraced the work which has been taken forward through the Localities. She advised the report was taken to the 7 Area Committees, with a lot of positive feedback received. FMcK spoke of the SLWGs which are supporting people in a preventative way and referred to the 2 case studies which give feedback from the work taking place at The Well and Link Life Fife. She recognises The Well is taking up a lot of numbers, despite it being only an 18hr/week service. FMcK commented positive feedback has been concise but she also recognised there are also negative impacts, mainly around resources. She told of stumbling blocks re DPIAs and ensuring data is secure, which has taken a bit of time. A regular report will come to Committee giving an update around Localities. Questions were invited. Cllr Liewald was delighted to see the increase in work throughout Localities. She commented some pieces of work which were trialled are now being emulated throughout Fife. NC asked if a timeline has been committed to bringing back updates from	

	Localities. FMcK was keen to bring news from the Area Committees, approximately every 6 months or more often should there be significant pieces of work to share. NC agreed this was suitable. The Committee were content to recommend the report to IJB which was presented for assurance and discussion.	**F McKay**
	6.3 Commissioning Strategy 2023 – 2026 incl Market Facilitation and Delivery Plan 2023-26 FMcK introduced the report and asked the Committee to understand there are legal requirements for commissioning contracting. The paper comes from the Strategic Plan and sets out how the work will be taken forward. Technically, HSCP must ensure all of their contracts are covered, incl National Care Home Contract, Care at Home Contract, all areas which are contracted and all the areas which HSCP fund through a Service Level Agreement, which is predominantly Third Sector Organisations. FMcK told of work which has taken place to technically ensure this is correct, engage with people whom HSCP current contract with and have Service Level Agreements with, she felt confident the work which has been brought forward to ensure this is correct and people understand the technicalities. This will be part of the return to Scottish Government as a facilitation and commissioning strategy which links to the Strategic Plan. Questions were invited. Paul Dundas wanted to thank Fiona and her Team for the paper and the Strategy itself. He wanted to draw upon the focus the team have placed on relationships which he felt was key. He spoke of the excellent engagement work which has taken place. FMcK wished to raise for awareness, the National Care Home Contract has not been agreed by COSLA or Scottish Care and is currently in dispute around funding. There is an interim position in place where an increase has been made to the National Care Home Rate, this is to cover the National Living wage. She advised, COSLA are still in negotiations with the care home providers. If a position cannot be reached, a local arrangement will be made which HSCP have taken legal advice on. She stated, this is not something we wish to do, which she explained. The paper was discussed and feedback was taken from the Committee. The Committee were happy to recommend the paper to the IJB	
	6.4 Advocacy Strategy FMcK stated the report brought to Committee is a renewal of the Advocacy Strategy. She advised, there is a contractual position under the Advocacy Strategy, where under the Mental Welfare Commission Act, there must be independent advocacy. A contract for this goes out for tender every 3 years. FMcK told of a range of independent advocacy organisations which have been	

	consulted with around the new Advocacy Strategy, throughout the process People First have worked to get views, supporting the work. FMcK referred to the detail in the report which outlines the work requirements. The strategy also covers children, which is required for children in the Health services and also Education and Children and Families. Update NHS' advocacy report, HSCP and Acute, so all signed up to the same process, a lot of detail within the report. Questions were invited. Cllr Liewald was delighted to see the report and commented on the depth of detail. She queried translations and cultural awareness, and asked what support and feed in is available. FMcK advised HSCP link in with Fife quality groups who are fully supportive, also link with Fife Islamic Centre and Asian organisations through work to support EQiA, thus ensuring the correct format is used. A translator can be made available or Apps used to translate using a mobile phone. Circles network is used for formal advocacy. No questions were asked. The Committee were content to recommend the paper to the IJB.	
	6.5 Collaborative Support for Care Homes LB introduced the report to Committee for assurance and discussion. She advised, following guidance from the Cabinet Secretary for Health and Sport in May 2020, all Health & Social Care Partnerships were directed to provide **"**Enhanced Clinical Professional and Care Oversight**"** to Adult Care Homes. This included responsibility and oversight/assurance of the Care Homes management during the CoVID19 pandemic. LB stated, the report gives an update on the current work and continuing support provided to Care Homes in Fife, considering key national documents and policies which underpin the work streams and direction of the Care Home Liaison Team (CHLT). The report also provides information from Contracts and Commissioning around the monitoring of performance and quality of all care homes in Fife. LB advised, the guidance set out 2020 was viewed under a differently focused lens and updated guidance was Issued by Scottish Government December 2022, providing NHS Boards with a vision and recommendations for future ways of working with the Care Home Sector. LB outlined the various recommendations. LB advised, Head of Nursing, Shona Adam, is working with FMcK and PD across Fife to implement the recent framework and told of close contacts to the National Group and she felt confident Fife are at the forefront of this work. FMcK told of close working with the care homes and was supportive of bringing the report to Committee for assurance. PD	

	wanted to take the opportunity to thank Lynn, Fiona and their Teams for how oversight has been managed in Fife and how this has been very successful, including the move through the transition. He welcomed the good use of language in the report around a 'collaborative improvement approach'. He felt there was a risk in the letter from Scottish Government asking for a 'continuous improvement approach' be employed which would give risk to confusion to the role of the Regulator and also where the continuous improvement agenda of the Care Inspectorate will sit. He felt there was a risk around the lack of funding Nationally and availability to pay locally is a risk to the ongoing relationship of trust, should the pressure be ongoing with care homes, through the voluntary way of working, at a time when financial sustainability is at risk. He spoke of the problems around the National Care Home Contract. PD told of meetings with all provider organisations to strengthen relationships through collaborative working. He felt it would be helpful to see the fullness of the spend locally. Also the SLWG models of care for care homes, he asked LB if he could discuss re-establishing this with her. LB will take offline. SF stated he could not see within the report 'allied health professional' he asked if this is not part of it. LB will take on board and will be included in the report. Support and assurance taken from the work and quality around care homes. Report to come back to Committee after review.	**L Barker** **L Barker**
	6.5 Q&CC Annual Statement of Assurance SB introduced the Q&CC Annual Statement of Assurance. She handed over to NC who advised the Paper is part of the assurance process to Committee. She highlighted, this year's report refers to the establishment of the Quality & Communities Committee. She recommended the date of when this happened should be added to the report (05.07.22), to explain when the Committees transitioned from one into the other and to explain the variance in attendance. NC explained, in the report there is not only a list of agenda items, but also narrative to draw out the areas the committee has discussed. Going forward, NC recommended this is themed, so it is clear what the discussions relate to, ie carers, delayed discharge, etc highlighted in bold, to make it very clear at a glance, the range of items which have been discussed and when/if items are to come back to committee. As a commitment to ongoing quality improvement, NC felt there is further work which can take place for next year's Assurance Statement, both regarding the workplan, the agenda items being covered and how this has been implemented and referenced within the assurance statement.	

	NC asked the Committee, if the Assurance Statement reflects what was discussed last year and does the committee feel, on the basis of this, can SB, on behalf of the committee, sign off the Assurance in terms of the work carried out, recognising there has been a change mid-year and we continue to embed the new Quality & Communities Committee. NC asked to highlight one of the main benefits of the change of Committee was a wider membership of the IJB being and the value received from this. There were no questions asked. The Committee was happy to approve. NC advised the Paper will now go to Audit and Assurance to give assurance to IJB for delivery of governance.	
	6.5 H&SCP Operational Assurance and Clinical Care Governance Framework NC wanted to highlight the key matter to doc at the meeting is the development of the Clinical & Care Governance Framework, which this committee will be commissioning, on behalf of the discussion today. LB introduced the report. She asked the Committee to recommend there are established operational governance and assurance mechanisms in place within HSCP with mechanisms for reporting the governance arrangements of IJB, NHS Fife and Fife Council and robust professional reporting lines to the Medical Director, Nurse Director and Chief Social Work Officer. Also, wide range of clinical and care governance matters were considered through the Clinically and Professionally led QMAG in 2022/23. The further development of the Q&CC work plan will strengthen the forward planning or reporting arrangements. An annual report will come to Committee to enable oversight of these arrangements. LB also stated work is being progressed to develop a clinical and care governance framework in line with the Integration Scheme which will further strengthen governance and reporting to the Q&CC. This report will come to Committee in November 2023 for approval to the IJB. No questions were asked. The Committee took assurance from the paper.	
7.0	**ITEMS FOR ESCALATION** No items for escalation.	
8.0	**AOCB** No further business raised.	
9.0	**DATE OF NEXT MEETING –** Friday 30th June 2023, 1000hrs MS Teams	

Information Governance Security & Steering Group (Meeting on 24 July 2023)
No issues were raised for escalation to the Clinical Governance Committee.

NOTE OF THE INFORMATION GOVERNANCE AND SECURITY STEERING GROUP HELD ON MONDAY 24TH JULY 2023, 1000, VIA MS TEAMS

Present:

Chair - Margo McGurk	Director of Finance & Strategy/ Deputy Chief Executive
Alistair Graham	Associate Director Digital & Information
Susan Fraser	Associate Director of Planning and Performance
Helen Hellewell	Associate Medical Director
Janette Keenan	Director of Nursing
Frances Quirk	Assistant RIK Director
Audrey Valente	Chief Finance Officer on behalf of Director of Health & Social Care
Duncan Wilson	Lead Pharmacist on behalf of Director of Pharmacy & Medicines

In Attendance:

Andy Brown	Principal Auditor
Michelle Campbell	Primary Care DPO on behalf of Head of Information Governance & Security / DPO
Gillian MacIntosh	Head of Corporate Governance
Allan Young	Head of Digital Operations, Digital & Information
Claire Neal	(Minute) PA to Associate Director, Digital & Information

Apologies:

David Miller	Director of Workforce
Claire Dobson	Director of Acute Services
Joy Tomlinson	Director of Public Health
Sharon Mullan	General Practitioner
Kirsty MacGregor	Associate Director of Communications
Dr Chris McKenna	Medical Director
Brian McKenna	HR Manager
Elizabeth Gray	Patient Relations Officer (on behalf of head patient relations)

1 CHAIRPERSON'S WELCOME AND APOLOGIES

M McGurk welcomed everyone to meeting and apologies were noted.

2 MINUTE & ACTIONS OF PREVIOUS MEETING 11th April 2023

Minutes were reviewed and agreed they were a true record and actions were discussed and updated accordingly.

3 MATTERS ARISING

3.1 ICO Audit – Action Plan

A Graham noted paper has been shared and item brought back to Group to provide an update to the action plan from the ICO Audit. The actions have been incorporated into the Assurance Report.

This audit was conducted in March and a number of stakeholders were involved. Actions are continuing to be dealt with and this is a combination of work already undertaken over the last 2 years.

M Campbell provided an update to Group noting they were not surprised by any of the findings received and some of these were on the to do list but due to workload these haven't been either commenced or completed. The project plan supports the work plan that is already ongoing within IG&S, and we are hopeful the timescale will be met.

M McGurk thanked for informative paper and noted within the last few months there has been the establishment of a national SIRO Network to help support understanding of the SIRO role

and its function. Two meetings have been coordinated by Scottish Government and these meetings are looking to discuss items of interest. M McGurk provided a brief overview to these meetings, and noted they would be keen for further offline discussions with M Campbell and A Graham on what to provide. M Campbell noted happy to assist in any they can.

A Graham advised that ICO would normally publish any ICO findings on their website for individual Boards but for NHS Scotland this was being amalgamated into a single report.

No other comments were raised.

It was noted this paper was provided as an update, which will continue at future meetings.
Assurance can be taken.

3.2 Information Asset Owner

M Campbell introduced paper and provided an overview:

- M Michie has joined the business and they are collating an Information Asset Register. We didn't have a register before, and this is focusing on the Digital assets.
- There has been engagement with many departments and are all responding well. The only department we are struggling with is Acute and Planned Care, but we are aware of the pressures these services are under so this is understandable.
- We are in a stronger position than last year, and we are continuing with our Records Management and Business Classification Scheme.

M McGurk thanked and noted this clearly links in with previous item discussed. Great to see progression.

A Graham advised this had been discussed with EDG members and this is a significant task to undertake for departments, so we are considering different ways to engage and how we approach. Work will continue with departments.

M McGurk queried if this also covers the Partnerships. M Campbell confirmed this does and is going well with HSCP.

No further comments were raised.

Assurance was taken from the progress.

4. Risk Management

4.1 Risk Management Report

A presentation was delivered by A Graham noting at the previous meeting a new tolerance arrangement was agreed this report is to provide an update.

An overview of report was provided, some of the points are listed below:

- There are currently 26 risks. With the initial Risk level, 18 high, 8 moderate, and 0 low. We are actively managing these risks and some risks have met their target rating.
- 10 risks have improved their risk, and none have deteriorated.
- Risk 1500, limited change with this risk. This mitigating action plan has been delayed to August, due to the changed timetable for NIS Audit.

A Young provided a brief update to NIS cycle noting the final result will be provided end of August and this will then inform going forward. Any findings will follow at next meeting.

A Graham noted an update to the risk profile categorisation with the new agreed tolerance statement. We have combined and categorised all risks for IG&S and D&I. Work is continuing to mange risk.

M McGurk thanked for the update and noted they like how this is presented and would like to see this format and reporting in other NHS Fife meetings. Also noted the impact on a Cyber event and can this ever not a high risk due to the impact and impact to the business.
Action – Presentation to be sent to Group. **CN**

No other comments were raised.
Assurance noted for this item.

5 Information Governance and Security Assurance and Accountability Framework

5.1 IGSAAF – Structure

A Graham shared presentation and provided an overview noting the below:

- Work has been ongoing to create this framework over the last 3 years.
- A review of the ICO Accountability and the NISD/Cyber Resilience Framework has been undertaken.
- Within this Framework, there are two separate sections – Executive Summary and Performance Assessment Reports.
- These are then broken down further into 4 other sections.

A Graham provided a highlight to each of these additional 4 sections. We advise on any improvement actions required to these. When the NISD results are provided we will understand the actions and will also implement these.

No comments were raised, and continuation of item is discussed below.

5.2 IGSAAF Report

Presentation was delivered by A Graham and provided feedback to the report.

The report will be broken down into several categories. A Graham provided a highlight to a few of these categories.

- Executive Summary – This section will provide a summary of these indicators.
- Frequency Reporting and their categories.
- Performance Summary – This will highlight the monthly measures.
- Risk Rating and tolerance levels.
- Key Milestones – once report available this will allow key milestones.

A discussion was undertaken, and it was noted this report will continue to develop and will be able to detail the ongoing improvement. A query was raised if anything in the report a statement on assurance levels could be incorporated.

A Brown noted they like the format of this document and appreciates the ongoing work which has been ongoing for the last three years and is continuously evolving. This report is providing good assurance and highlights the ongoing work with NIS and ICO. A Brown queried if this report was included in the feedback to ICO or NIS. A Graham replied this was included in the NIS Audit but not ICO due to timings.

M Campbell highlighted the similar assurance work onoing within GPs. A brief discussion was held, and it was queried with H Hellewell where this should be presented. It was noted possibly the Primary Care Oversight Group, but they will have an offline conversation for further discussions. M Campbell provided feedback on how they are engaging with GP Practices and this Framework.

No additional comments were noted.

A Graham provided feedback to the second section to report, Performance Assessment.

A brief summary was provided to the individual sections and explanation of the colour categorisation. A highlight of a few of these listed below:

- Leadership and Oversight.
- Policies and Procedures - NISD highlights a number of polices due for review.
- Training and Awareness - ICO has asked for specific training to job role rather than standard mandatory training. Work will continue to review this.
- SARs – Work is continuing with Subject Access Requests (SAR's) and a Single Point of Contact (SPOC) has been established. The use of an electronic system titled AXLR8 being used and ongoing work with Department to implement. Specific discussions continue with Legal Services to support their adoption.

A query was raised on our training compliance, how does this compare to other training and is it just IG training. A Graham replied this is comparable with other mandatory training. There are categories that are targeted, and this is on an upward trajectory.

A discussion was held on target level, and it was noted a possible deadline date or provide an example of the trajectory would be a good addition to the report. What a reasonable target could be? It was noted the use of green within report possibly signals good where it isn't. Conversation to be taken offline to discuss further.

A Graham also noted continuing work with Records Management, a highlight report will be presented to IG&S Steering Group to advise on the progress.

ICO has asked in the report to be clear on the incident reporting within 72 hrs. Work is ongoing within DATIX to ensure such items are clear for rapid investigation and to ascertain these incidents.

A Graham noted that each section could possibly have an assurance statement. M McGurk advised this would be good to have an executive summary so this could be presented to Clinical Governance Committee. It was noted the Assurance Framework could be taken to the CGC in August.

Action – Identify target levels. **AG**
Action – Assurance statement to CGC. **AG**

No comments were raised

6. DOCUMENTS FOR APPROVAL/COMMENTS

No items within Agenda

7. ITEMS FOR ESCALATION TO CLINICAL GOVERNANCE COMMITTEE

It was noted the improvement and Assurance Framework to be taken to CGC in August.

8. AOCB

No other items were advised. M McGurk thanked all for their hard work and the clear and concise ask within these papers. Thanks were provided for attending meeting.

9 DATE OF NEXT MEETING:

10th October 2023,0900 via MS Teams

MEDICAL DEVICES GROUP

(Meeting on 14 June 2023)

No issues were raised for escalation to the Clinical Governance Committee.

Medical Devices Group

Minute Medical Devices Group
Wednesday 14 June 2023 at 2 pm on Teams

Present

Neil McCormick, Director of Property & Asset Management (NMcC) (Chair)
Amanda Wong, Director of Allied Health Professionals (AW)
Donna Galloway, General Manager, Women Children & Clinical Services (DG)
Iain Forrest, Medical Physics Manager (IF)
Julia Cook, Infection Control Manager (JC)
Maxine Michie, Deputy Director of Finance (MM)
Claire Steele, Head of Pharmacy Medicines Supply & Quality (CS)
Kevin Booth, Head of Financial Services & Procurement (KB)

In Attendance

Richard Scharff, Radiology Clinical Activity Manager (RS)
Doreen Young, Head of Practice & Professional Development, Nursing Support (DY) for Nicola Robertson, Director of Nursing
Elizabeth Muir, Clinical Effectiveness Manager (EM) (joined at 2.25 pm)
Miriam Watts, General Manager, Directorate Office Emergency (MW) (left early - called away)
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, Chris McKenna, Alistair Graham, Aylene Kelman, Nicola Robertson (Doreen Young), Murray Cross, Jane Anderson.	
2	**MINUTE OF LAST MEETING/MATTERS ARISING** The Minute of 8 March 2023 was **approved** by the group.	
3	**GOVERNANCE**	

	3.1 Clinical Governance Committee (CGC) Meeting of 5 May 2023 Medical Devices SBAR & ToR - update Following approval at EDG, an updated Terms of Reference (ToR) was discussed at the CGC meeting on 5 May 2023 to effectively seek approval for the Medical Devices Group to sit under the CGC. The Capital Equipment Management Group (CEMG) focuses on capital spend in terms of the procurement of equipment on an annual basis. The Medical Devices Group is responsible for setting the policy around medical devices and should be clinically led. From previous discussions, the definition of medical devices is wide and ranges from implants and walking aids and software used in relation to the treatment and diagnosis of patients. The agreed definitions are included within the ToR. There are several links between the Medical Devices Group and FCIG in terms of funding priorities, however, the main purpose of the Medical Devices Group is to set the policy and for the CEMG to submit Business Cases and invest in capital equipment. The Medical Devices Group ToR is a good starting point in the process; however, it will need to be updated periodically due to regular policy developments and updates from Scottish Government. As the Medical Devices Group becomes more established, the group **agreed** to re-submit the ToR to the CGC to give a more comprehensive update when we will have a better understanding of the work that is being carried out and how we take this forward. 3.3 GP/E4-01 Medical Physics Operational Procedure Now **complete** and published on Stafflink. 3.4 GP/I4 Digital Solutions Procurement Policy Now **complete** and published on Stafflink.	
4	**FOR DISCUSSION** 4.1 Developing an Action Plan following NHS Fife's Review of Medical Equipment Management The group **agreed** to build a Medical Devices Policy Framework into its Action Plan. A discussion followed on Equip the new equipment database:	

	• Existing data will be transferred over from Micad to Equip. • Each piece of medical equipment will have a unique identifier. • 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. • VHK site initially then consideration will be given to extending to other sites. • Scan for Safety will then be implemented over time whereby a patient will be linked to every piece of equipment used in treatment and will allow us full traceability. • If medical equipment or a medical device is withdrawn, we can identify which patients were tagged to that specific piece of equipment or device. • This will eventually link to the RFID system allowing us to share and track equipment. • The unique identifier can be used across the UK and National Services Scotland (NSS) will have the ability to view data across all Boards. • This will result in better control around 'end of life' equipment for replacement purposes and will give NHS Fife an opportunity to make cost savings by being more efficient around purchasing. • It will allow NHS Fife to be more in tune with other Boards in Scotland allowing us to be more receptive around brands, types and particular issues that may arise. Medical Equipment Management System The Medical Equipment Management System will have medical equipment which requires maintenance, servicing, or repair. The Medical Equipment Management System is a sub-part of the Scan for Safety System. Scan for Safety System The Scan for Safety System will look after implants etc.	
5	**FOR INFORMATION** 5.1 SB27-ISON Developing a MD Policy Framework & Action Plan SB27-ISON Developing a MD Policy Framework & Action Plan was circulated and **noted** by the group. This will mirror NHS Fife's MD Policy Framework & Action Plan. 5.2 MHRA Future MD Regulation: GAP Analysis Survey (SB39) on In-house Manufacture of Medical Devices MHRA Future MD Regulation: GAP Analysis Survey (SB39) on in-house manufacture of medical devices was circulated and **noted** by the group.	

	It is important for NHS Fife to identify any equipment which is deemed to be modified in any way, shape or form. To date, equipment has been checked with Estates colleagues. Digital codes, through D&I will require to be checked. Medical clinical specialities will require to be checked. Consideration to be given to Orthodontics, Dental and Thermoplasty amongst others. **Action** – The group **agreed** for several members to meet to discuss in further detail with a view to completion.	**NMcC/IF**
6	**MINUTES FOR NOTING** 6.1 (a) Capital Equipment Management Group minute of 2 March 2023 was circulated for information and **noted** by the group. 6.1 (b) Capital Equipment Management Group minute of 4 May 2023 was circulated for information and **noted** by the group.	
7	**ANY OTHER BUSINESS** 7.1 NHS Fife Point of Care Testing Committee The Point of Care Testing Committee Minute (01.03.23) was circulated and **noted** by the group. In respect of sharing awareness and for noting point of care testing equipment as it is introduced across the organisation, Elizabeth Muir, Clinical Effectiveness Co-ordinator has requested Point of Care Testing Committee Minutes be added as a standard agenda item (for noting) at Medical Devices Group meetings. A discussion followed and the group **agreed** to this request. Medical Equipment in Community and Primary Care Settings The group **agreed** that future consideration will be given to the management and identification of equipment in these areas with particular emphasis on equipment purchased out with the CEMG and not captured on our system. Th group **agreed** the importance of independent contractors meeting our purchasing requirements.	

	Action - KR **agreed** to consider taking forward an analysis around equipment in Community and Primary Care settings that is not purchased through the procurement process. The group **agreed** that it would be helpful to have a Risk Register in the future to capture un-registered medical equipment. The group **agreed** the importance, as part of the Action Plan, we should have a dedicated Medical Device person to oversee the work required. 7.2 Suppliers Transmitting Data Policy The Medical Devices Group **agreed** for this to be deferred and **discussed** at the next meeting on13 September 2023. **Action** - Andrea add to agenda. 7.3 IRIC Safety Alerts through Datix Following discussion, the group **agreed** for a review of the Safety Alert process to deem whether it is fit for purpose. The group agreed to bring the process back for discussion with proposals on how we can make improvements. **Action** - NMcC to take forward.	**KR** **Andrea** **NMcC**
8	**DATE & TIME OF NEXT MEETING** Wednesday 13 September 2023 at 2 pm on Team	

RESEARCH INNOVATION & KNOWLEDGE GROUP

(Meeting on 21 June 2023)

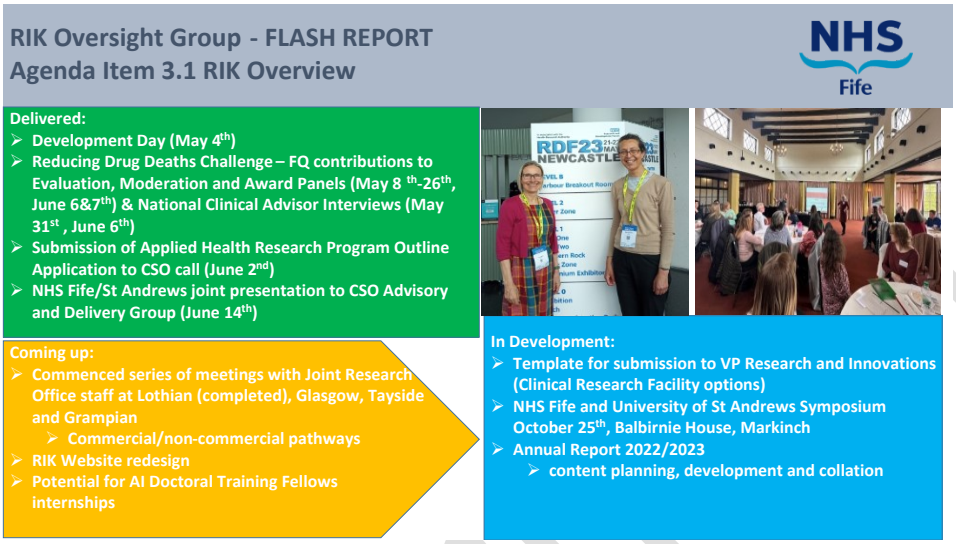
No issues were raised for escalation to the Clinical Governance Committee.

Research Innovation & Knowledge Group

RESEARCH, INNOVATION & KNOWLEDGE OVERSIGHT GROUP MEETING
MINUTES
Microsoft TEAMS,

	21 JUNE 2023 (11.00am – 12.00pm)	**ACTION**
	Present: Dr Chris McKenna, Medical Director, Executive Lead for Research, Innovation & Knowledge (CMcK) Prof. Frances Quirk, RIK Assistant Director (FQ) Dr Grant Syme, Physiotherapist Consultant (GS) Neil Mitchell, Innovation Manager (NM) Anne Haddow, Lay Advisor (AH) Alistair Graham, Associate Director, Digital & Information (AG) Sophie Given – Head of Nursing – Acute Services (SG) 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) In Attendance: Roy Halliday, R&D Support Officer – minutes (RH)	
1.0	**CHAIRPERSON'S WELCOME/APOLOGIES AND OPENING REMARKS** **Apologies;** Prof. Frank Sullivan, Director of Research, University of St. Andrews Ben Hannan – Director of Pharmacy Nicola Robertson – Director of Nursing Maxine Michie, Deputy Director of Finance Shirley-Anne Savage, Associate Director of Quality and Clinical Governance (S-AS)	
2.0	**STANDING ITEMS**	
2.1	**OVERSIGHT OF R, I K OVERSIGHT GROUP MINUTE** CMcK welcomed all to the meeting. The RIK Oversight Group Minutes were accepted with no amendments. **Actions:** Action 5.2 Reducing Drugs Death Challenge – NM is not in a position as yet to request support from BH/SG but will contact them in due course – Completed. 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 – In progress	

2.2	**OVERSIGHT OF RIK OPERATIONAL GROUP MINUTE AND ACTION LIST** KG advised that there was nothing from this meeting that needed escalated.	
3.0	**STRATEGIC PRIORITIES/INITIATIVES**	
3.1	**RESEARCH AND DEVELOPMENT**	



FQ advised that had been on the panels for the evaluation, moderation and award for the Reducing Drugs Death challenge and the National Clinical Advisor interviews.

FQ also advised that the team took part in a Development Day on 4th May, the day involved an overview of current state and strategic discussion, workshops, and discussion around website redesign.

FQ has worked with St. Andrews colleagues to support submission of an Applied Health Research programme application to the CSO, 83 applications were received with 8 going through to the next stage.

FQ and Penny Trotter (Approvals Lead) attended the R&D Forum in Newcastle, there were 850 attendees and a lot of interesting content although very “England focussed”.

FQ and colleagues from St. Andrews submitted a project outline for cohort 3 of the Doctoral Training Programme, early indications are that it was positively reviewed.

A meeting has taken place with colleagues at NHS Lothian/University of Edinburgh ACCORD office to discuss Commercial /Non-Commercial pathways with further meetings with NHS Glasgow, NHS Grampian, and NHS Tayside Joint Research Offices in the pipeline.

Discussions have been had with the Communications Team around a refresh of the RIK pages and a more visible profile on the NHS Fife website.

As part of the Joint Research Office planning a template has been agreed which will go to the Vice Principal of Research and Development at St. Andrews considering options for enhancing/refining Clinical Research facilities.

The 2nd joint NHS Fife/University of St. Andrews Symposium will take place on 25th October, an invitation has been sent to the Chief Medical Officer to be a keynote speaker at the morning session.

CMcK noted that there was a lot going on and it was really good to see RIK in Fife making a profile for itself.

4.0 RESEARCH AND DEVELOPMENT

4.1 CLINICAL RESEARCH UPDATE

KG highlighted from her report advising that the team are currently delivering National Principal Investigator Training which has been adapted from the NRS Training Forum, whilst not mandatory it will advise potential PIs of their responsibilities.

Consent training has been delivered to all the R&D Nurses, looking at documentation and ensuring we complied with MHRA requirements, this will be added to the RIK Education Programme going forward.

The first script on Chemocare has been done for a patient on the FOXTROT 3 study. KG would like to thank Alison Casey, Senior Pharmacist, Cancer Service & Clinical Trials for getting this service up and running.

KG advised that a new Clinical Research Assistant has recently started in the Oncology team, and the nursing team is now at full staffing.

KG, Dr Rajendra Raman and A&E Senior Nurses will be visiting Edinburgh in September as a scoping exercise to ascertain how to roll

	out research within the Emergency Department. KG also 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. The current Cardiology Research Nurse, Valerie Bryson will be retiring this year and planning is underway for her replacement and opportunities to develop cardiology studies. KG is hoping to have further discussion with Universities' and perhaps the NMC to ask that Clinical Research be added to the student nurse curriculum.
5.0	**INNOVATION**
5.1	**INNOVATION UPDATE**

NM advised that Phase I of the Mental Health challenge is now complete with applications now open for Phase II.

NM noted that NHS Fife was invited to join a meeting to discuss a potential self-help post ICU pathway along with Consultants from Lothian and Fife, however the company who are developing the tool are looking to roll in Lothian first of all with potential to include Fife and Borders at a later stage.

A member of the Psychology team, Joshua Muggleton has developed a Fife Neurodevelopment questionnaire with the aim to have this as a free to use downloadable resource for use by Clinicians and Researchers, work with the Central Legal Office has taken place to draft a Clickwrap license to allow the questionnaire to be hosted on the Psychology website for use across the UK.

NM also advised that the Scottish Health & Industry Partnership (SHIP) innovation challenges in Medicines and Dementia and Diabetes Remote Monitoring are both currently under evaluation, successful projects once selected should commence in October.

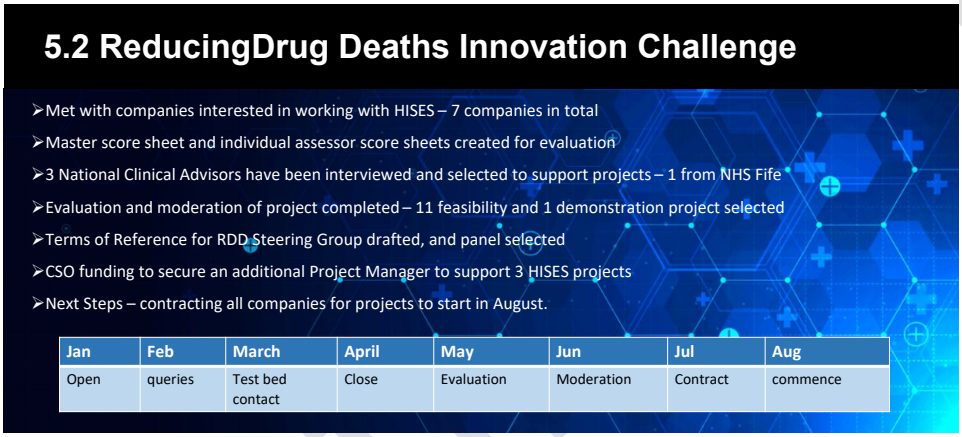
The Dermatology Artificial Intelligence SBRI has now closed and projects are under evaluation, Phase I will only take place in Tayside and may move out to other Boards at the Phase II stage.

NM advised that there is growing engagement with NHS Fife colleagues with initial discussion already taken place regarding potential projects in Medical Education/Simulation and Palliative Care.

Development is underway for SOPs and WIs for Innovation.

5.2 **REDUCING DRUG DEATHS CHALLENGE**

Small Business Research Initiative (SBRI) funded by SHIP Scottish Health and Industry Partnership | Office for Life Sciences



NM advised that he and Susanna Galea-Singer (Clinical Innovation Champion) had met with several companies who were interested in working with HISES and NHS Fife. Five of the companies submitted applications. The evaluation panel consisted of 14 members with 21 projects reviewed, NM would like to thank the panel for the time they gave to assist with this.

As it stands at the moment 11 feasibilities and 1 demonstration project have been selected.

The Terms of Reference for the RDD Steering Group has been drafted.This group will have responsibility for oversight and governance and approve the milestone and final payments for the companies.. The process is underway to select who will sit on the RDD Steering Group and currently awaiting confirmation from some of the potential members of availability.

The CSO have confirmed that they will fund an additional Band 6 Project Manager to support the projects that will run at NHS Fife.

Next steps will be contacting the companies and arranging contracts.

NM noted that publicity for the successful awards will be done nearer the

	time via a press release and the Communications Team.	
6.0	**LIBRARY & KNOWLEDGE SERVICES**	
6.1	**LIBRARY STAFFING REVIEW** FQ advised that there was nothing substantive to add at this time.	
7.0	**PARTNERSHIP UPDATES**	
7.1	**DOCTORAL TRAINING PROGRAMME** CMcC advised that there had been two new Fellows appointed (Cohort 2) in the DTP, commencing on 01st August and will have NHS Fife Clinicians working with them supervising along with FQ. A meeting took place yesterday to review the DTP proposals for next year. There had been a DTP training day for cohort 1 in May. A bid has been forwarded to the Applied Health Research programme and we will find out if successful in moving to stage 2 (Full Application) week commencing 10th July.	
7.2	**JOINT RESEARCH OFFICE** FQ advised that planning is underway for the joint symposium on 25th October with a call for abstracts due in the next few weeks. A commitment has been made to put more resource to support the Joint Research Office, A member of the team will be providing a bit more support to the working group and also working more closely with the Research & Integrity Office at St. Andrews around aligning some of our governance processes.	
7.3	**NHS FIFE & UNIVERSITY OF ST. ANDREWS PARTNERSHIP** FQ noted that the presentation she and Frank Sullivan gave to the CSO Advisory Group had been added to the TEAMS channel for the group to view.	
7.4	**R&D/FIFE COMMUNITY ADVISORY GROUP**. AH updated from her report (attached to the Agenda) and wished to draw attention to the bullet point 3, where members of the FCAC reviewed an application form involving a joint bid with NHS Fife and St. Andrews University. The group are now beginning to work more on projects involving NHS staff, but they would like to increase their involvement. AH asked members of this group if they could help raise awareness of the Fife Community Advisory Council amongst their colleagues and staff. FQ added that she is happy to work with the FCAC to do any further promotion around NHS Fife on top of what is already done.	
7.0	**AOCB** FQ asked AG if it might be helpful to have a discussion around the use of AI in its different contexts within healthcare at the next meeting. AG agreed that AI should be discussed at this meeting, and various other	

	forums.	
8.0	**DATE AND TIME OF NEXT MEETING** Tuesday 19th September, 14.00 – 15.00	

Resilience Forum

RESILIENCE FORUM

(Meeting on 8 June 2023)

No issues were raised for escalation to the Clinical Governance Committee.

Department of Public Health
Cameron House, Cameron Bridge, Leven, KY8 5RG

Minute of the NHS Fife Resilience Forum Meeting held on Thursday 08th June 2023 at 2:00pm via Microsoft Teams

Present:

Joy Tomlinson, Director of Public Health, NHS Fife **(Chair)**	**JT**
Susan Cameron, Head of Resilience, NHS Fife	**SC**
Craig Burns, Resilience Officer, NHS Fife	**CB**
Susan Fraser, Associate Director of Planning and Performance, NHS Fife	**SF**
Donna Galloway, General Manager, NHS Fife	**DG**
Samantha McLaughlin, Resilience Advisor, Scottish Ambulance Service	**SMcL**
Lorraine King, Business Manager, NHS Fife	**LK**
Paul Bishop, Head of Estates, NHS Fife	**PB**
Maggie Currer, Consultant, Emergency Department, NHS Fife	**MC**
Allan Young, Head of Digital Operations, NHS Fife	**AY**
Ian Campbell, Healthcare Chaplain, NHS Fife	**IC**
Margo McGurk, Director of Finance and Strategy/Deputy Chief Executive, NHS Fife	**MMcG**

In Attendance:

Stevie Rutherford, Personal Assistant, NHS Fife **(Minute Taker)**	**SRR**
Kevin McMahon, Head of Risk and Resilience, NHS 24, (joined meeting at 41:56 mins and left at 1 hour,19 mins)	**KMcM**

ACTION

1. Welcome and Introductions

JT (Chair) welcomed everyone to the meeting. A reminder was given that the meeting was being recorded to assist with minute taking.

2. Apologies

Christopher McKenna (CMcK), David Miller (DM), Alistair Graham (AG), Fiona McKay (FMcK), George Brown (GB), Janette Keenan (JK), Lynne Garvey (LG), Nicola Robertson (NR), Olivia Robertson (OR), Wilma Brown (WB)

3. Minutes of previous meeting (01st March 2023))

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

3.1 Action Tracker - 01st March 2023

SC reported that most of the items will be covered on today's agenda.

4. Matters Arising

Major Incident Plan Update

SC advised that the Major Incident Plan has been updated and an overview would be provided by SC and MC further down the meeting agenda.

SC provided a brief description about the change in approach to incident planning for NHS Fife. She noted the new Framework will be supported by training and exercising for staff once the document is finalised.

SLWG Prevent

SC advised that Scottish Government had sent all health boards a self-assessment tool.

SC advised an initial meeting has taken place with Prevent leads. The group are working on an action plan for NHS Fife. The plan will be shared when ready.

STAC Guidance to be shared

SC reminded Forum members that the guidance was updated on 26th January 2023. It was agreed to share this with the Forum and the refreshed guidance is attached as Appendix 2 within the Quarter 4 report which was circulated prior to today's meeting.

5. NHS 24 Major Incident Support – (Kevin McMahon, Head of Risk and Resilience NHS 24)

KMcM introduced himself as Head of Risk and Resilience for NHS 24. KMcM provided an overview of the services NHS 24 offer. He described the 111 system for logging calls, which is the initial contact for patients. In the event of a Major Incident, a call management system would be introduced which incorporates a queuing system for call management.

KMcM provided approximate breakdown of figures which make up the calls generally. NHS 24 receive over a million and a half calls a year, 30000-40000 calls a week, and around 3000 calls a day. But the weekend can be more. The emergency dental service is another source of high patient call numbers.

Over Christmas and New Year the number of calls increased. At that time the call waiting time was around 6mins.

NHS 24 provide a Digital Service (NHS Inform). This supports management of increasing demand from the 111 service. There are a range of various other services which may assist individuals including the mental health resources such as breathing space and living life, these services are likely to be most helpful during the recovery phase of a major incident.

NHS 24 have capacity to establish a special helpline to support local areas and an NHS 24 App promoting self-help which has SMS capability is available. NHS 24 could also assist with wider public communications via social media targeted to a particular area during an incident.

JT asked SC if there was potential to highlight some of the NHS 24 resources within the new Incident management Framework. It was also suggested there would be benefit in sharing the Framework document with external partners. SC

advised that benchmarking of the new Framework has been undertaken and it has been shared with select partners for feedback including Fife Council., NHS Tayside have also provided positive feedback. SC noted that there is an opportunity to share the plan more widely in future.

JT thanked KMcM for joining the meeting and providing an overview of the response NHS 24 can provide to support major incident management.

6. Resilience Governance & Assurance

6.1 Annual Assurance Report

SC explained that following recommendations from Internal Audit an annual assurance report has been developed which captures the work of the Resilience Forum. This will ensure greater transparency and understanding about the work of the Forum in future.

SC advised that the Executive Directors Group (EDG) had reviewed the assurance statement and it has been presented to the Clinical Governance Committee (CGC) in April this year.

SC highlighted a number of items in the assurance statement including work to update and refresh the Major Incident Plan. This will be replaced by the new Incident Management Framework.

SC described significant improvement in Business Continuity plans which are in place. A central ledger across acute and health and social care partnership has been established.

At the start of the year there were 75 areas which had been identified as requiring business continuity plans but this has increased significantly following discussion with teams and there are now 133 areas identified which require Business Continuity plans.

SC highlighted the Hazmat ''live play'' exercise which took place with Emergency Department (ED) colleagues at the Victoria Hospital, Kirkcaldy on the 26th August 2022. There will be work next year to put in place a testing and exercise program.

MMcG commented that the assurance statement was really good and it would be useful to share this report with the auditors (this has now been done since forum). MMcG asked where the report would go to next, and suggested it is tabled with Audit and Risk Committee come back to this meeting in September

ACTION – Annual Assurance statement report to be tabled with Audit and Risk Committee and copy of Assurance Statement to be shared with internal auditors by SC **SC**

6.2 Quarter 4 Resilience Report

SC highlighted that the report was prepared in collaboration with other resilience leads. SC noted there has been significant work over the last year updating digital resilience.

SC described work which has progressed to strengthen business continuity testing and exercising. CB advised he is providing two sessions per week of Business Continuity testing and exercising training to staff across the corporate acute and health and social care partnership.

SC noted that towards the end of the Quarter 4 report there is a section providing an overview of testing and exercising which has been completed. She highlighted the Scottish Ambulance Service no-notice Communication Test, (report attached). National test was on 08th March 2023.

7. Whole Systems Overview

7.1 H&SCP

LK reported that the assurance review team have reviewed almost half of the business continuity plans within the partnership, and fully assured 19 plans and feedback has been positive from staff.

LK further reported that she is progressing the Fife Health & Social Care Partnership Resilience Framework which is currently in draft format currently.

SC advised that the health and social care partnership are undertaking a situational awareness exercise for business continuity on 13th June 2023.

7.2 SAS

(Revised Communications Plan & Test)

SMcL reported no emerging concerns although there are general pressures. Continuing to be involved with exercises in Fife, Lothian and Borders and Forth Valley.

SMcL reported to the forum the next NHS Communication Plan test is due to take place between the 19th and 23rd June for tactical numbers only.

SC asked SMcL to attend next forum meeting in September 2023 to share the update communication. SMcL agreed to return and inform the forum on findings.

7.3 Acute, Recent Incidents (VHK and Water Pressure)

DG reported that she had been working closely with SC on development of the new Incident Management Framework. More work to be done around business continuity.

DG further reported that Fife Fire and Rescue (FFRS) have adopted a new call out system in place for attending at buildings with fires.

PB reported that FFRS will not attend alarms that come from buildings which have not got inpatient facilities.

PB provided a brief update about two recent water issues. The first was localised to the Victoria hospital and was a temporary lack of water, so water was ordered in the interim (over 1000 bottles).

PB reported another water issue affecting Cameron hospital and the wider area. The cause appeared to be related to work nearby on the new train tracks which caused an issue with the hot boiler, a new boiler has since been installed.

SC advised that project hydra may have some level of impact on the emergency department, SC raised the question if there would any contingency plans made by estates. Julie Farr to contact Acute Senior Leadership Team about this piece of work.

PB described the recent fire in phase 3, male toilets which caused significant disruption This was started by 2 youths. FFRS sent 6 pumps. The main issue for those in the building was smoke smoulder.

An initial debrief has taken place to learn from the incidents. MC highlighted the importance of ensuring clinicians are included in the de-brief process. DG advised that a clinical nurse manager had been part of the debrief relating to the fire.

7.4 Digital

AY provided an overview of activity since the last meeting. A slide presentation was shared.

Work is underway to establish a digital service catalogue, and working towards a full NIS audit in early July 2023.

AY reported further that NSS Cyber Excellence Desktop event will take place at Abertay University and will be hosting a real-life live exercise, this will take place on 19th June 2023. AY extended an invitation to members of the forum for this event.

AY advised that a critical incident response team within digital will be put in place in the near future.

ACTION: AY to feedback to forum next time on lessons learned from the Desktop event. **AY**

8. Emergency Planning

8.1 Incident Management Framework & Stakeholder Checklist

SC encouraged forum members to provide feedback.

SC gave a short presentation describing the key elements within the new Incident Management Framework. This is aligned with the OPEL framework and will retain the operational response element within the Major Incident Plan. MC provided a brief synopsis of the strategic, tactical and operational elements within the Response section of the Major Incident plan.

SC advised that next steps would be gaining feedback from Forum members, developing the documents further, and taking them to the Acute Senior Leadership Team (SLT) and then to the Executive Directors Group (EDG).

JT invited MC to provide an overview of the Response section within the Incident Management Framework. SRR shared the Response Element Slide presentation

on screen. MC described the approach across specific themes (strategic, tactical and operational) to the forum.

Action: Forum members were asked to provide feedback on draft Incident Management Framework by 22 June 2023. **ALL**

9. Training & Exercising

9.1 Testing and Exercising the Lockdown plan on page

CB described work is underway to update the lockdown framework. This will be the next emergency plan to be ratified. Once the Incident framework is ratified and circulated for wider stakeholder feedback the lockdown framework will be shared with the agreed distribution list.

CB concluded that mandated training would come into effect and security and building assessments will be actioned.

ACTION: Feedback from stakeholders within 4 weeks **CB**

10. Upcoming Significant Events

CB will circulate the upcoming events listing after the meeting.

10.1 Regional Resilience Events Brief

Cycling World Championships – 06 August 2023

Safe Steeple – 23 August 2023 at Tulliallan – Key people asked to save the date.

Diageo COMAH Site, Control of Major Accident Hazards, (Planning to start on 29th August 2023)

11. Any other business

NONE

12. Date of next meeting:

12.1 Schedule of meetings for 2023

07th September 2023
07th December 2023