NHS Fife Clinical Governance Committee

Fri 12 January 2024, 10:00 - 13:00

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 3 November 2023

Enclosed *Arlene Wood*

Item 03 - Clinical Governance Committee Minutes (unconfirmed) 20231103.pdf (13 pages)

10:00 - 10:10
10 min

4. Matters Arising / Action List

Enclosed *Arlene Wood*

Item 04 - Clinical Governance Committee Action List - 20240112.pdf (2 pages)

10:10 - 10:30
20 min

5. ACTIVE OR EMERGING ISSUES

5.1. Reinforced Autoclaved Aerated Concrete

Enclosed *Neil McCormick*

Item 05.1 - SBAR Reinforced Autoclaved Aerated Concrete.pdf (6 pages)
Item 05.1 - Appendix 1 Sample Survey Report.pdf (11 pages)
Item 05.1 - Appendix 2 Sample Risk Assessment.pdf (4 pages)

5.2. Notification to Health & Safety Executive (HSE) of Work in Atmosphere Containing Radon

Enclosed *Chris McKenna*

Item 05.2 - SBAR Notification to Health & Safety Executive of Work in Atmosphere Containing Radon.pdf (4 pages)

10:30 - 11:10
40 min

6. GOVERNANCE MATTERS

6.1. Internal Controls Evaluation Report 2022/23

Enclosed *Margo McGurk*

Item 06.1 - SBAR Internal Controls Evaluation Report 2022-23.pdf (3 pages)

Item 06.1 - Appendix 1 Internal Control Evaluation Report.pdf (36 pages)

6.2. Corporate Risks Aligned to Clinical Governance Committee, including Deep Dives: Covid-19 and Cyber Resilience

Enclosed *Chris McKenna / Peter Donaldson*

Item 06.2 - SBAR Corporate Risks Aligned to the CGC.pdf (6 pages)
Item 06.2 - Appendix 1 Corporate Risks aligned to the CGC as at 211223.pdf (8 pages)
Item 06.2 - Appendix 2 SBAR and Covid19 Closing Deep Dive.pdf (9 pages)
Item 06.2 - Appendix 3 SBAR and Cyber Resilience Deep Dive.pdf (7 pages)
Item 06.2 - Appendix 4 Assurance Principles.pdf (1 pages)
Item 06.2 - Appendix 5 Risk Matrix.pdf (2 pages)

6.3. Clinical Governance Oversight Group Assurance Summary from October & December 2023 Meetings

Enclosed *Shirley-Anne Savage*

Item 06.3i - Assurance Summary Clinical Governance Oversight Group October 2023.pdf (7 pages)
Item 06.3ii - Assurance Summary Clinical Governance Oversight Group December 2023.pdf (9 pages)

6.4. Review of Draft Annual Workplan 2024/25

Enclosed *Shirley-Anne Savage*

Item 06.4 - SBAR Review of Draft Annual Workplan 2024-25.pdf (3 pages)
Item 06.4 - Appendix 1 Review of Draft Annual Workplan 2024-25.pdf (5 pages)

6.5. Delivery of Annual Workplan 2023/24

Enclosed *Shirley-Anne Savage*

Item 06.5 - Delivery of Annual Workplan 2023-24.pdf (8 pages)

11:10 - 11:40
30 min

7. STRATEGY / PLANNING

7.1. Population Health & Wellbeing Strategy Mid-Year Review

Enclosed *Margo McGurk*

Item 07.1 - SBAR Population Health & Wellbeing Strategy Mid-Year Review.pdf (5 pages)
Item 07.1 - Appendix 1 Population Health & Wellbeing Strategy Mid-Year Review.pdf (46 pages)

7.2. Medical Appraisal and Revalidation Framework 2024-27

Enclosed *Chris McKenna*

Item 07.2 - SBAR Medical Appraisal and Revalidation Framework 2024-27.pdf (3 pages)
Item 07.2 - Appendix 1 Medical Appraisal and Revalidation Framework 2024-27.pdf (16 pages)

11:40 - 12:00
20 min

8. QUALITY / PERFORMANCE

8.1. Integrated Performance & Quality Report

Enclosed *Chris McKenna / Janette Keenan*

Item 08.1 - SBAR Integrated Performance & Quality Report.pdf (4 pages)
Item 08.1 - Appendix 1 Integrated Performance & Quality Report.pdf (16 pages)

8.2. Healthcare Associated Infection Report (HAIRT)

Enclosed *Janette Keenan*

- Item 08.2 - SBAR Healthcare Associated Infection Report.pdf (6 pages)
- Item 08.2 - Appendix 1 Healthcare Associated Infection Report.pdf (27 pages)

12:00 - 12:20
20 min

9. PERSON CENTRED CARE / PARTICIPATION / ENGAGEMENT

9.1. Patient Story

Presentation *Janette Keenan*

9.2. Patient Experience & Feedback Report

Enclosed *Janette Keenan*

- Item 09.2 - SBAR Patient Experience & Feedback Report.pdf (6 pages)
- Item 09.2 - Appendix 1 NHS Fife PET Flashcard December 2023.pdf (4 pages)
- Item 09.2 - Appendix 2 Recovery & Improvement Plan.pdf (5 pages)

12:20 - 12:50
30 min

10. ANNUAL REPORTS / OTHER REPORTS

10.1. Medical Appraisal and Revalidation Annual Report 2022/23

Enclosed *Chris McKenna*

- Item 10.1 - SBAR Medical Appraisal and Revalidation Annual Report 2022-23.pdf (3 pages)
- Item 10.1 - Appendix 1 Medical Appraisal and Revalidation Annual Report 2022-23.pdf (8 pages)

10.2. Participation & Engagement Annual Report 2022/23

Enclosed *Janette Keenan*

- Item 10.2 - SBAR Participation & Engagement Annual Report 2022-23 + Appendix.pdf (6 pages)

10.3. Research & Development Progress Report & Strategy Review 2023-25

Enclosed *Chris McKenna*

- Item 10.3 - SBAR Research & Development Progress Report & Strategy Review 2023-25.pdf (4 pages)
- Item 10.3 - Appendix 1 Research Strategy Priorities 2022-23.pdf (3 pages)
- Item 10.3 - Appendix 2 Research, Innovation and Knowledge Strategy 2022-25.pdf (16 pages)

10.4. Research, Innovation and Knowledge Annual Report 2022/23

Enclosed *Chris McKenna*

- Item 10.4 - SBAR Research, Innovation and Knowledge Annual Report 2022-23.pdf (5 pages)

12:50 - 12:55
5 min

11. LINKED COMMITTEE MINUTES

11.1. Area Clinical Forum held on 7 December 2023 (unconfirmed)

Enclosed

- Item 11.1 - Minute Cover Paper.pdf (1 pages)
- Item 11.1 - Area Clinical Forum Minutes (unconfirmed) 20231207.pdf (3 pages)

11.2. Area Medical Committee held on 10 October 2023 (unconfirmed)

Enclosed

Item 11.2 - Minute Cover Paper.pdf (1 pages)
Item 11.2 - Area Medical Committee Minutes (unconfirmed) 20231010.pdf (9 pages)

11.3. Area Radiation Protection Committee held on 14 November 2023 (unconfirmed)

Enclosed

Item 11.3 - Minute Cover Paper.pdf (1 pages)
Item 11.3 - Area Radiation Protection Committee Minutes (unconfirmed) 20231114.pdf (2 pages)

11.4. Cancer Governance & Strategy Group held on 2 November 2023 (unconfirmed)

Enclosed

Item 11.4 - Minute Cover Paper.pdf (1 pages)
Item 11.4 - Cancer Governance & Strategy Group Minutes (unconfirmed) 20231102.pdf (10 pages)

11.5. Clinical Governance Oversight Group held on 24 October 2023 (confirmed) & 12 December 2023 (unconfirmed)

Enclosed

Item 11.5i - Minute Cover Paper.pdf (1 pages)
Item 11.5i - Clinical Governance Oversight Group Minutes (confirmed) 20231024.pdf (10 pages)
Item 11.5ii - Minute Cover Paper.pdf (1 pages)
Item 11.5ii - Clinical Governance Oversight Group Minutes (unconfirmed) 20231212.pdf (13 pages)

11.6. Digital & Information Board held on 19 October 2023 (unconfirmed)

Enclosed

Item 11.6 - Minute Cover Paper.pdf (1 pages)
Item 11.6 - Digital & Information Board Minutes (unconfirmed) 20231019.pdf (6 pages)

11.7. Fife IJB Quality & Communities Committee held on 2 November 2023 (unconfirmed)

Enclosed

Item 11.7 - Minutes Cover Paper.pdf (1 pages)
Item 11.7 - Fife IJB Quality & Communities Committee Minutes (unconfirmed) 20231102.pdf (13 pages)

11.8. Health & Safety Subcommittee held on 8 December 2023 (unconfirmed)

Enclosed

Item 11.8 - Minute Cover Paper.pdf (1 pages)
Item 11.8 - Health & Safety Subcommittee Minutes (unconfirmed) 20231208.pdf (11 pages)

11.9. Infection Control Committee held on 6 December 2023 (unconfirmed)

Enclosed

Item 11.9 - Minute Cover Paper.pdf (1 pages)
Item 11.9 - Infection Control Committee Minutes (unconfirmed) 20231206.pdf (5 pages)

11.10. Information Governance & Security Steering Group held on 10 October 2023 (unconfirmed)

Enclosed

Item 11.10 - Minute Cover Paper.pdf (1 pages)
Item 11.10 - Information Governance & Security Steering Group Minutes (unconfirmed) 20231010.pdf (5 pages)

11.11. Research, Innovation & Knowledge Oversight Group held on 11 December 2023 (unconfirmed)

Enclosed

Item 11.11 - Minute Cover Paper.pdf (1 pages)
Item 11.11 - Research, Innovation & Knowledge Oversight Group Minutes (unconfirmed) 20231211.pdf (7 pages)

11.12. Resilience Forum held on 10 October 2023 (confirmed) & 7 December 2023 (unconfirmed)

Enclosed

Item 11.12 - Minute Cover Paper.pdf (1 pages)
Item 11.12 - Resilience Forum Minutes (confirmed) 20231010.pdf (9 pages)

12:55 - 13:00
5 min

12. ESCALATION OF ISSUES TO NHS FIFE BOARD

12.1. To the Board in the IPQR Summary

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

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13:00 - 13:00
0 min

13. ANY OTHER BUSINESS

13:00 - 13:00
0 min

14. DATE OF NEXT MEETING: FRIDAY 1 MARCH 2024 FROM 10AM - 1PM VIA MS TEAMS

Fife NHS Board

Unconfirmed

MINUTE OF THE NHS FIFE CLINICAL GOVERNANCE COMMITTEE MEETING HELD ON FRIDAY 3 NOVEMBER 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
Janette Keenan, Director of Nursing
Dr Chris McKenna, Medical Director
Carol Potter, Chief Executive

In Attendance:
Lynn Barker, Associate Director of Nursing
Sue Cameron, Head of Resilience *(deputising for Dr Joy Tomlinson)*
Nicky Connor, Director of Health & Social Care
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
Dr Gillian MacIntosh, Head of Corporate Governance & Board Secretary
Dr Iain MacLeod, Deputy Medical Director, Acute Services Division
Margo McGurk, Director of Finance & Strategy
Lynne Parsons, Employee Director *(part)*
Nicola Robertson, Associate Director of Nursing
Dr Shirley-Anne Savage, Associate Director of Quality & Clinical Governance
Dr Aylene Kelman, Clinical Director Health & Social Care Partnership *(observing)*
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 meeting is being recorded to aid production of the minutes.

The Chief Executive was pleased to announce that, at the recent Scottish Health Awards 2023, Dr Jo Bowden won the Doctor Award, whilst Dr Andrew Blaikie took home the prize for Global Citizenship. Dr Kerri Davidson and highly specialist physiotherapist Pierette Melville were also honoured by being shortlisted for the Doctor and Allied Health Professional awards respectively. The Chief Executive acknowledged that, for the Doctor of the Year award, there were only three Doctors across Scotland that reached the final, and it was extremely gratifying that two of the three were from Fife.

1. Apologies for Absence

Apologies were received from members Sinead Braiden (Non-Executive Member), Aileen Lawrie (Area Clinical Forum Representative), Joy Tomlinson (Director of Public Health) and routine attendees Susan Fraser (Associate Director of Planning & Performance), Norma Beveridge (Associate Director of Nursing), John Morrice (Consultant Paediatrician) and Elizabeth Muir (Clinical Effectiveness Manager).

2. Declaration of Members' Interests

There were no declarations of interest made by members.

3. Minutes of the Previous Meeting held on 8 September 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.

Action No 1 - Deep Dive: Off-Site Area Sterilisation and Disinfection Unit Service

The Director of Property & Asset Management provided a verbal update on the discussions that took place with the Board in relation to the Off-Site Area Sterilisation and Disinfection Unit Service. He noted the difficulties that were discussed, including the national position and scarcity of capital funding. It was advised that the Decontamination Group will discuss further at their meeting on 10 November 2023.

It was agreed to close this action, on the basis that risk oversight would form part of business-as-usual activities. It was also agreed to hold a future Board Development Session on the topic more generally, as suggested by the Board.

Action: Director of Property & Asset Management

4.1 Computerised Tomography (CT) Scanner Update

The Director of Acute Services provided an update on the recent CT scanners failure and advised that immediate mitigations had been put in place since the incident. It was also advised that a positive meeting took place with the supplier Siemens around going forward and detailed the mitigation actions that they have put in place, as detailed in the paper.

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

5. Patient Story

The Director of Nursing gave a presentation on an incident in which a patient suffered a fall, which impacted greatly on their clinical outcome, noting the learning from this. The Chair noted the importance of the committee reflecting on individual patient experiences as part of their business.

The Committee took **assurance** from the learning detailed in the presentation.

6. ACTIVE OR EMERGING ISSUES

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

The Medical Director advised that the letter is presented to the Committee to note the actions that the Board took in relation to the Cabinet Secretary's letter and the request within that letter.

The Chief Executive added that no response from the Scottish Government has been received, to date, and that this was mirrored across other NHS Scotland Health Boards. It was noted that at a recent Board Chairs' meeting, it was recognised that there are a range of styles, and a range of approaches, in terms of feedback from NHS Scotland Health Boards in relation to the response to the Cabinet Secretary's letter.

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

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

The Medical Director spoke to the letter. It was noted that the procedures have raised a significant concern for a number of years and that there are now various pathways in place to support women. The Medical Director advised that there are recommendations within the letter and reminders for doctors/clinicians in terms of good documentation, consent, and good medical practice.

It was reported that further assurance will be provided within our Board response to the letter in due course, and that teams are working through the recommendations within the letter, including a series of actions that will be put in train through the Medical Leadership Teams across the Health & Social Care Partnership and Acute Services.

7. GOVERNANCE MATTERS

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

The Medical Director reported that Risk 3: Covid-19 should probably now relate to the impact or management of another pandemic, rather than the consequence of the current. It was advised that this risk will be updated in due course, given the changes in our planning for any potential future pandemics. The Chair was supportive of closing the Covid-19 risk as a corporate risk and moving the risk to a wider infectious disease biohazard, and she queried the timescale. The Medical Director agreed, noting that this is a priority for the Director of Public Health.

It was reported that a deep dive took place on Risk 4: Optimal Clinical Outcomes at a recent Development Session, and that an update to the risk will be brought back to the Committee in January 2024, following comments and feedback at that session.

In terms of Risk 9: Quality & Safety, it was advised that consideration is being given to potentially reducing the risk level to moderate. However, it was noted that given the issues in relation to the Countess of Chester Hospital Inquiry, the Chief Executive

is currently commissioning a review of governance arrangements around the internal triangulation of any safety concerns raised, and therefore the risk level has remained at high.

Risk 16: Off-Site Area Sterilisation and Disinfection Unit Service was covered under agenda item 4.

For Risk 17: Cyber Resilience, it was reported that our Network and Information Systems (NIS) audit improved significantly this year, and that the impact and consequences of this risk are going to be considered in due course in relation to potentially improving the risk rating.

C Grieve, Non-Executive Member, commented that the update was generally positive, and the Chair agreed. Staff were thanked for their efforts in this regard.

The Committee took a **"reasonable" level of assurance** that, all actions, within the control of the organisation, are being taken to mitigate these risks as far as is possible to do so.

Deep Dive: Digital & Information

The Associate Director of Digital & Information spoke to the deep dive on Risk 18: Digital & Information. It was reported that the root causes are detailed in the paper, and an overview was provided, including partnership working and financial challenges. It was also reported that the Digital & Information Strategy 2019 – 2024 has been reprovisioned into a new strategy that is aligned to our Population Health & Wellbeing Strategy and that it provides mitigation in terms of the risk. The refreshed Digital & Information Strategy will provide the evidence to reduce the risk rating to moderate, through a number of management actions.

Following a question from A Haston, Non-Executive Member, around the timescale for the action in relation to the assessment of existing capabilities, an explanation was provided on reaching the target date of January 2024, with it noted that there are planned workshops through the Digital & Information Board in relation to automation and artificial intelligence, and actions from those workshops will include capability assessments.

The Chair queried NHS Fife's position on the National Digital Maturity Assessment, particularly around the capabilities element. In response, it was advised that the national assessment is linked to our assessment of existing capabilities, and that work is in progress around the validation of the data.

A Haston, Non-Executive member, commented on the consequence risk rating 5 being extreme, and queried how that was set. The Associate Director of Digital & Information advised that there had been periods of system unavailability due to third party suppliers, and that the risk rating would be considered for review for the next iteration.

Following a question from the Chair, it was advised that the funding ratio for Digital and Information falls below recommended investment levels for benchmarking across the four home nations.

The Committee took **assurance** from the deep dive.

7.2 Clinical Governance Oversight Group Assurance Summary from August 2023 Meeting

The Associate Director of Quality & Clinical Governance advised that the summary addressed a request from an internal audit recommendation to provide additional assurance to the Committee, and that the summary captures discussions from the Clinical Governance Oversight Group meeting in August 2023.

A Haston, Non-Executive Member, questioned how the agenda for the Clinical Governance Oversight Group meetings are set. It was advised that the group have a workplan which informs the agenda, and any emerging issues are brought forward.

Members welcomed the summary, noting the helpful detail within.

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

7.3 Delivery of Annual Workplan 2023/24

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

The Chair requested that a rationale around the deferment of the Mental Health Estates Initial Agreement be added to the workplan. The Medical Director advised that this item had been deferred due to financial constraints and he explained that there was no requirement to prioritise the business case. The Director of Finance & Strategy explained the financial position and advised that the Initial Agreement is part of a larger business plan for mental health. It was also noted that interim improvements to the mental health estate is underway meantime.

Action: Associate Director of Quality & Clinical Governance / Board Committee Support Officer

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

8. STRATEGY / PLANNING

8.1 Annual Delivery Plan Quarter 2 Performance 2023/24

The Director of Finance & Strategy advised that the report describes performance against improvement actions which were agreed in the Annual Delivery Plan, using a Red Amber Green (RAG) status that was prescribed by the Scottish Government. The differentiation that the report describes actions, rather than outcomes, was highlighted.

The Director of Finance & Strategy explained that improvement actions that are completed or on track, such as in relation to staff absence and supporting staff return safely back to work, may take a significant period of time to see any impact. The Director of Nursing added that national input is awaited for some of the deliverables at red status.

Assurance was provided that the Executive Directors' Group are working towards triangulating the Annual Delivery Plan Quarterly Reports with the Integrated Quality & Performance Report and the Population Health & Wellbeing Strategy Outcomes Report. An illustration was provided to explain the triangulation.

Following a question from the Chair, regarding the suspended/cancelled deliverables, the Director of Pharmacy & Medicines explained the Hospital Pharmacy Redesign and advised that there are plans for medicine automation, which will be affected by capital availability. It was noted that this work is ongoing through the Digital Medicines Board. It was also advised that there is hospital transformation work being published by the Scottish Government, which will require the Directors of Pharmacy and Directors of Acute Services to look at the clinical aspects and explore how they modernise moving forward. The Deputy Medical Director provided assurance that there is a large amount of work ongoing with the relevant stakeholders and that this will be fed into the Clinical Governance Oversight Group, before going to the Committee. The Director of Pharmacy & Medicines noted that this deliverable is superseded, as opposed to suspended/cancelled, and agreed to update for the next iteration of the report.

Action: Director of Pharmacy & Medicines

Members commented that the report was very helpful.

The Committee took **assurance** on the Quarter 2 update submitted to the Scottish Government.

8.2 Cancer Strategic Framework Delivery Plan 2023/24

The Medical Director advised that the paper provides an update from the Cancer Transformation Team on how we will best deliver the transformative work across the whole system. The challenges were highlighted, and it was reported that there is a commitment for the innovative and transformative work, alongside business-as-usual.

A Haston, Non-Executive Member, queried the practicalities of using the delivery plan as a working document and keeping track of actions. In response, the Associate Director of Quality & Clinical Governance explained that the team work hard to keep the actions on track, and she agreed to provide more detail on the underlying work for the next iteration, to provide greater assurance to the Committee. It was agreed future reports will provide a progress update section against the actions on the plan.

Action: Associate Director of Quality & Clinical Governance

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

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

The Medical Director reported that the National Cancer Strategy is a helpful document and ambitious in terms of transformation and delivery. It was advised that the NHS Fife Cancer Framework was developed before the national strategy was published, due to expertise within the Cancer Transformation Team, and that there are similar themes. It was advised that the detail around progression towards genomics is limited, however, there is sufficient detail around new and emerging technologies within the NHS Fife strategy.

A Haston, Non-Executive Member, questioned the emphasis on psychological support and therapies as part of the mental health aspect to the strategy. The Director of Health & Social explained the improving cancer journey pathway work, the linked work with skilled professionals, and joined-up working with agencies. The Deputy Medical Director added that the journey pathway work also includes people with long term conditions.

The Chair queried the specifics around workforce numbers and achievement dates within the National Delivery Plan and what that means to Fife. The Medical Director agreed to provide further detail on the workforce plans, noting the complexities, and agreed that further detail will be worked on for the Committee and the NHS Fife Cancer Framework.

Action: Medical Director

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

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

The Associate Director of Quality & Clinical Governance highlighted the key points from the report and advised that the new Risk Management Framework is now complete and published, after receiving Board approval. It was also highlighted that the deteriorating patients' workshop and realistic medicines workshop were both delivered successfully, with positive feedback received on both. The Chief Executive added that elements of the realistic medicines workshop were presented to the Board at their recent Development Session, and that there is an ambition and appetite to drive realistic medicines forward. The Chief Executive thanked all involved in the workshops.

It was advised that a lot of work has been undertaken, and continues, in relation to reviewing the effectiveness of the Organisational Learning Group, and an update will be brought back to the next Committee meeting.

Action: Associate Director of Quality & Clinical Governance

The Chair questioned how the Committee can ensure that the voice of lived experiences around safety, quality, care experience and harm is heard at Committee level. The Chief Executive agreed to consider how to take this forward, outwith the meeting.

Action: Chief Executive

The Committee noted the excellent progress made.

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

8.5 Incident Management Framework

The Director of Nursing spoke to the report on behalf of the Director of Public Health.

A Haston, Non-Executive Member, acknowledged the large amount of work that has been carried out in developing the framework. C Grieve, Non-Executive Member, agreed and questioned the training and exercise elements. The Head of Resilience advised that the next steps are the training and exercise elements at the right levels

across all our workforce, including senior managers. It was also advised that training plans are being developed, and that training is already available for incident response.

The Chief Executive added that major incidents training has previously taken place. The Deputy Medical Director expanded on the work that is ongoing in relation to the training and exercise elements, and provided assurance that there is an ongoing process in looking at how major incidents are dealt with in the Acute settings. The Director of Acute Services added that there is a strong linkage between the Resilience Team and the Acute Senior Leadership Team, and that there are clear plans and processes in place, and clear decision making structures.

The Head of Resilience advised that business continuity incidents, and emergency response, forms part of incident management, and that a rolling programme has been introduced. It was also advised that bite-sized update sessions have been provided as a support mechanism for managers in relation to emergency planning and contingencies.

The Chief Executive acknowledged all the hard work of the Resilience Team, noting that the team itself has also been strengthened through various appointments.

The Director of Nursing confirmed that the Incident Management Framework was approved by the Executive Directors' Group.

The Committee **acknowledged** the Incident Management Framework as the new management strategy for oversight and escalation of incidents within NHS Fife.

9. QUALITY/PERFORMANCE

9.1 Integrated Performance & Quality Report (IPQR) including Deep Dive: In-Patient Falls

The Director of Nursing provided an overview on the in-patient falls position statement and the IPQR, as detailed in the paper.

The Chair queried if there were any concerns or risks associated with the Local Adverse Event Review (LAER) and Significant Adverse Event Review (SAER) closure rate. The Director of Nursing advised that a significant amount of work has been carried out on managing the adverse events reviews, and that there had been significant changes to improve the closure rate. The Medical Director added that the timelines for reviews are monitored carefully within the Adverse Events Teams. He also advised that there is a rapid and quick understanding on any adverse events that have happened, with Executive-level oversight, and that mitigating actions are put in place immediately.

C Grieve, Non-Executive Member, acknowledged the hard work that has taken place, as reflected within the IPQR.

A Haston, Non-Executive Member, thanked the team for the deep dives, which she noted provides a greater improvement on understanding and the work that has been undertaken.

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

9.2 Medicines Safety in NHS Fife: Review and Improvement

The Director of Pharmacy & Medicines reported that the paper is presented to the Committee to provide assurance on the review and improvement work that is being continued to ensure the safest medicines in Fife. It was also reported that close working is carried out to ensure there is a robust governance for medicines throughout the organisation for all aspects of use. It was advised that the report highlights some of the medicine safety programme work.

It was advised that a Medicine Response Group has been formed, which meet weekly, and that a Medicines Bulletin is produced, which includes shared learning. It was highlighted that there is a multidisciplinary improvement plan and that the Safer Use of Medicines Group is being rebranded into the Medicine Safety & Policy Group and will link in with the High-Risk Pain Medicines Programme. The Director of Pharmacy & Medicines also highlighted some of the key statistics from the report.

A Haston, Non-Executive Member, questioned the medicine incident statistics, and if assurance can be provided that Fife is not an outlier. In response, it was advised that there is no national reporting and learning system, however, assurance was provided that the Director of Pharmacy sits on the NHS Lothian Area Drug & Therapeutics Committee and has visibility of their approach in terms of numbers. Assurance was also provided that NHS Fife has good examples of reporting no harm incidents. The Director of Pharmacy & Medicines also confirmed that the Medicines Safety Group, which is multidisciplinary, have oversight and ownership of actions.

The Medical Director highlighted the importance of shared learnings and noted that NHS Fife has a positive culture towards medicine safety.

The Chair questioned if the medicine related hospital admissions numbers within the national report, is a similar position in Fife. In response, it was advised that this is a complex area, and a brief explanation was provided on the affecting factors.

K MacDonald, Non-Executive Member, commented positively on the report.

The Committee took **assurance** with regards to the current position with medicines safety in Fife and the summary of actions for the next 12-month work plan.

9.3 Healthcare Associated Infection Report (HAIRT)

The Director of Nursing reported that the surgical site surveillance programme is still paused.

It was also reported that there had been a safe delivery of care inspection since the last report, and the report has since been published on the Health Improvement Scotland (HIS) website. An update on the report and its related action plan will come to the next Committee meeting.

It was advised that cleaning compliance is above the target at 95.9%. In terms of hand hygiene, it was reported that a local solution is being explored. It was also noted that three wards in community hospitals are presently closed due to Covid.

The Chair queried the reconciling information in the HAIRT report with the unannounced inspection report, particularly around the healthcare environment, cleanliness and maintenance, and hand hygiene aspects. The Director of Nursing advised that the environment in Ward 5 had influenced the scoring. It was also advised that issues were highlighted around escalation processes and work is ongoing to improve this, and that the Infection Control Team are supporting training with volunteers and staff in relation to hand hygiene.

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

10. DIGITAL / INFORMATION

10.1 Digital & Information Strategy 2019-24 Update

The Associate Director of Digital & Information provided an update and reported that the deliverables have been reviewed, as per appendix 1. It was advised that a further 25 additional deliverables, as detailed in appendix 3, emerged during the strategic period, with a number of those relating to the pandemic response and the requirements for the National Treatment Centre. An update was also provided on the assessment range, progress of the deliverables and themes, as detailed in the paper. It was noted that an agile model is required within Digital & Information that can align to emerging priorities and support the delivery of technology to benefit patients and staff.

A Haston, Non-Executive Member, highlighted that the paper states 'that the scale of demand for digital solutions does not match the available funding or resourcing, and that ranking is a key requirement for all initiatives'. She questioned how the ranking will be prioritised. The Associate Director of Digital & Information provided an explanation and noted the importance of being able to pivot and be agile to the requirements of the clinical services and teams and advised that this is being addressed. It was also advised that the decision-making matrix has been reviewed for ranking. The Chief Executive highlighted the link to the strategy and advised that a balance is required around our ambition, clinical risk, and the financial consequences.

Following a question from the Chair, the Associate Director of Digital & Information stated that there is a commitment from the Digital & Information Board for a workshop to help support the overt commitment on balancing what will be taken forward.

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

11. PERSON CENTRED CARE / PARTICIPATION / ENGAGEMENT

11.1 Patient Experience & Feedback Report

The Director of Nursing was pleased to advise that the stage 2 complaints response rate is at its highest position, compared to the previous two years. She stated that this was reflective of all the hard work that the services and Patient Experience Team have

taken forward. An overview on the assessment and workforce planning sections of the report was provided.

C Grieve, Non-Executive Member, questioned if a level of detail will be available around the complexities, in terms of risks, now that the complexity scoring tool is embedded. In response, the Director of Nursing explained that testing is being carried out to ensure the criteria is correct, and that work is ongoing in relation to NHS Lothian's experience on the tool. The Chief Executive explained the stage 2 process for complaints and the work that is being carried out to review response letters.

Following a query from K MacDonald, Non-Executive Member, around safety issues following complaints, the Director of Nursing confirmed that actions are put in place as quickly as possible, and that learnings are shared. Discussion took place on collaboration and shared learnings across the various areas. The Director of Nursing agreed to provide further detail on shared learnings in the next quarterly report.

Action: Director of Nursing

Following a query from the Chair, the Chief Executive confirmed that any harms that are identified through complaints or adverse events would be added to Datix.

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

12. ANNUAL REPORTS / OTHER REPORTS

12.1 Mid-Year Resilience Assurance Report

The Head of Resilience provided a brief overview on the contents of the report.

C Grieve, Non-Executive Member, highlighted that the Resilience Team are now working with key stakeholders to enable associated framework guidance, and he questioned if the guidance was an existing framework. In response, the Head of Resilience explained that the approach to the framework was re-strategised. It was also advised that there is a policy for business continuity management systems, and that a systems approach is being explored to support that policy.

The Chief Executive highlighted that the Incident Management Framework attached to the report was slightly out-of-date.

The Chair requested further detail in the report with regards to Turas training compliance.

Action: Head of Resilience

The Chair acknowledged the hard work of the Resilience Team.

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

12.2 Hospital Standardised Mortality Ratio (HSMR) Update Report

The Medical Director highlighted the HSMR for NHS Fife during 2022/23 was 0.95.

Following a query from the Chair, the Medical Director agreed to seek clarity on the reason Queen Margaret Hospital is excluded from the data.

Action: Medical Director

The Committee took **assurance** that HSMR is monitored as a key quality performance indicator and took **assurance** that the HSMR for NHS Fife is in keeping with the national average.

12.3 Infection, Prevention & Control Annual Report 2022

The Director of Nursing highlighted the excellent work of the Infection, Prevention & Control Care Home Team, and advised that they won the 'Team of the Year' award at the recent NHS Fife Staff Awards.

Following a question from A Haston, Non-Executive Member, the Director of Nursing advised that there were no requests from internal audit in relation to infection, prevention & control, and that this is covered in the HAIRT report, which is the standard reporting template.

A Haston, Non-Executive Member, requested a summary graph from 2019, to include a target, be added to the report, to make it easier to analyse the data. The Director of Nursing agreed to take the request forward to the team.

Action: Director of Nursing

The Chair queried the escherichia coli bacteraemias (ECB) data in relation to NHS Fife being higher than the Scottish average. It was advised that this data is variable, and it was noted that NHS Fife was below the national average the previous quarter.

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

12.4 Volunteering Annual Report 2022/23

The Director of Nursing advised that the report provides a flavour of the work undertaken during 2022/23 and describes the plans for the service moving forward. The report also highlights the invaluable work of our volunteers and their huge commitment and dedication.

An overview on the workforce of the volunteering team was provided.

The Director of Pharmacy & Medicines highlighted that volunteering roles can help with people's confidence to get back into employment, and that this demonstrates how NHS Fife contributes beyond its functions, and as an Anchor Institution.

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

13. LINKED COMMITTEE MINUTES

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

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

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

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

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

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

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

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

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

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

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

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

14. ESCALATION OF ISSUES TO NHS FIFE BOARD

14.1 To the Board in the IPQR Summary

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

14.2 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.

15. ANY OTHER BUSINESS

There was no other business.

Date of Next Meeting – Friday 12 January 2024 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 12 January 2024

NO.	DATE OF MEETING	AGENDA ITEM / TOPIC	ACTION	LEAD	TIMESCALE	COMMENTS / PROGRESS	RAG
1.	03/11/23	**Clinical Governance & Strategic Framework Delivery Plan 2023/24 – Mid-Year Report**	To provide an update around the work being undertaken in relation to reviewing the effectiveness of the Organisational Learning Group.	**CP**	On hold	A verbal update will be provided at the meeting.	On hold
2.	08/09/23	**IPQR**	Consideration to be given to the actions required to improve the key deliverable risk ratings, metrics and to expanding the narrative in relation to organisational learning, with regards to Significant Adverse Events Review (SAER).	**CM**	March 2024	Adverse Manager will review the IPQR section with a view to adding narrative on any organisational learnings from SAERs.	Deadline not reached
3.	03/11/23	**Patient Experience & Feedback Report**	To provide further detail on shared learnings in the next quarterly report.	**JK**	March 2024	The next report (Q3) covers Oct – Dec 2023 and will be presented to the Committee in March. The next report will provide the requested information.	Deadline not reached
4.	03/11/23	**Annual Delivery Plan Quarter 2 Performance 2023/24**	The status for the deliverable for Hospital Pharmacy Redesign to be updated in the next iteration of the report.	**BH**	March 2024		Deadline not reached
5.	03/11/23	**Mid-Year Resilience Assurance Report**	To provide further detail in the report with regards to Turas training compliance.	**JT**	End of Year Report	A fuller update will be included within the Resilience end of year report. The TURAS training report was specific to PREVENT training.	Closed

NO.	DATE OF MEETING	AGENDA ITEM / TOPIC	ACTION	LEAD	TIMESCALE	COMMENTS / PROGRESS	RAG
6.	03/11/23	**Infection, Prevention & Control Annual Report 2022**	To take forward to the team, the request to have a summary graph from 2019, to include a target, added to the report, to make it easier to analyse the data.	**JK**	January 2024	Complete.	Closed
7.	03/11/23	**Cancer Strategic Framework Delivery Plan 2023/24**	To provide more detail on the underlying work for the next iteration.	**SAS**	January 2024	Detail has been added, and an updated version of the 2023/24 plan can be provided, if requested.	Closed
8.	07/07/23	**Development Session**	A Development Session to be arranged on Excellence in Care.	**JK/HT**	March 2024	Session arranged for 12 March 2024.	Closed
9.	03/11/23	**Alignment of NHS Fife Cancer Framework and the National Cancer Strategy 2023-2033 and Cancer Action Plan for Scotland 2023-2026**	To provide further detail on the specifics around workforce numbers and achievement dates within the National Delivery Plan and what that means to Fife.	**CM**	January 2024	Complete. The Cancer Transformation Manager has taken the 2022 cancer workforce information from the Cancer Framework and asked staff to provide an update of current staffing.	Closed
10.	03/11/23	**Clinical Governance & Strategic Framework Delivery Plan 2023/24 – Mid-Year Report**	To consider how to take forward how to ensure that the voice of lived experiences around safety, quality, care experience and harm is heard at Committee level.	**CP/JK**	January 2024	CP will consider this as part of the organisational participation and engagement work.	Closed
11.	08/09/23	**Patient Experience & Feedback Report Q1**	To bring back to the next Committee meeting, a more robust improvement plan.	**JK**	January 2024	A more robust improvement plan has been developed. This is included as an appendix in the PEaF SBAR (not quarterly report) that goes to each Committee.	Closed

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**12 January 2024**
Title:	**Reinforced Autoclaved Aerated Concrete Update**
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

This report relates to:

- Emerging issue

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

- Safe
- Effective
- Person Centred

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

- 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

Work is underway across Scotland to survey all NHS buildings which may potentially contain Reinforced Autoclaved Aerated Concrete (RAAC).

2.2 Background

RAAC is a lightweight form of concrete used mainly in roof, floor and wall construction in the UK during the second half of the 20th century. It has been found in a range of buildings, both in the public and private sector.

The material is known to be less durable than other forms of concrete, particularly where it has been damaged by water or where it was not formed correctly during the original fabrication. RAAC was used widely from the 1960's until it was phased out in the 1990's.
NHS Scotland Assure (part of NHS National Services Scotland) are co-ordinating a programme of work to carry out discovery surveys of all properties across the NHS estate that have been identified as potentially containing RAAC. A list of all buildings being surveyed across the NHS Estate in Scotland has been published on the NHS National Service Scotland website Reinforced Autoclaved Aerated Concrete (RAAC) Discovery Survey Programme - List of Properties | National Services Scotland (nhs.scot).

Using assessment criteria provided by NHS Scotland Assure, NHS Fife has identified several buildings within our Estate which may potentially contain RAAC and has supplied this information to NHS Assure. This list of buildings identified was a desk-based exercise based primarily on when the buildings - or parts of buildings - were built. While it is likely that parts of some of our buildings will contain RAAC, we will only know definitively once more detailed surveys are carried out.

2.3 Assessment

We have identified 26 blocks (elements of buildings) within our estate that we have passed to the National Programme for further assessment. The criteria for identifying areas were agreed nationally and included the following questions: -

1. Was the building, or any part of the building or extensions constructed between 1960 and 1989?
2. Is any part of the roof structure flat, or was previously flat (with a new pitched roof over)?
3. Is any part of the roof structure a low pitch (<45 degrees) long span sloped roof?
4. Is any part of the roof construction concrete?

A desktop survey is carried out if the answer to all questions is yes. The desktop survey identifies the risk of the block potentially containing RAAC based on the design information shared with the external partner employed by NSS (Currie & Brown).

Any of the blocks which are identified as high or medium risk of having RAAC have been physically surveyed by a Structural Engineer managed by the external partner (WSP).

Of the 26 blocks, 21 have been identified as having a high or medium risk of containing RAAC and 21 have been surveyed to date. The final Block has now been removed from the programme as it is derelict and unused.

Following surveys (See Appendix 1 for an example), 16 blocks have had no RAAC discovered (see Table 1), 5 have discovered RAAC (see Table 2).

The remaining 5 blocks have not yet been surveyed. The National Programme is prioritising high and medium likelihood risk areas before moving to low-risk areas (see Table 4).

Site Name	Block Name	Likelihood Category	RAAC
Kelty Health Centre	Kelty Main Block	High Likelihood of RAAC	NO
Kinghorn Health Centre	Kinghorn Main Block	High Likelihood of RAAC	NO
Leven Health Centre	Leven Main Block	Medium Likelihood of RAAC	NO
Queen Margaret Hospital	Boiler House	Medium Likelihood of RAAC	NO
Queen Margaret Hospital	Wards 05-07 ICASS	Medium Likelihood of RAAC	NO
Queen Margaret Hospital	Wards 01-04	Medium Likelihood of RAAC	NO
Victoria Hospital	Kitchen & Dining Room	Medium Likelihood of RAAC	NO
Victoria Hospital	Fife Area Labs North	High Likelihood of RAAC	NO
Victoria Hospital	Hayfield House	High Likelihood of RAAC	NO
Victoria Hospital	P1 Main Building	High Likelihood of RAAC	NO
Whyteman's Brae Hospital	Victoria Radio Network	Medium Likelihood of RAAC	NO
Whyteman's Brae Hospital	Boiler House	High Likelihood of RAAC	NO
Whyteman's Brae Hospital	Generator	High Likelihood of RAAC	NO
Whyteman's Brae Hospital	Day Hospital & Ravenscraig	High Likelihood of RAAC	NO
Whyteman's Brae Hospital	Day Hospital Entrance	High Likelihood of RAAC	NO
Whyteman's Brae Hospital	Ward Block	High Likelihood of RAAC	NO

Table 1 - Blocks where RAAC has not been identified.

Site Name	Block Name	Likelihood Category	RAAC
Kirkcaldy Health Centre	Kirkcaldy Main Block	High Likelihood of RAAC	YES
Lynebank Hospital	Tayview & Ward 12 Offices	High Likelihood of RAAC	YES
Lynebank Hospital	Psychology, Health Records & Health Storage	High Likelihood of RAAC	YES
Lynebank Hospital	Main Building	High Likelihood of RAAC	YES
Queen Margaret Hospital	P1 Main Block	Medium Likelihood of RAAC	YES

Table 2 - Blocks where RAAC has been identified.

Site Name	Block Name	Likelihood Category	RAAC
Cameron Hospital	Linen Room Closed	Removed from Programme	N/A

Table 3 - Blocks which have not yet been surveyed.

Site Name	Block Name	Likelihood Category	RAAC
Randolph Wemyss Memorial Hospital	Kitchens, Boiler House & Wards 01&02	Low Likelihood of RAAC	Low Risk
Victoria Hospital	Tunnel P1 Base to Labs Base	Low Likelihood of RAAC	Low Risk
Victoria Hospital	Tunnel Kitchen Base to Service Yard Base	Low Likelihood of RAAC	Low Risk
Victoria Hospital	Central Laundry	Low Likelihood of RAAC	Low Risk
Victoria Hospital	P2 Main Building	Low Likelihood of RAAC	Low Risk

Table 4 - Low Likelihood of Containing RAAC Not yet surveyed.

Where RAAC has been discovered (5 blocks) the blocks can be divided into 2 distinct categories: -

- Blocks where RAAC has been identified but where there is no immediate cause for concern (Table 5) where the surveys have recommended periodical monitoring (annually or longer). We will put mechanisms in place to monitor these areas on an annual basis by suitably qualified personnel.

Site Name	Block Name	Monitoring
Lynebank Hospital	Tayview & Ward 12 Offices	Annual
Queen Margaret Hospital	P1 Main Block	Annual

Table 5 - Areas for Annual monitoring

- Blocks where further investigation is required: -

Site Name	Block Name	Further Investigation
Kirkcaldy Health Centre	Kirkcaldy Main Block	YES
Lynebank Hospital	Psychology, Health Records & Health Storage	YES
Lynebank Hospital	Main Building	YES

Table 6 - Areas for further investigation

For the blocks where further investigation is required (Table 6), discussion is ongoing Nationally about how this can be done consistently across Scotland. While this is being carried out, risk assessments (See Appendix 2 for example) have been caried out in the 3 areas identified above by our Health and Safety Manager, which have resulted in several mitigating actions which have now been put in place.

On further review of our estate, based on our experience of attending all of the surveys, there are 3 blocks (Table 7) in addition to the 27 initial blocks which our Compliance team have recommended are included in the National Survey Programme which are: -

Site Name	Block Name
Adamson Hospital	Tarvit Ward
Cupar Health Centre	Cupar Main Block
Glenrothes Hospital	Glenrothes Main Block

Table 7- Additional blocks

We expect these to be included in the National Programme, following a desktop survey exercise by the external partner which has been commissioned by NSS.

2.3.1 Quality, Patient and Value-Based Health & Care

We have not yet identified areas where patient care is affected by RAAC and the areas where further investigation is required are not primarily patient facing.

2.3.2 Workforce

We are committed to providing staff with a continuously improving & safe working environment. We have taken a risk-based approach to minimising the risks to all staff.

2.3.3 Financial

In the short-term we have identified a contingency sum of £50k to support further investigations and provide any short-term mitigations. In the longer-term we will ensure that RAAC is included in the risk assessed backlog maintenance capital expenditure plan, where necessary. It is anticipated that those areas containing RAAC may have significant costs in the future if the RAAC becomes unstable or reaches the end of its life.

2.3.4 Risk Assessment / Management

The Asset Management System prioritises work based on the condition of the different blocks and systems within the estate. The system will be updated with RAAC information and will be used to prioritise backlog maintenance and capital expenditure going forwards.

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

An Impact Assessment has not been carried out.

2.3.6 Climate Emergency & Sustainability Impact

There is no immediate impact on climate emergency and sustainability although there is a preference going forward to reuse existing buildings rather than replacement given the embodied carbon created during the construction period.

2.3.7 Communication, involvement, engagement and consultation

A post was published on Blink in September 2023 and following a discussion at Area Partnership Forum, an NHS Fife website has been developed Reinforced Autoclaved Aerated Concrete (RAAC) | NHS Fife to provide information in a transparent manner. It is likely that this resource will be updated with the information included in this paper as soon as reasonably possible.

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.

- Estates & Facilities Senior Management Team on 25 October 2023
- Executive Director Group on 2 November 2023
- Fife Capital Investment Group on 8 November 2023

2.4 Recommendation

Members are asked to take **assurance** from the update.

Following approval at Fife Capital Investment Group, the paper will be considered by the following groups:

Fife Clinical Governance Committee
Staff Governance Committee
Area Partnership Forum/Local Partnership Forum
Health & Safety Sub-Committee

3 List of appendices

The following appendices are included with this report:

- Appendix 1 - Sample Survey Report
- Appendix 2 - Sample Risk Assessment

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

INSPECTION REPORT R006

ISSUE DATE:	10 August 2023	**CONFIDENTIALITY:**	Confidential
SUBJECT:	RAAC Discovery Inspection		
PROJECT:	NHS Scotland Assure RAAC Investigations	**AUTHOR:**	#012
CHECKED:	#003	**APPROVED:**	#003

SUMMARY DETAILS

NHS Board:	NHS Fife	
Site Code:	F810H	
Site Name:	Lynebank Hospital	
Block No.:	D0	
Block Name:	Main Building	
Inspection Date:	03/08/2023	
Structural Engineers	#003	#012
NHS Estates	Robert Terry	
Summary Status	RAAC observed	Action required as noted

INSPECTION REPORT R006

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INTRODUCTION

This report has been prepared to summarise the findings of a visual structural inspection carried out at the property described above. The purpose of the inspection was to establish whether Reinforced Autoclaved Aerated Concrete (RAAC) is present in representative locations and to make observations about the condition of RAAC in those locations. This report is not intended to be an appraisal of the whole structure, nor is it intended to report on structural matters unrelated to RAAC. Should those services be required by NHS Scotland Assure then a separate report should be commissioned.

The inspection was conducted from ground level externally and from floor level internally, except where ladders were used to view above suspended ceilings. It should be noted that ceilings tiles were taken down in a limited number of locations, because the building remained live and because the asbestos management plan indicated that some locations were unsuitable for inspection. Nevertheless, in our opinion sufficient locations were inspected to decide whether RAAC was present or not.

Our report reflects the building and its condition at the time of inspection, however if RAAC becomes wet or is overloaded it will become distressed, and its capacity will reduce. For this reason, the building fabric, including the rainwater goods, must be regularly maintained and access to floors and roof structures should be managed.

The reader may not assume that locations not expressly described in this report are free from defects, damage, and distress. Nor can it be guaranteed that RAAC is not present in locations that were not viewed.

This report is for the exclusive use of NHS Scotland Assure and shall not be relied upon by third parties without the permission of WSP expressed in writing.

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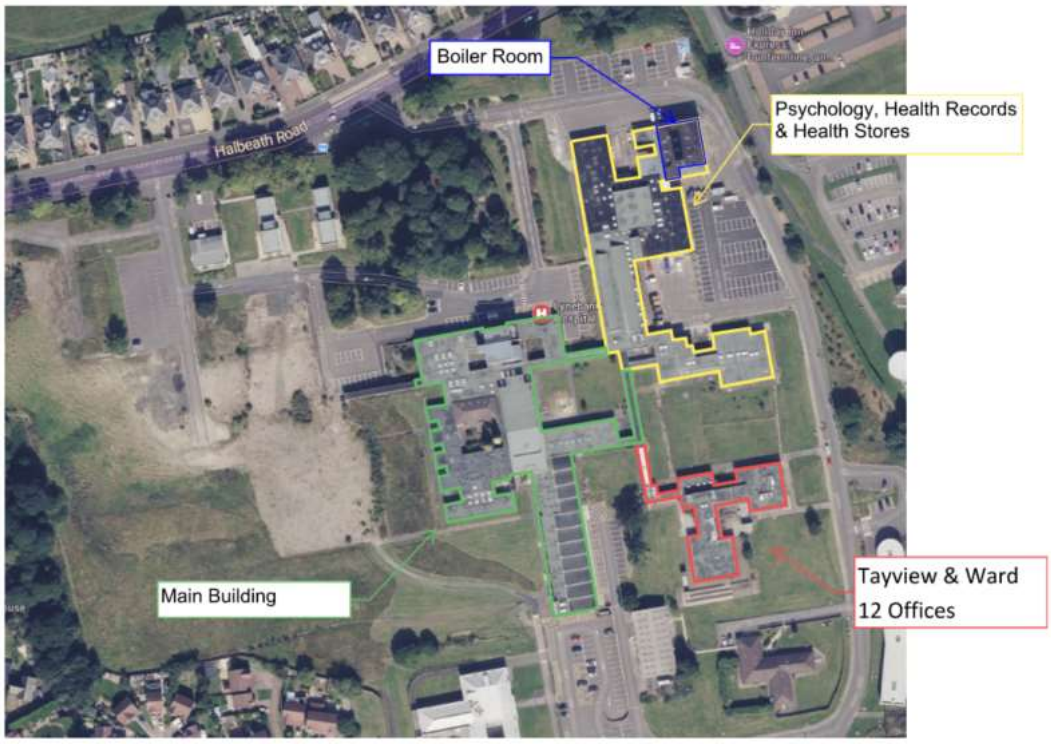
INSPECTION LOCATIONS

The floor plan below shows locations where the structure was observed from inside the ceiling void. Only voids positively identified as being free from asbestos in the relevant report were considered for inspection. Some of those were in rooms that were in use at the time of our visit and consequently these were not selected for inspection. Locations with fixed plasterboard ceilings, and no access hatches, were also discounted as no intrusive works were to be undertaken.

The locations that were viewed were consistent with the building being a system build. For this reason, it is reasonable to assume that they are representative of the structure. We do not foresee a need to view additional locations in the building for the purpose of RAAC Discovery.

Site Plan



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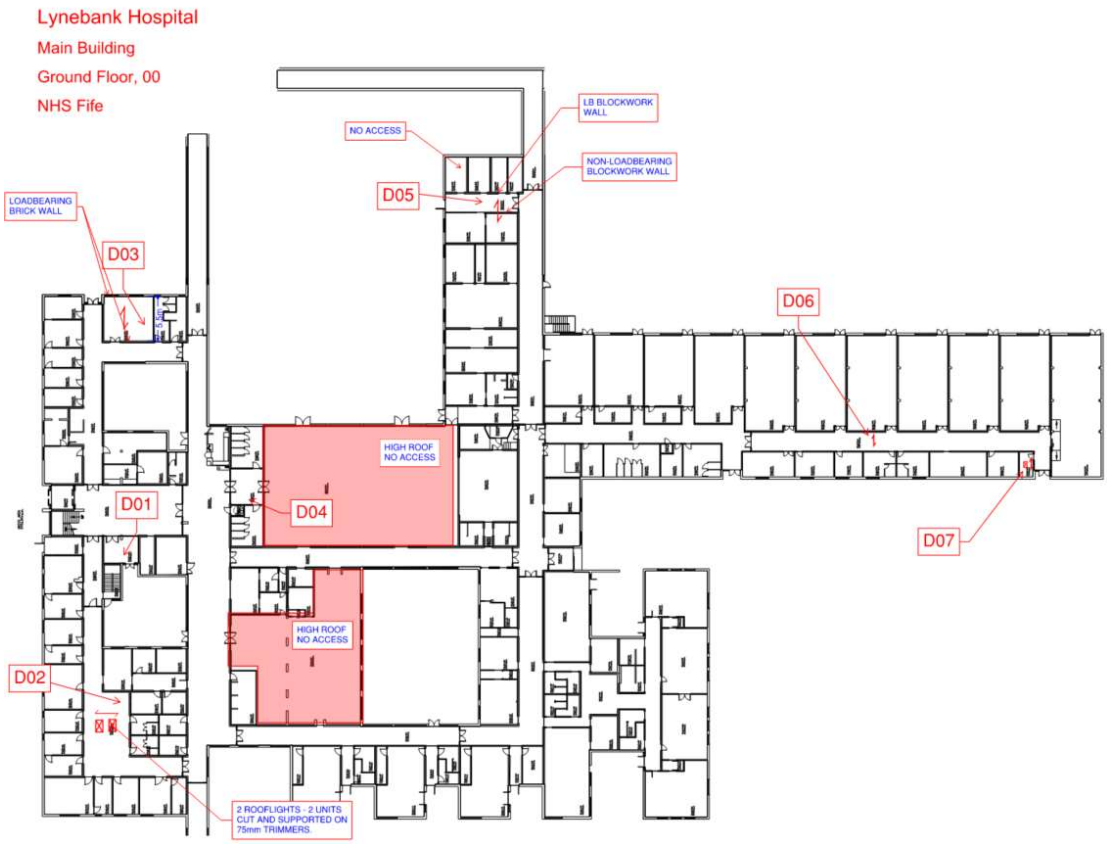
OBSERVATIONS

Lynebank Hospital is formed of multiple buildings constructed as one project circa mid-1970s. This inspection report includes only Block D0 – Main Building.

The multistorey central portion of the main building which houses the main entrance was constructed from reinforced cast in-situ concrete and the single storey surrounding buildings were formed from RAAC roof slabs supported on load bearing block or brick walls with precast concrete lintels or steel beams where walls were not present. Rooflights were present in the single storey roofs but most of these have been covered by suspended ceilings. The upstands to the rooflights appear to have been formed from timber and chipboard or plywood.

Block D0 – Main Building



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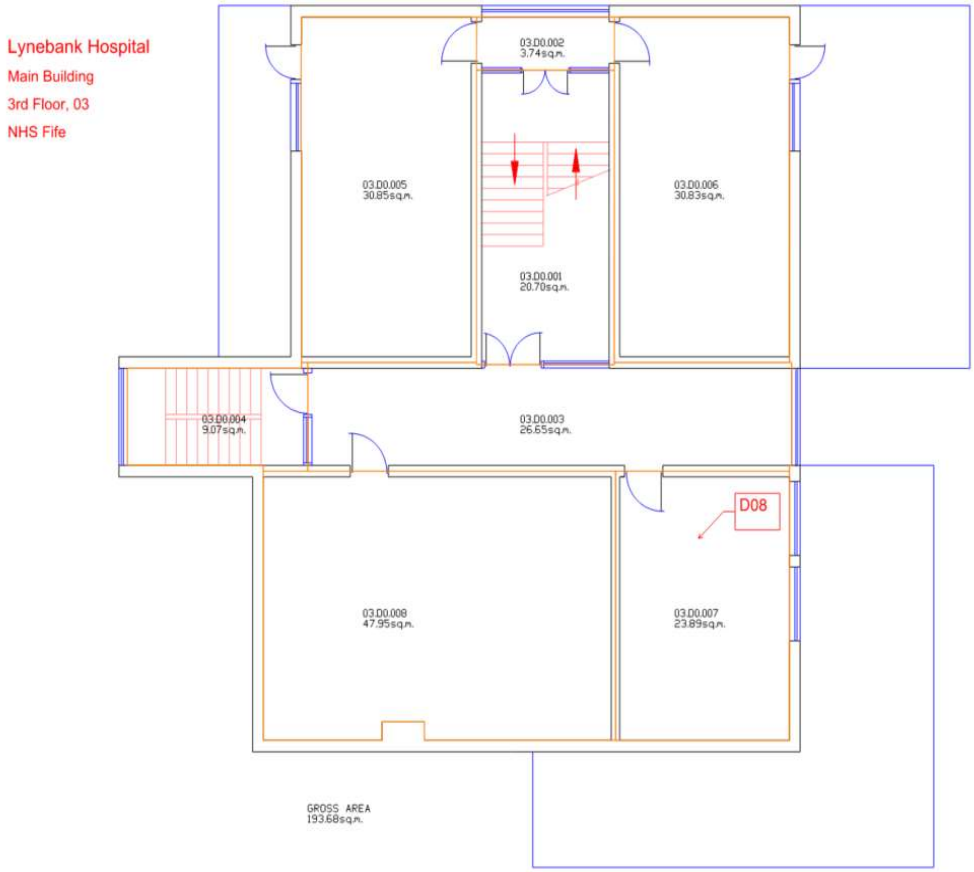

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Block D0 – Main Building

Location	Comments	Image
D01	RAAC not observed / No action Reinforced cast in-situ concrete flat slab observed above the ceiling in the central main building.	
D02	RAAC observed / Medium risk – Inspect annually RAAC slabs supported on 215mm brick wall. Units typically 600mm wide. There are two rooflights trimmed with 75mm wide steel box/angle, actual bearing of slabs not determined. Two no. RAAC slabs cut and supported on trimmer steel at each end of each rooflight. Services and ceilings fixed to RAAC slabs. One no. slab damaged by localised spalling around previous fixing. No evidence of transverse or longitudinal cracking or excess deflection noted. Nor was there any evidence of water ingress.	

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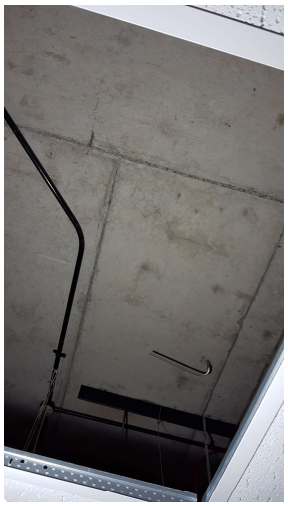
D03	RAAC observed	Medium risk - Inspect annually	
	RAAC slabs observed spanning 5.5m between loadbearing brick walls. Ceiling and nominal services fixed to 600mm wide slabs. Evidence of deflection at midspan. Slabs appeared dry with no staining. Slab in contact with brick partition wall in direction of span has 10mm spalling, though no reinforcement has been exposed. Bearing lengths on brick walls could not be determined.		
D04	RAAC not observed	No Action	
	Flat Reinforced Concrete slab supporting floor above of multistorey RC central section of main building.		
D05	RAAC observed	Low risk - Inspect in 3 years	
	RAAC observed above ceiling spanning between block walls. Slab bearing length unknown. Ceiling part supported on walls and part supported by slabs. Electrical conduits supported by slab. No water ingress, cracking, spalling or deflection observed.		

	Bearing length could not be determined.		
D06	RAAC observed	High risk - Action required	
	RAAC observed above ceiling. There is a gutter outlet through roof slab with evidence of prolonged water ingress around downpipe causing staining on slabs. Intrusive inspection/investigation is recommended to determine if supplementary support is needed and sources of water should be treated. Services prevent close inspection, and re-appraisal by endoscope should be considered. Bearing width could not be observed.		
D07	RAAC observed	High risk - Action required	
	Rooflight at centre where two slabs have been cut. Two slabs have been cut and supported on steel trimmers, trimmer 75mm wide but it is not clear whether the full width has been used for bearing. That said, the span of trimmed units is short. There is evidence of water ingress to slab around rooflight. Water heater located directly below so may be causing issue. Transverse cracks noted adjacent to external wall location. However, slabs are short span. Action required in this location to determine bearing width, although supplementary support is expected to be required due to cracking. Sources of water ingress should also be treated.		

INSPECTION REPORT R006

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D08 (Third Floor)	RAAC not observed | No Action Reinforced concrete walls and roof observed.	
External Facade	RAAC not observed | No Action External façade generally brick/block cavity wall with white rendered brick at the head. Multi-storey section of the main building formed with reinforced cast in-situ concrete façade.	

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CONCLUSIONS

In general, the RAAC panels that were viewed were dry, and did not deflect excessively. Nevertheless, there were locations where water ingress and localised distress was evident. It was not possible to determine the bearing length of the slabs in most cases.

For these reasons, the frequency of intervention and reinspection is outlined on a case-by-case basis. We have made determinations based on the decision matrices shown below in the next page.

The frequency of inspection should be increased to annually if the roof finishes or rainwater goods become compromised in the intervening period or if distress becomes evident. Our recommendation assumes that the roof and rainwater goods are inspected and cleaned during scheduled maintenance of the property and that access to the affected structures is controlled so that RAAC panels are not overloaded. If subsequent annual inspection was to reveal increased distress, then interventions should take place.

At location D06 where there appears to be long term water ingress better access to the slab is required to make an accurate assessment of its condition. Remedial action is also required to prevent further water ingress to the slab. Should the slab have significantly deteriorated, suitable remedial action should be made.

It is important to note that our assessment of condition reflects the locations that were inspected. Other locations may be in a different condition. A detailed inspection of all RAAC panels, including intrusive work to inspect bearings, is required to provide a comprehensive assessment.

INSPECTION REPORT R006

ISSUE DATE:	10 August 2023	**CONFIDENTIALITY:**	Confidential
SUBJECT:	RAAC Discovery Inspection		
PROJECT:	NHS Scotland Assure RAAC Investigations	**AUTHOR:**	#012
CHECKED:	#003	**APPROVED:**	#003

Risk assessment if water ingress is observed				
Deflection	Major Cracking or spalling	Minor cracking/ or spalling within 500mm of support	Minor cracking or spalling away from the supports	No visible defect
Deflection >span/100	Red	Red	Red	Red
Span/100<Deflection<span/200	Red	Red	Red	Red
Span/200<Deflection<span/250	Red	Red	Amber	Amber
Deflection<span/250	Red	Red	Amber	Amber

Risk assessment if NO water ingress is observed				
Deflection	Major Cracking or spalling	Minor cracking/ or spalling within 500mm of support	Minor cracking or spalling away from the supports	No visible defect
Deflection >span/100	Red	Red	Red	Red
Span/100<Deflection<span/200	Red	Red	Amber	Amber
Span/200<Deflection<span/250	Red	Amber	Green	Green
Deflection<span/250	Red	Amber	Green	Green

Assessment Category	Risk Category	
Red	Critical Risk	Requires urgent remedial works which may include taking out of use or temporary propping to allow the safe ongoing use of a building. Depending on the extent, this may be part or all of the building. Combined with awareness campaign for occupants including exclusion zones.
	High Risk	Requires remedial action as soon as possible. Combined with awareness campaign for occupants, which may include exclusion zones, signage, loading restrictions and the need to report changes of condition, e.g., water leaks, debris, change in loading etc
Amber	Medium Risk	Requires inspection and assessment on a regular basis, e.g., annually Combined with awareness campaign for occupants, which may include signage, loading restrictions and the need to report changes of condition, e.g., water leaks, debris etc
Green	Low Risk	Requires inspection and assessment occasionally, say 3-year period depending on condition. Combined with awareness campaign for occupants, which may include signage, loading restrictions and the need to report changes of condition, e.g., water leaks, debris etc

[1]

[1] IstructE, 'Reinforced Autoclaved Aerated Concrete (RAAC) Investigation and Assessment – Further Guidance' 2023

RECORD OF GENERAL RISK ASSESSMENT (Based on HSE's five steps to risk assessment)				NHS Fife
Date of Assessment:	**29/09/2023**	**Assessment Reference:**	**RAAC – LBH 01**	
Department	**Estates - RAAC**	**Assessment Revision:**	**Rev.00**	
Manager Responsible	**Paul Bishop**			
Risk Assessor(s)	**Billy Nixon, Jim Wishart, Bob Terry,**			

Step 1(a)- Description of Task and Environment

The purpose of this risk assessment is to respond to the summarised findings of a visual structural inspection carried out by WSP to establish whether Reinforced Autoclaved Aerated Concrete (RAAC) is present in representative locations and to make observations about the condition of RAAC in those locations.

Utilising Inspection Reports R005 R006 – Lynebank Hospital, this risk assessment is a collaboration between stakeholders to assess the risks highlighted and indentify what control measures would be proportional to the evaluated risk to both staff and patients.

Step 1(b) What are the hazards	Step 2- Who might be harmed & how	Step 3(a)- Current Controls	Step 3(b) Evaluate the risks
RAAC present within the buildings	Staff, Visitors, Users of LBH – RAAC planks failing due to water ingress – falling debris, plank failure	1. Structural Engineering Contractor to be employed to undertake more intrusive survey to determine accurate bearing lengths of RAAC Planks 2. RAAC management strategy being created to carry out annual inspections of roof planks. 3. Excessive deflection was not observed by WSP in majority of areas 4. No evidence of moisture present or water ingress observed by WSP in majority of areas 5. WSP advised triennially inspection for sections of the buildings 6. Roof inspection and maintenance carried out annually	Remote (1) x Major (4) Low Risk (4)
A01 – Bearing edge of cut slab less than recommended 75mm	Staff, Visitors, Users of LBH – RAAC planks failing due to limited bearing support – falling debris, plank failure	7. No evidence of transverse cracks at supports observed by WSP 8. No evidence of water ingress observed by WSP 9. No evidence of excessive deflection observed by WSP 10. RAAC planks observed to be reasonable condition by WSP 11. Acrow Prop with baton to be placed directly next to steel angle support sections to increase bearing size 12. Monthly inspection of area to inspect for any potential debris or movement of Acrow Prop	Remote (1) x Major (4) Low Risk (4)

		13. No permitted access to roof area directly above RAAC plank indentified while building is occupied(marked drawing on WSP report)	
A04 – Close inspection not possible due to height of ceiling void	Staff, Visitors, Users of LBH – RAAC planks failing due to water ingress – falling debris, plank failure	14. No evidence of excessive deflection observed by WSP 15. No evidence of cracking observed by WSP 16. No services or suspended ceiling mounted to RAAC planks 17. Installation of larger inspection hatch to allow better access to ceiling void 18. Potential water ingress to be investigated and remedied 19. Additional supports to be discussed once closer inspection has been carried out 20. Room is not continually occupied throughout the day. 21. No permitted access to roof area directly above RAAC plank indentified while building is occupied(marked drawing on WSP report)	Unlikely (2) x Major (4) Moderate Risk (8)
A05 – Bearing edge of cut slab less than recommended 75mm	Staff, Visitors, Users of LBH – RAAC planks failing due to limited bearing support – falling debris, plank failure	22. No mention of excessive deflection observed by WSP 23. No mention of cracking observed by WSP 24. No mention of water ingress observed by WSP 25. Limited span of RAAC plank due to covering corridor area 26. All main services in ceiling void are supported from steel angles spanning the corridor 27. Monthly inspection of area to inspect for any potential debris or evidence of change in condition of RAAC planks at bearing ends	Remote (1) x Major (4) Low Risk (4)
A06 – Water ingress and deterioration of RAAC plank	Maintenance staff of LBH – RAAC planks failing due to water ingress – falling debris, plank failure	28. Acrow Prop x 2 with baton to be placed at bearing edge of RAAC planks to provide additional support 29. No public access and limited access into area by maintenance staff – approx 1hr per day 30. Potential water ingress to be investigated and remedied 31. No permitted access to roof area directly above RAAC plank indentified while building is occupied(marked drawing on WSP report)	Unlikely (2) x Major (4) Moderate Risk (8)
A07 – Bearing edge of cut slab less than recommended 75mm, mechanical damage	Maintenance staff of LBH – RAAC planks failing due to limited bearing support – falling debris, plank failure due to mechanical damage	32. No evidence of water ingress observed by WSP 33. Acrow Prop with baton to be placed directly under area of mechanical damage 34. Monthly inspection of area to inspect for any potential debris or evidence of change in condition of RAAC planks at bearing ends 35. Roof-light plank section limited in length	Unlikely (2) x Major (4) Moderate Risk (8)

A08 – Water ingress and deterioration of RAAC plank	Maintenance staff of LBH – RAAC planks failing due to water ingress – falling debris, plank failure	36. Old boiler house / clinical waste store / garages are not to be accessed regularly by staff 37. Decision to be made on full closure after additional survey.	Possible (3) x Major (4) Moderate Risk (12)
D06 – Bearing edge of plank less than recommended 75mm, water staining	Staff, Visitors, Users of LBH – RAAC planks failing due to water ingress – falling debris, plank failure	38. Potential water ingress to be investigated and remedied around gutter outlet through RAAC plank 39. Limited span of RAAC plank due to covering corridor area 40. Additional supports to be discussed once closer inspection has been carried out using endoscope due to amount of services 41. Monthly inspection of area to inspect for any potential debris or evidence of change in condition of RAAC planks at bearing ends	Unlikely (2) x Major (4) Moderate Risk (8)
D07 – Bearing edge of plank less than recommended 75mm, water staining	Staff, Visitors, Users of LBH – RAAC planks failing due to water ingress – falling debris, plank failure	42. Acrow Prop with baton to be utilised to support sections to increase bearing size and cracking 43. Limited span of RAAC plank due to covering corridor area 44. Potential water ingress either from roof-light or water heater to be investigated and remedied 45. Monthly inspection of area to inspect for any potential debris or evidence of change in condition of RAAC planks at bearing ends 46.	Unlikely (2) x Major (4) Moderate Risk (8)

Severity / Likelihood	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Certain (5)	Low risk (5)	Moderate risk (10)	High risk (15)	High risk (20)	High risk (25)
Likely (4)	Low risk (4)	Moderate risk (8)	Moderate risk (12)	High risk (16)	High risk (20)
Possible (3)	Very low risk (3)	Low risk (6)	Moderate risk (9)	Moderate risk (12)	High risk (15)
Unlikely (2)	Very low risk (2)	Low risk (4)	Low risk (6)	Moderate risk (8)	Moderate risk (10)
Remote (1)	Very low risk (1)	Very low risk (2)	Very low risk (3)	Low risk (4)	Low risk (5)

Step 3(c)- What Further Action is Necessary? Step 4- Record Your Findings and Implement Them

Action Required	Person Responsible	Action Date	Action Taken	Completed Date
A01 – 1 x Acrow Prop with batons installed to support RAAC Plank	James Wishart	27/10/23	Acrow supports installed 20/11/23	21/11/23
A04 – Installation of larger inspection hatch to allow better access to ceiling void	James Wishart	27/10/23	Works complete 20/11/23	21/11/23

A06 – Acrow Prop x 2 with baton to be placed at bearing edge of RAAC planks to provide additional support	James Wishart	27/10/23	Acrow supports installed w/e 20/10/23	20/10/23
A07 – Acrow Prop with baton to be placed directly under area of mechanical damage	James Wishart	27/10/23	Acrow supports installed w/e 20/10/23	20/10/23
A08 – Communicate closure of areas	James Wishart	27/10/23	Boilerhouse and coal stores(garages) locked off. Alternative location for clinical waste bins agreed, due to be locked off Friday 27th October.	27/10/23
D06 – Additional inspection with endoscope	James Wishart	27/10/23	Modular ceiling so no need for additional hatch. Additional supports and beams ordered ready for installation if required.	21/11/23
D07 – 1 x Acrow Prop with batons installed to support RAAC Plank	James Wishart	27/10/23	Acrow supports installed 20/11/23	21/11/23

Has the risk assessment been agreed with Manager responsible?	**Yes**	**No**
Manager responsible Signature & Date		

Have the findings of this risk assessment been communicated to all relevant people?	**Yes:** ✓	**No:**
Method(s) of communication: **Emailed to stakeholders**		
Risk assessment completed by:		
Signature(s): 		
How soon should this assessment be reviewed and how regularly afterwards?	Review immediately following an incident or if there have been significant changes in RAAC condition	

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**12 January 2024**
Title:	**Notification to Health and Safety Executive (HSE) of Work in Atmosphere Containing Radon**
Responsible Executive:	**Dr Chris McKenna, Executive Medical Director NHS Fife**
Report Author:	**Laura Cluny, Principal Clinical Scientist NHS Lothian & Nicola Macdonald, RPA and Head of Radiation Protection NHS Lothian**

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Emerging issue
- Legal requirement

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

- Safe

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

- Well informed
- 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

Following routine monitoring for Radon levels in the workplace, a facility in NHS Fife has been found to have Radon levels above the action level of 300Bq/m^3 defined under the Ionising Radiation Regulations (IRR) 2017. The facility is Kinghorn Medical Practice.

2.2 Background

It is a requirement under the Health and Safety at Work Regulations for Employers to make assessments of Radon levels in all workplaces in Radon affected areas, and any occupied basements. Radon monitoring was carried out by Earth Environmental and Geotechnical

Ltd, on behalf of NHS Fife from June to September 2023. All sites were compared to the map of Radon affected areas; no sites were within Radon affected areas however a number of sites had occupied (>50 hours annually) basements, which therefore required monitoring.

46 sites were reviewed in total:

- 32 did not require Radon monitoring
- 10 sites had Radon levels <100Bq/m^3 and re monitoring is required in 10 years:
- 3 sites had Radon levels 100 – 200Bq/m^3 and re monitoring is required in 5 years:
- 1 site had Radon levels > 300Bq/m^3 and remedial action is required: Kinghorn Medical Practice

Three monitors were positioned at the Kinghorn Medical Practice in the staff room, IT server room and community staff office used by Health Visitors. The seasonally adjusted, annual average Radon level calculated from each monitor was just above the action level of 300Bq/m^3: results were 331, 304 and 322Bq/m^3, respectively.

2.3 Assessment

As the action level was exceeded, a notification to HSE is required to inform them that staff are working in an environment where Radon levels exceed 300Bq/m^3. The Employer is also required to take action to reduce Radon levels to below this value.

On the 5th of December 2023, NHS Lothian Radiation Protection staff met with the NHS Fife Estates Manager at Kinghorn Medical Practice to review the facility and discuss actions. It was confirmed that offices in the basement are used regularly by community staff and there are plans to convert an additional office into a GP Practice room. There is an extract ventilation system within the basement, however on visual inspection this appeared to be only partially working with disconnections in the pipework.

An RPA advice note was issued on the 7th December 2023, with the following recommended actions to be carried out by the Estates Department:

- Assess existing ventilation within the basement level of the Kinghorn Medical Practice
- Undertake remedial works to repair existing ventilation, adding additional extract vents if required; a target level of ~ 6 ACH was discussed
- Following ventilation remedial works, instigate a three month period of repeat monitoring to include all offices within the basement
- Further remedial works will be considered as required, based on the results of repeat monitoring.

NHS Lothian Radiation Protection completed the required HSE Notification for work in areas with Radon concentration exceeding 300Bq/m^3 on the 12th of December 2023.

NHS Lothian Radiation Protection have additionally completed a health and safety risk assessment for staff working in this area, as well as a communication to staff. This was distributed on the 12th of December 2023; further information sessions were also offered and will be arranged if required.

2.3.1 Quality, Patient and Value-Based Health & Care

Not relevant: this paper relates to a staff work environment and the health and safety of staff only.

2.3.2 Workforce

Information has been provided to staff working at the Medical Practice on the risks associated with Radon. Following distribution of the communication to staff, concerns have been raised to the Health Visitor team lead around the work environment at the Kinghorn Medical Practice. The Radiation Protection service have offered additional information on Radon related risks, however there are additional staff concerns around damp, ventilation, and lack of natural light.

2.3.3 Financial

There is no significant financial impact expected as a result of the Radon action level being exceeded. Financial impact is limited to the cost of minor remedial ventilation works by the Estates Department and a repeat period of Radon monitoring.

2.3.4 Risk Assessment / Management

NHS Lothian Radiation Protection have completed a general health and safety risk assessment for staff working in this area.

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

Not relevant.

2.3.6 Climate Emergency & Sustainability Impact

Not relevant.

2.3.7 Communication, involvement, engagement and consultation

This was initially discussed at NHS Fife Radiation Protection Committee on 14th November 2023, which is attended by managers and senior staff from services using ionising radiation and MRI. Following the subsequent site visit, an update summarising the findings and recommended actions for the Estates Department was provided to the Kinghorn Medical Practice manager. A further communication to staff working in the area, providing information on Radon and associated risks, was also distributed.

2.3.8 Route to the Meeting

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

- NHS Fife Radiation Protection Committee, 14th November 2023

2.4 Recommendation

This paper is provided to members for:

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

3 List of appendices

The following appendices are included with this report:

- N/A

Report Contact
Laura Cluny
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Nicola Macdonald, RPA and Head of Radiation Protection, NHS Lothian
Nicola.Macdonald@nhslothian.scot.nhs.uk

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**12 January 2024**
Title:	**Internal Control Evaluation**
Responsible Executive/Non-Executive:	**M McGurk, Director of Finance & Strategy**
Report Author:	**J Lyall, Chief Internal Auditor / B Hudson, Regional Audit Manager**

1 Purpose

This report is presented for:

- Assurance

This report relates to a:

- Local policy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation and Background

As Accountable Officers, Chief Executives are responsible for maintaining a sound system of internal control to manage and control all the available resources used in the organisation. The work of Internal Audit and the assurances provided by the Chief Internal Auditor in relation to internal control are key assurance sources taken into account when the Chief Executive undertakes the annual review of internal controls, and form part of the consideration of the Audit and Risk Committee and the Board prior to finalising the Governance Statement which is included and published in the Board's Annual Accounts.

This review aims to provide early warning of any significant issues that may affect the Governance Statement.

2.2 Assessment

Key Themes

Audit Scotland – NHS Scotland 2023, issued February 2023, stated that 'the NHS in Scotland faces significant and growing financial pressures. These include inflation; recurring pay pressures; ongoing Covid-19 related costs; rising energy costs; a growing capital maintenance backlog; and the need to fund the proposed National Care Service. These pressures are making a financial position that was already difficult and has been

exacerbated by the Covid-19 pandemic, even more challenging'. Internal Audit reports have recorded similar concerns and highlighted the strategic changes required. The financial risk for NHS Fife, NHSScotland and the public sector has continued to increase.

As reported in the Internal Audit Annual Report for 2022/23, the challenge now is balancing short term risks against longer term risks which can only be mitigated through strategic change. T

We previously highlighted the need for realistic workforce plans. The NHS Fife Workforce Plan 2022-2025 was published in November 2022 and work is underway to inter-relate and align financial and workforce planning via the Strategic Planning Resource Allocation (SPRA) process.

Continuing staff shortages and increased demand for staff means that effective workforce planning remains key in supporting the achievement of the Board's operational, financial and strategic objectives.

Maintaining operational performance against mandated targets remains extremely challenging. While operational improvements will have a limited impact on performance, genuinely strategic solutions must be identified, with a focus on working closely with partners to address underlying capacity and flow issues. The Board has continued to respond, and risk assess to ensure the most urgent work is prioritised.

NHS Fife continues to progress its Risk Management Framework Improvement Programme. The Board's overall approach to risk management has been revised with a new Corporate Risk Register replacing the Board Assurance Framework. Current risk scores and achievement of target scores by target dates will require careful consideration and constant monitoring to ensure they fully reflect current risk and controls and are realistic.

The Clinical Governance Strategic Framework and associated Annual Delivery Plan were approved by Fife NHS Board on 28 March 2023. The framework outlines the governance and assurance reporting routes for clinical governance throughout the full span of NHS Fife responsibilities.

2.3.1 Quality, Patient and Value-Based Health & Care

The Institute of Healthcare Improvement Triple Aim (Better population health, better quality of patient care, financially sustainable services) is a framework that describes an approach to optimising health system performance and is a core consideration in planning all internal audit reviews.

2.3.2 Workforce

Management responsibilities, skill sets and structures are a core consideration in planning all internal audit reviews.

2.3.3 Financial

Financial Governance is a key pillar of the Annual Internal Audit Plan and value for money is a core consideration in planning all internal audit reviews.

2.3.4 Risk Assessment/Management

The internal audit planning process which produces the Annual Internal Audit Plan takes into account inherent and control risk for all aspects of the Audit Universe. Individual internal audit assignments identify the key risks at the planning stage and our work is designed to evaluate whether appropriate systems are in place and operating effectively to mitigate the

risks identified. Legal requirements are a core consideration in planning all internal audit reviews.

This report contains narrative on the overall system of Risk Management as well as detailed commentary on a number of individual risks. It will be supplemented by a detailed review of Risk Management later in this financial year.

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

All internal audit reviews which involve review of policies and procedures examine the way in which equality and diversity is incorporated in Board documentation.

2.3.6 Climate Emergency & Sustainability Impact

This report has no impact on the Board's likelihood of meeting the aims and targets outlined by the NHS Scotland Climate Emergency & Sustainability Strategy.

2.3.7 Communication, involvement, engagement and consultation

All papers have been produced by Internal Audit and shared with the Director of Finance and Strategy.

2.3.8 Route to the Meeting

Audit & Risk Committee on 13 December 2023.

2.4 Recommendation

The Committee is asked take **assurance** from the Internal Control Evaluation.

3 List of appendices

Appendix 1 - Internal Control Evaluation Report.

Report Contact
Jocelyn Lyall
Chief Internal Auditor
Email jocelyn.lyall2@nhs.scot

FTF Internal Audit Service

Internal Control Evaluation 2023/24

Report No. B08/24

Issued To: **C Potter, Chief Executive**
M McGurk, Director of Finance and Strategy and Deputy Chief Executive

G MacIntosh, Head of Corporate Governance/Board Secretary
Executive Directors Group
H Thomson, Board Committee Support Officer

Audit Follow-Up Co-ordinator

Audit and Risk Committee
External Audit

Contents

Draft Report Issued	28 November 2023
Management Responses Received	6 December 2023
Target Audit & Risk Committee Date	13 December 2023
Final Report Issued	**07 December 2023**

EXECUTIVE SUMMARY

1. As Accountable Officers, Chief Executives are responsible for maintaining a sound system of internal control and to manage and control all the available resources used in the organisation. This review aims to provide early warning of any significant issues that may affect the Governance Statement.

OBJECTIVE

2. The NHS Fife Internal Audit Plan provides cyclical coverage of all key elements of Corporate, Clinical, Staff, Financial and Information Governance.
3. Together the mid-year Internal Control Evaluation (ICE) and the Annual Report provide assurance on the overall systems of internal control, incorporating the findings of any full reviews undertaken during the year and providing an overview of areas which have not been subject to a full audit. These reviews do not, and cannot, provide the same level of assurance as a full review but do allow an insight into the systems which have not been audited in full. This interim review gives early warning of issues and provides a holistic overview of governance within NHS Fife.
4. The draft Annual Delivery Plan (ADP) 2023/2024 was signed off by Scottish Government (SG) on 11 August 2023. The NHS Fife draft Medium Term Plan for 2023-2026, was submitted to SG on 7 July 2023, with feedback to be provided. SG guidance advised that the draft Medium Term Plan should take into consideration service changes which Boards are preparing for locally over the next 3 years, and identify through horizon scanning, issues which may require local, regional, or national planning input.
5. The ICE will be presented to the December 2023 Audit and Risk Committee, allowing the year-end process to be focused on year-end assurances and confirmation that the required actions have been implemented. The ICE provides a detailed assessment of action taken to address previous internal audit recommendations from the 2022/23 ICE and Annual Report.
6. This review will be a key component of the opinion we provide in our Annual Internal Audit Report and will inform the 2024/25 Internal Audit planning process.
7. Our audit specifically considered whether:
    - Governance arrangements are sufficient, either in design or in execution, to control and direct the organisation to ensure delivery of sound strategic objectives.

AUDIT OPINION

8. Ongoing and required developments and recommended actions are included at Section 2.
9. The Annual Internal Audit Report was issued on 19 June 2023 and was informed by detailed review of formal evidence sources including Board, Standing Committee, Executive Directors Group (EDG), and other papers.
10. As well as identifying key themes, the Internal Audit Annual Report made six specific recommendations in the following areas
    - Ongoing development of risk management, risk appetite, deep dives, Key Performance Indicators (KPIs) and clarification and formalisation of the joint risk management process with Fife IJB.
    - Requirement to provide a year-end assessment to the Staff Governance Committee (SGC) concluding on implementation of the strands of the Staff Governance Standard and action required to achieve full compliance.

- Requirement for the SGC Annual Assurance Statement to include a statement confirming the Whistleblowing Champion's opinion on the adequacy of NHS Fife's whistleblowing arrangements.
- Requirement to present a financial sustainability action plan to the Finance, Performance and Resources Committee (FPRC) and Board, demonstrating clear links to the Population Health and Well Being Strategy (PHWS), the Workforce and Digital & Information strategies, and service redesign and transformation.
- Requirement to record, monitor and have contingency plans in place to manage the risk of a sudden cessation for brokerage, which, unmitigated, could impact on service provision.
- Requirement to identify and report to the CGC on those elements of the 2019-2024 Digital & Information (D&I) Strategy which will not be delivered by 31 March 2024, stating the impact upon NHS Fife's strategic ambitions and how this is being addressed in the next D&I Strategy. The next iteration should also include at the outset a resourcing and financial assessment to assess its likelihood of being delivered within the stated timescale and the risks associated with non-delivery.

11. Outstanding actions from previous ICE and Annual Internal Audit Report recommendations are shown in table 1. 11 actions have been completed since the issue of our Annual Internal Audit Report.
12. Overall, there has been good progress on actions to address recommendations from the 2022/23 ICE and Annual Report. Where action is still to be concluded, the Board has been informed of the planned approach and timescales, as well as associated improvement plans.
13. In this report we have provided an update on progress to date and, where appropriate, built on and consolidated previous recommendations to allow refreshed action and completion dates to be agreed.
14. We recommend that this report is presented to each Standing Committee so that key themes can be discussed and progress against the recommendations can be monitored.

KEY THEMES

15. Detailed findings are shown later in the report, and for context, relevant Corporate Risks against each strand of Corporate Governance are included. Key themes emerging from this review and other audit work during the year are detailed in the following paragraphs.
16. Audit Scotland – NHS Scotland 2022, issued February 2023, stated that 'the NHS in Scotland faces significant and growing financial pressures. These include inflation; recurring pay pressures; ongoing Covid-19 related costs; rising energy costs; a growing capital maintenance backlog; and the need to fund the proposed National Care Service. These pressures are making a financial position that was already difficult and has been exacerbated by the Covid-19 pandemic, even more challenging'. Internal Audit reports have recorded similar concerns and highlighted the strategic changes required. The financial risk for NHS Fife, NHSScotland and the public sector has continued to increase.
17. As reported in the Internal Audit Annual Report for 2021/22, the challenge now is balancing short term risks against longer term risks which can only be mitigated through strategic change. The shape of future strategy will be dependent on a number of complex factors, with some subject to change. However the Board has continued to respond, and risk assess, to ensure the most urgent work is prioritised.

18. We previously highlighted the risks associated with the National Workforce Strategy for Health and Social Care and the need for realistic plans. The NHS Fife Workforce Plan 2022-2025 was published in November 2022 and work is underway to inter-relate and align financial and workforce planning via the Strategic Planning Resource Allocation (SPRA) process. Workforce risks remain very high across NHSScotland, and the current risk and target risk scores will require careful consideration to ensure they reflect local, national and international pressures and the extent to which these are and can be mitigated locally.
19. Continuing staff shortages and increased demand for staff means that effective workforce planning remains key in supporting the achievement of the Board's operational, financial and strategic objectives.
20. Maintaining operational performance against mandated targets remains extremely challenging. While operational improvements will have a limited impact on performance, genuinely strategic solutions must be identified, with a focus on working closely with partners to address underlying capacity and flow issues.
21. NHS Fife continues to progress its Risk Management Framework Improvement Programme. The Board's overall approach to risk management has been revised with a new Corporate Risk Register replacing the Board Assurance Framework. A Risks and Opportunities Group continues to meet and aims to embed an effective organisational risk management framework and culture, including assurance mapping principles. Current risk scores and achievement of target scores by target dates will require constant monitoring to ensure they fully reflect current risk and controls and are realistic.
22. The Clinical Governance Strategic Framework and associated Annual Delivery Plan were approved by Fife NHS Board on 28 March 2023. The framework outlines the governance and assurance reporting routes for clinical governance throughout the full span of NHS Fife responsibilities.
23. This report contains a number of recommendations that reflect the changes to the risk environment in which the Board operates. Our recommendations are aimed at ensuring coherence between Governance Structures, Performance Management, Risk Management and Assurance.

KEY DEVELOPMENTS SINCE THE ISSUE OF THE ANNUAL REPORT INCLUDED:

- Following the approval of the PHWS in March 2023, NHS Fife has moved to the delivery stage with associated reporting to the Board and Committees.
- Reporting continues on OPEL (Operational Pressures Escalation Levels) on the NHS Fife intranet, to support proactive management of increased activity, and the related impact on capacity and flow.
- Approval of the Whole System Property and Asset Management Strategy at the September 2023 Board meeting.
- Approval of the Five-year Medium Term Financial Plan by the NHS Fife Board in March 2023.
- An updated approach to achievement of savings with 3 horizon levels for in year and the future.
- SG sign off of the 2023/24 Annual Delivery Plan (ADP) on 11 August 2023.
- Approval of the Risk Management Framework in August 2023 and ongoing development of Risk Management arrangements, including a Corporate Risk Reporting tool and Risk Summary Dashboard as guidance for risk owners.
- Approval of the Clinical Governance Strategic Framework by Fife NHS Board in March 2023 and the implementation of elements of associated Delivery Plan.

- Ongoing work to implement the Health & Care (Staffing) (Scotland) Act 2019 (Safe Staffing Legislation).
- Whistleblowing directives issued by the Independent National Whistleblowing Officer continue to be implemented by NHS Fife, with improvements being made to the procedures for completing investigations and reporting thereon.
- Continuing development of the Integrated Performance Quality Report (IPQR).

ACTION

24. The action plan has been agreed with management to address the identified weaknesses. A follow-up of implementation of the agreed actions will be undertaken in accordance with the audit reporting protocol.

ACKNOWLEDGEMENT

25. We would like to thank all members of staff for the help and co-operation received during the course of the audit.

Jocelyn Lyall, BAcc CPFA
Chief Internal Auditor

TABLE 1		
Annual Report 2022/23 (B06/24) - Update of Progress Against Actions		
Agreed Management Actions with Dates	**Progress with agreed Management Actions**	**Assurance Against Progress**
1. Development of Risk Management a. Greater use of risk appetite including greater detail in risk reports presented to standing committees on how the risk appetite will affect strategy, decision-making prioritisation, budget setting and organisational focus. b. Deep Dive Reports to include: • Further assessment as to which key management actions will impact on the target score with success criteria stated. • A focus on key controls only, providing overt assurance and an overt conclusion on the effectiveness of implemented controls. • An assessment of the proportionality of proposed actions and whether they should be sufficient to achieve the target score. c. Revised Risk Management KPIs presented to the Audit and Risk Committee (ARC) that take account of previous internal audit recommendations and allow ARC members to assess the overall effectiveness of the system of Risk Management. d. Revised Risk Management Framework approved by the ARC providing a detailed description of joint Risk Management arrangements with the IJB including responsibility for operational risks, responsibility for sharing of information and responsibility for provision of assurance consistent with the IJB Risk Management Strategy. ***Action Owner: Director of Finance & Strategy*** **Original target implementation date 31 March 2024.**	a. Corporate Risks papers presented to each standing committee state if risks are within or outwith risk appetite. Review of the Board's risk appetite has not taken place yet. Risk reports to standing committees do not yet include greater detail on how the risk appetite will affect strategy, decision-making prioritisation, budget setting and organisational focus. b. The Risks and Opportunities Group (ROG) is progressing changes to the deep dive process, and these should be evident in deep dive papers presented to Standing Committees in the remainder of 2023/24. c. The development of KPIs for the risk management process is a work in progress. d. The revised NHS Fife Risk Management Framework, including a description of RM arrangements with the IJB that satisfies our recommendation, was approved by Fife NHS Board on 26 September 2023 (Complete).	 On track
2. Staff Governance Standards a. A year-end report to be presented to the Staff Governance Committee providing year-end feedback on: • The action taken on each strand of the Staff Governance Standards during 2023/24. • Reflection on how successfully and effectively these have been implemented.	a. The Annual Internal Audit Report for 2022/23 (B06/24) was presented to SGC on 20 July 2023 and the minutes record: *'The Director of Finance & Strategy highlighted the Staff Governance section within the report and was pleased to advise that there were only two recommendations, both in the lower category, which merit attention'* b. As per 2a above	 On track

• What actions are being taken forward into 2024/25, plus the further coverage planned for each strand during 2024/25. b. The Staff Governance Committee Annual Report and Statement of Assurance to include a conclusion on compliance with the different strands of the Staff Governance Standards based on the paper referred to in 2a above. ***Action Owner: Director of Workforce*** **Original target implementation date 31 March 2024.**	Internal Audit is monitoring implementation of these recommendations as part of the Audit Follow-up process and will contact management closer to the implementation date to confirm reporting will be completed as agreed.	
3. Whistleblowing The Staff Governance Committee Annual Report and Statement of Assurance including a statement confirming the Whistleblowing Champion's opinion on the adequacy NHS Fife's whistleblowing arrangements. ***Action Owner: Director of Workforce*** **Original target implementation date 31 March 2024.**	As per 2a above Internal Audit is monitoring implementation of this recommendation as part of the Audit Follow-up process and will contact management closer to the implementation date to confirm reporting will be completed as agreed.	 On track
4. Financial Sustainability Action Plan A Financial Sustainability Action Plan to be presented to the FPRC which: • Demonstrates clear links to the Population Health and Well Being Strategy, the Workforce and Digital & Information strategies, and service redesign and transformation. • Includes the following overtly to the required savings: ○ a clear process and timetable for the setting and implementation of organisation priorities ○ a clear methodology for agreeing areas for de-prioritisation. ○ a robust process for identifying and delivering service change. • Includes the process for formal monitoring of operational and strategic savings programmes. • Includes provision of overt positive assurance to the Board that NHS Fife has the capacity and capability (both in terms of planning and operations) to drive transformational change, whilst maintaining business as usual and delivering savings, both in the short and longer term. • Includes a clear delineation of the cultural changes required to ensure that financial sustainability receives sufficient priority both strategically and operationally, in the face of competing pressures and conflicting Scottish Government priorities. ***Action Owner: Director of Finance & Strategy***	The Financial Performance and Sustainability Report includes actions aimed at achieving financial sustainability and has been presented to EDG, FPRC and Fife NHS Board. The Financial Performance and Sustainability Report links to the Annual Delivery Plan which links to the Corporate Objectives which are aligned to the Public Health & Wellbeing Strategy. The process to determine corporate objectives for 2024/25 will include the setting and implementation of organisation priorities and de-prioritisation will be included in this. The broader service change objectives are aligned with the other significant change programmes. The Financial Improvement and Sustainability Board is monitoring actions being taken to improve efficiency savings performance.	 Completed

Original target implementation date 31 March 2024		
5. Brokerage Contingency Planning. NHS Fife to record, monitor and have contingency plans in place to manage the risk of a sudden cessation for brokerage, which, unmitigated, could impact on service provision. ***Action Owner: Director of Finance & Strategy*** **Original target implementation date 30 September 2023**	NHS Fife is in dialogue with SG who are aware of the potential brokerage required at Year-End.	 Completed
6. Digital & Information Strategy a. Clinical Governance Committee (CGC) to be updated regarding the impact on strategic ambitions & new D&I Strategy of elements from previous strategy not yet delivered. b. The new D&I Strategy to include a resource & financial assessment supporting the likelihood of the revised D&I Strategy being delivered within the stated timescale. ***Action Owner: Associate Director of Digital & Information*** **Original target implementation date 31 July 2024.**	a. The D&I Strategy update to CGC on 3 November 2023 included analysis of the delivery of items from the 2020-24 D&I Strategy and clearly shows items partially or not delivered. The update also identifies themes to be taken forward to the next iteration of the strategy (Complete). b. The D&I Strategy update to CGC on 3 November 2023 confirmed that this will be supported by a financial framework.	 On track
ICE Report 2022/23 (B08/23) - Update of Progress Against Actions		
Agreed Management Actions with Dates	**Progress with agreed Management Actions**	**Assurance Against Progress**
1. Committee Assurances a. The Board's action list, which is currently maintained and followed up by the Corporate Governance & Board Administration team, will be tabled for review at future Board meetings. b. Risk sections within the SBAR papers presented to the Standing Committees and the Board should fully articulate the risks associated with the report, the linkage to the relevant Corporate or Operational risk and any related consequences. c. SBARs on Policy Updates to include a risk assessment on each policy which has passed the renew date, highlighting the risks and possible consequences of the policy not being reviewed within the timescale and superseded policies will be removed from Stafflink. ***Action Owner: Head of Corporate Governance & Board Secretary*** **Original target implementation date 30 June 2023.**	a. The Board's Action List was included on the agenda for its meetings on 31 January and 28 March 2023 and a comparison of the two Action Lists shows that it is being updated between meetings (Complete). b. The revised SBAR template and associated guidance were issued in November 2023, so time is needed to evidence the use of these in practice at Board and Committee meetings. An extended timescale to 31 March 2024 has been agreed to allow this. c. Discussion on the policies that have lapsed review dates took place at EDG on 2 November 2023 and a risk-based approach to prioritise the review and update policies was agreed and relevant assurances regarding this were provided by the relevant responsible Executive Directors. FPRC were notified of this on 14 November 2023 (Complete).	 Minor slippage on agreed timelines

2. Risk Management a. Risk Management KPIs to be presented for approval and reported to the Audit and Risk Committee. b. Risk appetite to be overtly reflected in the corporate risk register updates to standing committees, particularly within target scores, when risks are updated and reviewed. ***Action Owner: Director of Finance & Strategy*** **Original target implementation date 30 June 2023.**	a. KPIs for Risk Management are still being updated and a date for presentation to ARC has not yet been agreed This recommendation has been superseded by B06/24 Point 1c. b. The Corporate Risk Register presented to ARC on 15 March 2023 includes the risk appetite for each strategic priority and indicates for each risk whether the current risk rating is above, below or within that risk appetite. This format will be used for presentation to all Standing Committees.	 Completed
3. Clinical Governance and Assurance re Services Delegated to the Integration Joint Board a. Regular reporting to the Clinical Governance Oversight Group (CGOG) providing assurance that recommendations made following external body visits are being progressed through service action plans to completion. b. Reporting on risk associated with Adult and Child Protection to the CGOG. ***Action Owner: Director of Health and Social Care Partnerships*** **Original target implementation dates a - 30 April 2023 & b – 31 July 2023.**	a. Inspections and methodology reported to CGOG on 18 April 2023 and future reporting scheduled in CGOG 2023/24 workplan. b. Report on risk 10 regarding Adult and Child Protection was presented to the CGOG meeting on 20 June 2023.	 Completed
4. Clinical Governance Strategic Framework & Clinical Governance Risk Management a. The Clinical Governance Strategic Framework (CGSF) to be presented to Fife NHS Board for approval. b. Adult and Child Protection and the latest guidance (Scottish Government's NHS Public Protection Accountability and Assurance Framework to be considered as part of the 2023/24 workplan for the Clinical Governance Strategic Framework. c. The Terms of Reference for the CGOG to be amended to include a specific responsibility regarding consideration of external reviews and whether appropriate action has been undertaken to address any recommendations made. d. A meeting of the Organisational Learning Group (OLG) to be held focused on how to build in the consideration of issues identified in external reports into future OLG agendas and the analysis that would need to be undertaken to provide the OLG with the information to discharge their responsibility as per its Terms of Reference item 2.4 regarding consideration of whether internal controls and associated reporting mechanisms need to be improved if they did not identify issues highlighted in inspections undertaken by external regulators/auditors. e. Minutes of OLG meetings to be routinely presented to the CGOG.	a. The CGSF was approved by Fife NHS Board on 28 March 2023. b. The Mid-Year Update on the Clinical Governance Strategic Framework presented to CGOG on 24 October 2023 and CGC on 3 November 2023 includes reference to the Scottish Government's NHS Public Protection Accountability and Assurance Framework. c. CGOG Terms of Reference was appropriately updated and was noted by CGOG on 24 October 2023 acknowledging their acceptance of the changes made. d. A review of the OLG commissioned by the Chief Executive has concluded and the recommendations made supersede this recommendation. e. The minutes of the OLG meeting held on 18 August 2023 were included on the CGOG Agenda for its meeting on 24 October 2023. f. The updated CRR presented to EDG on 17 August 2023 includes the revised wording of the risk. The Director of Acute Services advised that the scoring is reviewed regularly and was last updated at the end of April. The risk	 Completed

f. The description of risk 7 on the CRR to be updated to more accurately describe the risk associated with deferred treatment due to late presentation due to the pandemic (eg: changing the '*could*' in 'This time delay could impact clinical outcomes for the population of Fife' to '*will*'). and the scoring of this risk to be revised to take account of the related performance information. g. The anticipated deep dive analysis to be undertaken on risk 7 to be prioritised and to be undertaken in a manner that clearly explains the scale of the risk and better describes the controls in place. h. The alignment of Risk 7 to be reconsidered with specific consideration given to whether assurance on its management should be provided to the CGC. i. The difficulties in meeting targets for Serious Adverse Events Reviews to be reported to the CGC. ***Action Owner: Medical Director*** **Original target implementation date 31 August 2023.**	was scored at 16 High when reported to FPRC in November 2022 and is reported as 20 High to FPRC in May 2023. g. The deep dive into risk 7 has been undertaken and was presented to FPRC on 14 March 2023 and CGC on 7 July 2023. The deep dive into the related CRR 5 was undertaken and presented to EDG on and was presented to CGC on 5 May 2023. h. The alignment of risk 7 is to continue to be to FPRC but it was presented to CGC on 7 July 2023. i. The narrative included in the IPQR presented to CGC on 3 March 2023 highlighted the performance issues regarding the Adverse Events Management Process and the action being taken to address this.	
10. IG&S Incident Reporting to CGC The IG&S update report for the Clinical Governance Committee to be updated to include a section for IG Incident Management including: ○ Reasons for any instances of non-compliance with the 72-hour statutory timescale for reporting to the ICO and what has been done to prevent this from happening in future. ○ Sufficient information to allow an opinion on whether any of the incidents reported to date should be considered for disclosure within the Board's Governance statement. ***Action Owner: Associate Director of Digital and Information*** **Original target implementation date 31 May 2023.** **Extended to 29 February 2024 (TBC)**	IG&SSG Updates to CGC on 3 March and 8 September 2023 – (both Item 9.1) - Summary of Incident Reporting in the period including assurance regarding compliance with the 72-hour timescale for reporting to the ICO but does not include a statement regarding whether or not any of the incidents will warrant disclosure in the Board's Governance statement. This is to be included in the update presented to CGC on 12 January 2024.	 Minor slippage on agreed timelines
11. D&I Strategy Risk • D&I Workforce Plan to be added to the Corporate Risk Register as a mitigation to risk 18 – regarding the D&I Strategy to allow assessment of its implementation and effectiveness. ***Action Owner: Associate Director of Digital and Information*** **Original target implementation date 31 May 2023.** **Extended to 30 November 2023**	The risk report presented to CGC on 8 September 2023 includes the following as mitigation against corporate risk 18: '*Active review of the Strategy deliverables against current strategic objectives. This includes financial and workforce planning*'.	 Complete

CORPORATE GOVERNANCE

Corporate Risks:

Risk 1 – Population Health and Wellbeing Strategy – Moderate (12); Target (12) Moderate by March 2024 - Below Risk Appetite

There is a risk that the ambitions and delivery of the new organisational Strategy do not deliver the most effective health and wellbeing and clinical services for the population of Fife.

Risk 2 – Health Inequalities – High Risk (20); Target (10) Moderate by March 2024 - Within Risk Appetite

There is a risk that if NHS Fife does not develop and implement an effective strategic approach to contribute to reducing health inequalities and their causes, health and wellbeing outcomes will continue to be poorer, and lives cut short in the most deprived areas of Fife compared to the least deprived areas, representing huge disparities in health and wellbeing between Fife communities.

Governance Arrangements

The Code of Corporate Governance was updated and approved at the May 2023 Board meeting.

Board and Committee Development Sessions covered a diverse range of topics and are critical for gaining further insight into key areas. The Annual Internal Audit Report 2022/23 (B06/24) highlighted that learning and key actions from these sessions should be recorded with formal outputs to ensure that actions are taken forward. The Board Secretary has advised that notes are taken on Development Sessions where appropriate and these used as part of the planning and design of topics under development.

The ARC members attended training sessions on the Annual Accounts, the role & function of the ARC and Risk Management. The CGC have considered Medical Education, Addiction Services, the Research relationship between NHS Fife and the University of St Andrews and Optimal Clinical Outcomes. The Public and Wellbeing Committee has considered topics which include Child and Adolescent Mental Health Service and Psychological therapies and Integrated Screening. The Staff Governance Committee has considered continuously improving a safe working environment, promoting the health and wellbeing of staff, and iMatters.

Self- Assessment

The second edition (November 2022) of the Blueprint for Good Governance was presented to the March 2023 ARC. It describes the latest good governance practice including active and collaborative governance. A National survey for Board members, (self-assessment) is closing on 1 December 2023 and a Development Session will be held in February 2024 to reflect on the outcomes of the National Survey.

In March 2023 Governance Committees completed self-assessments and identified improvements which are being progressed within the Committee Action Lists. We will review the progress of the identified improvements and comment in the Internal Audit Annual Report 2023/24 (B06/25).

Committee Assurance

Standing Committees review their Terms of References annually. Internal audit review of Standing Committee papers found that where serious issues are reported, for example adverse findings from an inspection by a regulator, the papers do not conclude on whether the issue is likely to warrant disclosure in the Board's Governance Statement. A process should be introduced to prompt consideration by committee members, throughout the year, of issues that may warrant disclosure in the Board's Governance Statement.

Policies

A General Policies and Procedures paper presented to the 2 November 2023 EDG provided an update of the status of policies as at October 2023. 36 (64%) of the 56 General Policies were up to date, 12 (21%) were beyond their due date and review work was underway within departments for 8 (14%) of General Policies. We noted good practice in that the paper reported the potential risk management implications of overdue policies and the EDG will take a risk-based approach to prioritise out-of-date policies that are significantly beyond their due date.

Internal Audit will undertake a review of Policies and Procedures as part of the 2023/24 audit plan, to ensure that the update of policies is risk-assessed, delivered and monitored appropriately and that updated policies are published effectively, and superseded versions removed from circulation.

Culture and Values

A Board Development Session in April 2023 focussed on Culture, Values and the Role of the Board. The NHS Fife Code of Corporate Governance refers to culture and values, and we have evidenced examples of the Board and its officers embracing and promoting these values.

Strategy

The Public Health & Wellbeing Strategy (PHWS) was approved at the March 2023 Board meeting. The Public Health and Wellbeing Committee (PHWC) has oversight of the delivery of the PHWS and a Mid-Year Report to the November 2023 meeting provided a six-monthly update on delivery. Progress during the first 6 months was provided (to September 2023) with planned activity to the end of March 2024 highlighted. The report uses the three-horizons framework to plan the first year, medium-term and longer-term objectives, to describe how ongoing work will collectively contribute to the system change required.

The internal audit B14/23 on Strategic Planning, will evaluate the development of the Strategic Plan.

Operational Planning

The draft ADP 2023-24 is in line with SG guidance and was presented to the Board before submission to SG by end of July 2023, and subsequent approval on 11 August 2023. It was approved by the Board in September 2023. There are three ADP related submissions: the draft ADP1, the draft ADP2 (spreadsheet with detailed actions, milestones and risks) and the draft Medium-Term Plan (MTP) 2023/26, which was submitted to Scottish Government on 7 July 2023. Quarterly updates on ADP delivery are reported to the FPRC.

We commended the OPEL tool within our B08/23 Internal Control Evaluation report. OPEL supports management of increased activity, and the related impact on capacity and flow and scores continue to be reported on a daily basis on Stafflink to provide organisational awareness of the extreme pressures within the system and the high-risk environment the Board operates within.

Assurance Mapping

Committee Assurance Principles were endorsed by the NHS Fife ARC in May 2021. Internal Audit will continue to promote the use of the assurance principles through continued leadership of the Assurance Mapping Group, chaired by the Chief Internal Auditor, attendance at the Risks and Opportunities Group, and though internal audits.

Integration

The Integration Scheme was reviewed and approved by NHS Fife Board in September 2021. A Ministerial Strategic Group (MSG) published a report in 2019 outlining proposals to develop the features of good Integration. An MSG self-assessment was carried out by the Fife Health and Social Care Partnership and reported to the NHS Fife Finance, Performance and Resources Committee (PRC)

in January 2023. Sixteen key features were established, 6 were partially established. Internal Audit would expect an update report is provided to a future NHS Fife Finance, PRC meeting.

Performance

The Integrated Performance & Quality Report (IPQR) has continued to be reviewed and enhanced by the IPQR group, which was set up following the Board's Active Governance Workshop held in November 2021. The IPQR report now provides a Public Health and Wellbeing section and Statistical Process Control charts where relevant. This demonstrates improved connectivity through inclusion of Corporate Risks aligned to strategic priorities. Providing extracts of the IPQR for each Standing Committee has facilitated focussed scrutiny of the performance areas most relevant to each. The November 2023 IPQR included uptake of Covid and Flu winter vaccination programme and staff vacancies.

The Board, the FPRC, the SGC, the CGC and the PHWC have received regular performance reports against a range of key measures (Scottish Government and local targets). Projected & Actual Activity for Patient TTG, New Outpatients and Diagnostics are also reported.

The latest IPQR presented to the November 2023 Board meeting highlighted:

- Eight indicators are on schedule to meet Standard/Delivery trajectory: Inpatient Falls, Inpatient Falls with Harm; Pressure Ulcers; SAB HAI/HCAI; C Diff; IVF Treatment Waiting Times; Freedom of Information Requests and Antenatal access.
- The Cancer 31 Day DTT current performance is at 90.6% with a target of 95%, which is a decrease in performance from last year.
- The Cancer 62 Day DTT current performance is 77.1% against a target of 95%, which has decreased in performance since last year.
- The following indicators show an Amber status, which is behind the target but within 5% of the Standard/Delivery trajectory: Cancer 31 Day DTT; Major/Extreme Adverse Events - % Closed on Time; Detect Cancer Early; Immunisation 6 in 1 at Age 12 months and Immunisation MMR2 AT 5 Years.
- Twelve indicators are not achieving target but are performing within the Mid-Range quartile for benchmarking: Cancer 62 Day RTT, S1 Complaints Closed in Month on Time, S2 Complaints Closed in Month on Time; 4-Hour Emergency Access (A&E) & (ED); Patient TTG%; New Outpatients; Diagnostics; Sickness Absence; CAMHS Waiting Times; Psychological Therapies Waiting Times (Statistical Process Control has identified this as an outlier and negatively outside the control limits) and Drugs & Alcohol Waiting Times.
- Performance in September for the 4-Hour Emergency Access decreased from 79% to 73.3%, significantly below the 95% national target and just below the 24-month average of 73.9%.

The pressures on the system are making performance against a range of targets challenging for NHS Fife in common with the entirety of NHSScotland.

Risk Management

The Risk Management Framework 2023-2025 was approved at the September 2023 Board meeting, following consideration by the ARC in August 2023. A delivery plan is being developed to support the implementation of the Framework.

More than 60% of the Corporate Risk scores are above risk appetite, meaning that action to bring risk scores within appetite and within a short timeframe are required. The annual review of risk appetite

has not yet taken place. Within the context of the unprecedented challenging external environment we are of the opinion that risk appetite needs to be revisited.

The implementation of Deep Dive risk reviews is designed to provide Governance Committees with assurance on the appropriate management of risk. We commend the paper to the 2 November 2023 EDG, where recommended criteria for undertaking a Deep Dive review was agreed. The triggers for invoking a Deep Dive review were outlined as, Proposed New, Deteriorating and Static, Corporate Risks, and Proposed De-escalation of a risk. Internal Audit will review these arrangements, including a review the full Deep Dive process, within B14/24 Risk Management this year.

The Risk and Opportunities Group (ROG) continues to meet to provide leadership and promote and embed an effective risk management culture.

Risk management dashboard operational guidance and a demonstration of the Risk Summary Dashboard was provided to the 2 November 2023 EDG. The dashboard is designed to guide risk owners through a series of activities to facilitate effective risk management. The implementation approach for the ROG to take this forward was agreed by the EDG. KPIs for operational risks have been developed and will continue to be refined as part of the ROG agenda.

Action Point Reference 1 – Governance Statement Disclosures

Finding:

Papers have been presented to each standing committee that highlight serious issues, but they have not concluded on, or prompted discussion on, whether these issues are likely to require disclosure in the Board's Governance Statement.

Audit Recommendation:

A process should be implemented that ensures serious issues are highlighted to all Standing Committees and members are prompted to agree if the issue warrants disclosure in the Board's Governance Statement. This may include a direction in the SBAR supporting the relevant paper, along with providing members with the key considerations for deciding upon disclosures from the relevant section of the Scottish Public Finance Manual:

- '*might the issue prejudice achievement of the business plan or other priorities?*
- *could the issue undermine the integrity or reputation of the organisation?*
- *what view does the audit committee take on the issue?*
- *what advice or opinions have internal audit and/or external audit given?*
- *might the issue make it harder to resist fraud or other misuse of resources?*
- *does the issue put a significant programme or project at risk?*
- *could the issue divert resources from another significant aspect of the business?*
- *could the issue have a material impact on the accounts?*
- *might financial stability, security or data integrity be put at risk?*'

A register of potential disclosures should be maintained and considered at year-end when preparing the Board's Governance Statement.

Assessment of Risk:

Merits attention		There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**

Management Response/Action:

Standing Committees each reflect on their year's business at the point of reviewing their annual assurance report. Significant work has been taken forward in recent years to enhance the content and detail of these reports, ensuring that the information provided within is comprehensive, robust and relevant for the purpose of providing assurance to the Board. It is at that point where committees discuss and decide on any potential disclosures, reflecting on the year's business overall and the movement of potential disclosure issues throughout the year (some in-year issues can be satisfactorily resolved by year-end, for instance).

In totality, the consideration of each Standing Committee's assurance statement influences the content and conclusions of the Governance Statement, which is discussed in draft and agreed with the Audit & Risk Committee. We believe the process in place at present is robust and appropriately reflective, without the need for a rolling issue list to be created, or additional changes to the SBAR template.

Action by:	Date of expected completion:
Head of Corporate Governance & Board Secretary	**N/A**

CLINICAL GOVERNANCE

Corporate Risks:

Risk 3 – COVID-19 Pandemic – Moderate (9); Target (12) Moderate by October 2023 – Below Risk Appetite

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.

Risk 5 - Optimal Clinical Outcomes – High Risk (15);Target (10) Moderate by March 2024 – Within Risk Appetite

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.

Risk 9 - Quality & Safety – High Risk (15);Target (10) Moderate by March 2024 – Above Risk Appetite

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.

Risk 16 - Off-Site Area Sterilisation and Disinfection Unit Service – Moderate Risk (12);Target (6) Low by April 2026 – Within Risk Appetite

There is a risk that by continuing to use a single offsite 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.

Risk 17 & 18 are aligned with the Clinical Governance Committee but are considered under the Information Governance section below.

Risk 7 is aligned with the Finance Performance and Risk Committee. We recommended that consideration be given to aligning this risk to the Clinical Governance Committee. This was considered but it was felt appropriate that the risk remained aligned to the FP&RC. The Clinical Governance Committee was updated on the deep dive into this risk at its 7 July 2023 meeting.

Risk 7 - Access to Outpatient, Diagnostic and Treatment Services - High Risk (20);Target No target due to uncertainty over level of funding – Above Risk Appetite

There is a risk that due to demand exceeding capacity, compounded by unscheduled care pressures, NHS Fife will see deterioration in achieving waiting time standards. This time delay will impact clinical outcomes for the population of Fife.

Clinical Governance Framework

The Clinical Governance Strategic Framework was approved by Fife NHS Board on 28 March 2023 and the annual delivery plan and progress update was presented to the Clinical Governance Oversight Group (CGOG) in October 2023, setting out the workstreams, objectives, leads, timescales and their status.

The only item reported as having slipped was the Risk Management Policy which is being revised following Board approval of the NHS Fife Risk Management Framework at the end of August 2023.

A Fife Health and Social Care Partnership (HSCP) Clinical & Care Governance Strategic Framework is in development and is to be presented to the IJB for approval by January 2024. This will outline arrangements for providing strategic direction and assurance on health and social care to the IJB, Fife Council and NHS Fife. This framework will complement the existing NHS Fife Clinical Governance Strategic Framework which describes HSCP Clinical and Care Governance Assurance Arrangements.

Fife IJB report F06/22 - Clinical and Care Governance was issued on 31 October 2023 and provided reasonable assurance on developments to Clinical and Care Governance Assurance processes and made two significant and three moderate recommendations. The significant findings related to the reporting of assurance regarding the management of the corporate risk recorded regarding Child and Adult Protection and establishing regular reporting on Adult and Child Protection to Fife Council's People and Communities Scrutiny Committee and the IJB's Quality and Communities Committee and SLT Governance and Assurance.

Clinical Governance Committee

Updated CGC Terms of Reference (ToR) were included in the Code of Corporate Governance approved by Fife NHS Board on 30 May 2023 and include a membership change related to patients' representative, responsibility for oversight of patient experience and feedback mechanisms and other administrative items.

The CGC 2023/24 annual workplan is presented to each CGC meeting with the latest update indicating that CGC should receive all items in 2023/24.

Clinical Risk Management

The four corporate risks detailed at the start of this section have been aligned to the CGC, as have two Information Governance risks.

Risk 7 - Access to Outpatient, Diagnostic and Treatment Services is aligned to the Finance Performance and Risk Committee. Internal audit previously recommended this risk should be aligned to the CGC, but we were advised that the risk would remain aligned to the FPRC. However, the CGC was updated on the deep dive into this risk on 7 July 2023.

The CGC has also considered deep dive assurance reports for risks 9, 16 and 18 in 2023/24 and reviewed the corporate risks aligned to the Committee on 8 September 2023 and 3 November 2023.

Clinical Performance Reporting

The latest IPQR presented to CGC on 3 November 2023 highlighted the following areas which are not achieving target, with the SBAR providing detailed narrative and actions to improve:

- Adverse Events - August 2023 – 48.4% LAER/SAERs closed on time against a target of 50%:
- Escherichia Coli Bacteraemia (ECB) (HAI/HCAI) - August 2023 – 38.4 HAI/HCAI per 100,000 Occupied Bed Days against a target of 33.0
- Complaints (Stage 1 & Stage 2) - August 2023 - Stage 1 closed in month on time 42.6% against a target of 80% & Stage 2 closed in month on time 11.1% against a target of 50%. (A project and improvement plan is being developed by the Patient Experience Team in conjunction with a Senior Project Manager to improve performance in this area).

Quality Performance Indicators (QPIs) included in the Clinical Governance Strategic Framework are reported to the CGC along with details of remedial action being taken to address any indicators that were performing below target with the exception of:

- Adverse Events Improvement Actions (70% target for closure of actions within timescales)

- Complaint Closed- Stage 1 (80% target) – The summary table on the IPQR reported 42% for this, significantly below the target of 80% but there is no narrative included in the Clinical Governance section and any remedial action being taken (there is narrative regarding Stage 2 performance and improvement actions).

External Review

External Inspection Reports are included on an Activity Tracker document routinely considered by the Clinical Governance Oversight Group (CGOG).

In response to a recommendation in our 2022/23 ICE report (B08/23) a HSCP Inspection Update is presented to each CGOG meeting as a standing agenda item.

We commend the presentation of the papers on the HIS inspection and the Fatal Accident Enquiry to the CGC. These papers highlighted the serious issues raised to CGC members but, in common with other standing committees, did not include a conclusion on whether they require to be included as disclosures in the Board's Governance Statement at year-end and the members of the CGC were not asked to consider this. A recommendation relevant to this is included in the Corporate Governance section above at Action Plan Point 1.

The Cabinet Secretary requested all Boards in Scotland provide assurance that their processes and systems for the early identification, reporting and robust timely investigation of patient and staff safety concerns are fully effective. The NHS Fife Chief Executive commissioned a review of the Organisational Learning Group (OLG) which had a remit to ensure that the learning gained from events is used to optimise patient safety, outcomes and experience and to enhance staff wellbeing and job satisfaction. Our 2022/23 ICE report recommended that the OLG need to consider the effectiveness of internal control and reporting systems in relation to adverse findings in external reports.

Healthcare improvement Scotland (HIS) Inspection Report

HIS undertook an unannounced inspection on Acute Hospital Safe Delivery of Care at Victoria Hospital between 31 July and 2 August 2023 and reported serious concerns about the condition of the healthcare-built environment within the older building of the hospital and stated nine requirements and made two recommendations. The initial findings from the inspection were reported to CGC in September 2023 ahead of the publication of the final report on 26 October 2023. This update informed CGC that NHS Fife took immediate action to address issues identified by relocating a ward to another area in the hospital and bringing forward a planned programme of ward refurbishment. The timing of the publication of the final report did not allow enough time for an update to be provided to the CGC meeting in November 2023 but an update on progress to address the findings in the report is to be provided to the January 2024 CGC meeting. We are advised by the Director of Nursing that this update will consider the effectiveness of internal control and reporting systems (ie why corrective action wasn't undertaken before the issues were highlighted by HIS and what improvements need to be made to ensure that should similar issues occur, Senior Management are promptly notified).

Fatal Accident Enquiry

CGC were updated on the outcome of the fatal accident enquiry into death of a patient in the intensive care unit (ICU) at Victoria Hospital in October 2019. The report identified three specific shortcomings in the care of the patient and stated that had any one of the three been undertaken properly this might realistically have resulted in the death being avoided. The action plan to address the 8 recommendations made in the report was presented to CGC and the status of the actions is to be monitored by the Acute Services Division CGC which reports into CGOG.

Significant Adverse Events

The revised Adverse Events Policy (reviewed February 2023) is available on Stafflink and includes a flowchart of the revised process which links to further Adverse Events Management Resources on Stafflink.

The target related to closing SAERs within timescale has only been achieved in 1 month of the 5 reported to date. Actions designed to improve this are being implemented and are reported as being on track for implementation by 31 March 2024.

Duty of Candour (DoC)

The latest DoC Annual Report presented to the CGC on 3 March 2023 related to the financial year 2021/22 and included an update on DoC activity in 2022/23 to date. We have been advised by management that the 2022/23 DoC annual report for presentation to CGC in March 2024 will include an update on DoC activity in 2023/24.

Action Point Reference 2 – Performance Monitoring

Finding:

Quality Performance Indicators (QPIs) included in the Clinical Governance Strategic Framework should be reported to the CGC along with evidence of review and remedial action. We confirmed that reporting on QPIs to CGC or CGOG is evident in 2023/24 and that remedial action was reported where required, with the following exceptions:

- Adverse Events Improvement Actions (70% target for closure of actions within timescales) – not included in the IPQR or the Adverse Events reporting to CGOG
- Complaint Closed- Stage 1 (80% target) – the summary table on the IPQR reported 42% for this significantly below the target of 80% but there is no narrative on this and on remedial action included in the Clinical Governance section.

Audit Recommendation:

Performance reporting for the Clinical Governance Strategic Framework QPIs referred to in the finding above should be added to the performance reporting to CGC.

Assessment of Risk:

Moderate  Weaknesses in design or implementation of controls which contribute to risk mitigation.
Requires action to avoid exposure to moderate risks to achieving the objectives for area under review.

Management Response/Action:

Adverse Events:

The action closure rate was added to IPQR from January 2023. The initial target was set at 70%, however it quickly became apparent that we would not be able to meet this until improvements were made to the actions module on Datix and some training and education was devised and delivered. This was escalated through to CGOG on 20 June along with an overview of the short and long term goal for the improvements required. There was agreement to have a staggered approach to achieving the target. The target was reduced to 50% to be achieved by March 2024, at which time it would be reassessed and increased to the 70% if appropriate. An update on the short term goals was provided in August 2023, both of which will have been captured in the minutes.

Actions on Stage 1 Complaints:

The Patient Experience Team (PET) are working with services to improve the compliance of Stage 1 complaints, focusing on ensuring these are resolved locally at the service level via telephone or face-to-face, aiming to reduce the number of Stage 1 written complaint responses required. A new Stage 1 template has been created and tested within Acute to raise awareness of these complaints being resolved locally and highlight lessons learned.

The PET dashboard has been launched, raising awareness and providing up-to-date data regarding all open, Stage 1, Stage 2, enquiries and concerns.

A new weekly complaint report has been created and highlights the compliance target of 80% for Stage 1s and the previous month's data for Acute and H&SCP and whether the target has been achieved. A PET staff page has been created on Blink to raise awareness of the PET and the complaints process. There is greater engagement with PET and Services, focusing on open complaints, providing support, advice, and training. Roles and responsibilities with PET have been streamlined, releasing time for the support officers to focus on stage 1 complaints, concerns, and enquiries. PET will link with Planning and Performance Team to include narrative in IPQR.

Action by:	Date of expected completion:
Director of Nursing / Planning & Performance Team	**31 December 2023**

STAFF GOVERNANCE

Corporate Risks:

Risk 11 - Workforce Planning and Delivery – High Risk (16); Target (8) Moderate by March 2025 – Above Risk Appetite

There is a risk that if we do not implement effective strategic and operational workforce planning, we will not deliver the capacity and capability required to effectively.

Risk 12 - Staff Health and Wellbeing – High Risk (16);Target (8) Moderate by March 2025 – Above Risk Appetite

There is a risk that if due to a limited workforce supply and system pressure, we are unable to maintain the health and wellbeing of our existing staff, we will fail to retain and develop a skilled and sustainable workforce to deliver services now and in the future.

Risk 19 – Implementation of Health and Care (Staffing) (Scotland) Act 2019 [HCSA] – Moderate (12); Target (9) Moderate (no date given) – Within Risk Appetite

Taking account of ongoing preparatory work, there is a risk that the current supply and availability of trained workforce nationally, will influence the level of compliance with HCSA requirements. While the consequences of not meeting full compliance have not been specified, this could result in additional Board monitoring /measures.

Governance Arrangements

The SGC approved revised Terms of Reference in March 2023 and updates on the progress of the 2023/24 SGC workplan are reported to each meeting.

Workforce Strategy/Planning

The NHS Fife Workforce Plan 2022-2025, agreed by the Board and Scottish Government (SG), was published in November 2022. Internal Audit will comment on the plan within internal audit B17/23 – Workforce Planning, which will be presented to the SGC once finalised. Work to capture information on the identifying and meeting future workforce requirements is ongoing, with the granular information to be obtained by service-based workforce plan templates.

An update on the Three-Year Workforce Plan 2022-25 was presented to the September 2023 SGC meeting with an action plan to address both SG feedback and the recommendations from the Internal Audit Annual Report 2022/23 (B06/24). The majority of the actions are scheduled for completion by March 2024, with the timescale for one action to be confirmed.

The Workforce Plan should provide an opportunity to identify strategic solutions to critical workforce risks and a coherent, cohesive and proportionate response to extreme pressures is needed. The Medium Term Plan 2023-26 highlights the positive steps being taken by NHS Fife to develop and sustain its workforce.

Risk Management

The SGC has oversight of the Workforce Delivery & Planning and Staff Health & Wellbeing corporate risks, both of which have a current high rating. The planned date to reduce the risk score from high to moderate for both risks has been changed to the end of March 2025 (previously March 2023). Whilst these target dates are more realistic, due to the pressures within the system achievability of these dates may need to be reconsidered over time.

A paper on implementation of the Health & Care (Staffing) (Scotland) Act 2019 (Safe Staffing Legislation) was presented to the 14 September 2023 SGC meeting, to update it on the action being

taken to comply with this legislation, which has to be fully implemented by 1 April 2024. To help manage this a new corporate risk has been created, which will be reported to the SGC.

Staff Governance Standards

The SG do not require a staff governance action plan for 2023/24 and no further guidance on Staff Governance Standard (SGS) monitoring procedures has been issued. NHS Fife does ensure the principles of the SGS are followed through:

- SGC workplan reports on the strands of the SGS are presented.
- Signposting other papers to the strand of the SGSs to which they relate.
- Board Development Days.

A date for reporting on the Well-Informed strand has yet to be confirmed.

The Internal Audit Annual Report 2022/23 concluded that further improvements could be made to monitoring and reporting on compliance with the SGS with progress on track for financial year end reporting.

A copy of the 2022/23 Annual Monitoring Return was presented to the 9 November 2023 SGC meeting prior to submission to the SG. For 2021/22 the SG provided feedback on suggested topics for further consideration, which were highlighted to the SGC. The SGC has not been provided with an update on whether action was taken in response to them, and we recommend that this is done.

A workforce policy update to the November 2023 SGC covered development and maintenance of local HR policies and Once for Scotland Workforce Policies. To raise awareness of workforce policies a number of briefing sessions have been held across various sites and virtually over the month of October 2023 with more scheduled for November 2023.

Staff Experience

An update paper on the Annual Delivery Plan (ADP) 2023/24 was presented to the 14 September 2023 SGC meeting to enable monitoring of workforce aspects, with the ADP a standing agenda item at the SGC. Nursing and midwifery staffing issues including the number of registered nurses needed and those entering the workforce, a decrease in for nursing courses in Scotland in 2023 and significant vacancy challenges within NHS Fife.

The September 2023 SGC was informed that iMatters engagement for 2023 had improved and was 66% compared to a national figure of 59%.

Whistleblowing

Implementation of whistleblowing arrangements and reporting was reviewed in Internal Audit Report B18-23. Steps are being taken to fully implement the directives of the Independent National Whistleblowing Officer, including quarterly and annual reporting of whistleblowing instances, investigation and implementation of lessons learned.

Recommendations made by Internal Audit have yet to be fully implemented and are being monitored through the Audit Follow-Up Protocol. This includes a recommendation that the SGC Annual Statement of Assurance 2023/24 includes an overt opinion on the adequacy of existing whistleblowing arrangements, supported by a concluding statement from the Whistleblowing Champion.

Remuneration Committee

The Remuneration Committee (RC) reviewed its terms of reference at its March 2023 meeting and completed a self-assessment of its performance.

Appraisals

The RC reviewed the completion of the 2022/23 performance appraisal process for the Executive and Senior Manager Cohort at its May and June 2023 meetings. The RC approved the 2022/23 objective setting process for the Executive and Senior Management Cohort at its June 2023 meeting. The RC agreed the Chief Executive's 2023/24 objectives at its May 2023 meeting and the 2023/24 Executive Cohort objectives at its July 2023 meeting. The RC also agreed that, due to the importance of ensuring that there is sufficient robust evidence to support the performance rating applied to each member of staff, the RC would further consider the appraisal process at a future date. We recommend this is built into the RC workplan.

The completion of annual Agenda for Change appraisals was 40% as at 31 October 2023, demonstrating a slight continuous improvement (38% at 31 March 2023 and 33% at 31 October 2022), but highlighting that more action to improve staff engagement is required. The SGC was advised that the appraisal performance is being monitored and actions to support staff engagement continue, with current initiatives to increase the focus on this process and sustain improvement ongoing.

Presentation of the 2022/23 Annual Report on Medical Consultant and GP appraisals to the November 2023 SGC has been delayed until the January 2024 meeting, due to the need to collate additional information on the appraisal strategic framework.

Core Skills Training

Core training compliance at 31 October 2023 was 63% (57% in May 2023) against the target of 80%, as reported to the November 2023 SGC meeting.

The SGC was advised of work to increase compliance to the 80% target by 31 March 2024, including:

- Developing compliance improvement trajectories across services to target and prioritise activity.
- Further engagement with training owners to establish delivery plans and improve levels of staff attendance/completion.
- The roll out of enhanced manager reporting to support compliance monitoring activity.
- Completion of a full core training compliance review to develop and refine the programme to improve role specific training requirement.

Sickness Reporting

Sickness absence is now reported to the SGC on a regular basis through the Promoting Attendance update reports, which detailed work being undertaken towards improving attendance and wellbeing. This is supplemented by summary data in the IPQR presented to each SGC. The absence rate at 30 September 2023 was 6.93%, which compares with a Scottish average of 5.94% and the target of 4%. The committee was advised that a range of support packages are being made available to help support the mental health of staff, including resources available on the Healthy Working Lives website, plus the Live Positive - Stress Management Toolkit. An Attendance Management training programme continues to be delivered in partnership to groups of managers within NHS Fife.

Action Point Reference 3 – SG Annual Monitoring Return	
Finding:	
The Scottish Government (SG) Annual Monitoring Return update to the 20 July 2023 SGC advised that the same 'streamlined' approach would be adopted for the 2022/23 return as in 2021/22, with the SG providing feedback on topics it feels Boards should concentrate on. The SGC was advised of SG feedback on the 2021/22 Return and areas that NHS Fife may wish to feed into the Staff Governance Plan and subsequent Return for 2022/2023. An example included feedback received from iMatter roadshows 'Have a natter because iMatter'. The SGC has not been advised as to whether the reported matters have been progressed and these areas do not feature specifically in the 2022/23 Annual Monitoring return presented to the 9 November 2023 SGC meeting.	
Audit Recommendation:	
Future updates to the SGC within the Annual Monitoring Return should include an update on action to address SG feedback from previous years.	
Assessment of Risk:	
Merits attention 	There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**
Management Response/Action:	
We note the recommendations and will work with the Staff Governance Committee chair to progress the necessary updates	
Action by:	**Date of expected completion:**
Director of Workforce	**31 March 2024**

FINANCIAL GOVERNANCE

Corporate Risks:

Risk 13 Delivery of a Balanced In-Year Financial Position – High Risk (16); Target (8) Moderate by March 2025 – Above Risk Appetite

There is a risk that due to the ongoing impact of the pandemic combined with the very challenging financial context both locally and nationally, the Board will not achieve its statutory financial revenue budget target in 2023/24 without further planned brokerage from Scottish Government.

Risk 14 Delivery of Recurring Financial Balance over the Medium-Term – High Risk (16); Target (12) Moderate by March 2024 – Above Risk Appetite

There is a risk that NHS Fife will not deliver the financial improvement and sustainability programme actions required to ensure sustainable financial balance over the medium term.

Risk 15 Prioritisation & Management of Capital Funding – Moderate (12); Target (8) Moderate by April 2026 – Within Risk Appetite

There is a risk that lack of prioritisation and control around the utilisation of limited capital and staffing resources will affect our ability to deliver the PAMS and to support the developing Population Health and Wellbeing Strategy.

Medium Term Financial Plan (MTFP)

The SG issued formal guidance on financial planning covering the financial years 2023/24 to 2025/26 with final plans to be submitted to SG by 16 March 2023. The guidance required that Boards currently unable to deliver financial balance in 2022-23 without support from SG develop a Financial Recovery Plan to demonstrate how balance will be achieved within three years.

In agreement with SG, NHS Fife developed a 5-year plan on the basis that it provides a more realistic and credible timescale within which NHS Fife can achieve financial sustainability and commence brokerage repayments for the financial support received in the years 2022/25.

The MTFP was endorsed by the FPRC (Reserved Business) on 14 March 2023, followed by Board approval (Reserved Business) on 28 March 2023. It provides clarity on funding and expenditure assumptions with areas of greatest risk and uncertainty highlighted. It presents a range of potential scenarios which demonstrate the impact of changes to key parameters, with a £10.9m financial gap identified for 2023/24.

MFTP – SG Response and Brokerage Required

The SG acknowledged the position outlined in the MTFP in March 2023, with the Board advised to undertake the following actions:

- Provide an update on progress against actions set out in the financial recovery plan, including the work carried out in collaboration with the IJB and regional partners.
- Develop a plan to deliver 3% recurring savings in 2023-24 and develop options to meet any unidentified or high-risk savings balance.
- Develop other measures to be taken to further reduce the financial gap.
- Review key underlying drivers of the deficit and specific risks as presented within the Financial Plan.
- Focus on addressing Covid-19 legacy costs, including additional bed capacity.

The NHS Fife Financial Improvement and Sustainability Programme aims to mitigate the financial gap and deliver against the SG actions. Financial reporting to the Board and FPRC has highlighted that currently there is a high possibility that NHS Fife will require a level of brokerage from the SG

to deliver the identified financial gap of £10.9m it is however now clear that the in-year financial gap is materially increasing, the latest forecast is £23m, this position has been reported to NHS Fife Board and SG. The Board will work towards reducing the final level of brokerage where that is possible.

Internal Audit Annual Report 2022/23 (B06/24) previously highlighted that "*NHS Fife Board needs to assure itself that it has the capacity and capability sufficient to drive strategy, and the associated transformation programme as well as delivering savings of £15m a year*." NHS Fife needs to ensure it has the capacity to drive forward required savings, if it is to have any chance of avoiding the use of further brokerage in 2023/24 and onwards.

Current Financial Position for the period to 30 September 2023

Finance reporting to Board and FPRC has been transparent, and the Director of Finance and Strategy has consistently and clearly articulated financial challenges through EDG, Standing Committees and the Board.

The MTFP reports an underlying deficit of £25.9m with a £15m cost improvement plan and a projected residual gap of £10.9m for 2023/24. A £15.9m revenue overspend was reported for the six months to the end of September 2023. The financial report reflects the continuing impact of the historic and emerging financial pressures set out in the medium-term financial plan and, more importantly, reflects the limited progress to deliver against the agreed £15m cost improvement programme.

The overall financial overspend of £15.9m incudes extra funding allocations of £7.5m pro rata for the period to September 2023 (full year £15.1m) which, if they had not been received, would have substantially impacted the current overspend.

The SG has highlighted in recent letters to NHS Fife, following Quarter 1 results and the forecast year end position, that NHS Fife need to identify more actions between now and the financial year end to improve the forecast outturn and move towards break even.

Cost Improvement Plans (Savings)

In line with national expectations and highlighted above, a 3% cost reduction target was allocated across the Board core revenue resource limit which included the funds delegated to the Fife H&SCP. A cost improvement target of £4.6m was delegated to the partnership and the remaining £15m is the responsibility of NHS Fife to deliver.

The Financial Improvement and Sustainability (FIS) Board meets monthly. The update on the status of the FIS Programme to the end of September 2023 noted that £5.38m of cost improvement plans was confirmed as delivered, however only £2.56m is confirmed on a recurring basis. The absence of recurring savings will impact on subsequent years.

The MTFP savings identified £10m of temporary staff reduction and £5m of surge capacity reduction. The spend on temporary staffing has remained high and as highlighted in financial reports spending this year, this is more than last year, with only £0.31m confirmed savings. Initial plans to reduce surge capacity have not materialised and the Director of Finance has reported that savings will not be made in this area due to ongoing pressures within Acute Services. Other areas have been identified as providing savings but as of September 2023, £9.62m remains as unconfirmed.

The FIS report to the November 2023 FPRC refocused the approach to recovery options in 2023/24 (Horizon 1), for example, introducing a different approach to achieve supplementary staffing reduction with a "*focus on determining the impact and effectiveness of the additional measures taken over the past 12 months to increase substantive staffing to enable a reduction in premium cost agency staffing*". Further work (Horizon 2) is planned to assess the viability of a range of other options to deliver greater value and, where possible, achieve cost reductions over the medium

term, with options including Service Redesign, Estates Review, Reducing Corporate Overheads, Optimising Digital Opportunities and review of Waste systems. Horizon 3 will aim to drive forward the Values Based Healthcare discussion with clinicians to determine whether there are opportunities to realise greater value from the c£900m revenue budget based on considering how services might be delivered in the future.

Savings identified within the FIS Programme are currently operational rather than strategic in nature. Now that the PHWS has been approved and in-year and medium term plans are in place, the linkage of future cost improvement programmes to the operational delivery of the PHWS should be made explicit within future reporting.

Finance Risk Reporting Revenue

There are two corporate financial risks, one for in year delivery of the financial plan and the second related to the longer-term financial plan.

The update provided to the FPRC in November 2023 for Risk 13 - Delivery of a balanced in-year financial position noted the position '*has materially deteriorated in Q2 with very limited progress against the in-year cost reduction target. This position has been reviewed to determine actions which can be taken to reduce the level of forecast overspend. Despite ongoing attempts to reduce costs and a commitment to avoid any additional investment in our services, it is highly likely that the Board will require significant financial brokerage to break-even*'.

We commend the openness of the reporting of the financial position and the forewarning that brokerage will likely be required. We recommend that both target and actual risk scores are reviewed, to ensure they fully reflect the deterioration in the financial position and the challenging environment. The target risk scores due to be achieved by 31 March 2024 appear to be optimistic in the circumstances.

We reiterate our view from the Internal Audit Annual Report 2022/23 (B06/24) that the organisation must assure itself that it has both capacity and can affect cultural change sufficient to deliver the required level of savings in addition to business as usual. Key actions should follow from the production of the PHWS in terms of prioritisation and service change.

Property Asset Management, Net Zero and Capital Risk

In September 2023 NHS Fife Board approved the Whole System Property and Asset Management Strategy, developed from the previous Property Asset Management Strategy. This new Strategy demonstrates links to the PHWS. It is anticipated that the SG will request a 'Whole System Initial Agreement' and this new Property Strategy provides the strategic direction to develop this approach.

The capital plan for 2023/24 was approved in March 2023 as part of the MTFP. Reporting of the capital plan to the FPRC is frequent, with the latest report in November 2023 highlighting no significant risks but issues remain with long lead in times within the supply chain and continued inflationary challenges.

The new strategy highlights the importance of Net Zero, having started the process of creating net-zero carbon road maps for all NHS Fife sites as part of its building energy transition programme. This will show what NHS Fife needs to do to achieve net-zero emissions and the costs associated with that.

The Prioritisation & Management of Capital funding risk is reported to the FPRC, and a Deep Dive is due to be presented to the January 2024 meeting. As part of this we would expect an assessment is provided on the adequacy and effectiveness of key controls and actions.

Asset Verification

Physical checking of a sample of assets is a management requirement within the NHS Fife Financial Operating Procedures. Internal Audit have been provided with evidence that physical checking of equipment has been undertaken during the financial year to date.

INFORMATION GOVERNANCE

Information Governance

Corporate Risks:

Risk 17 – Cyber Resilience – High Risk (16); Target (12) Moderate by September 2024 – Above Risk Appetite

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.

Risk 18 – Digital and Information – High Risk (15);Target (8) Moderate by April 2025 – Above Risk Appetite

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.

Governance and Assurance

The Information Governance and Security Steering Group (IG&SSG) and Digital and Information Board (D&IB) continue to provide assurance to the CGC. The latest IG&S update was presented to CGC in September 2023, with a further update scheduled for March 2023. Updates on the D&I Strategy were provided to CGC in July and November 2023.

The IGS Accountability and Assurance Framework Report has been developed following a mapping exercise between the Scottish Public Sector Cyber Resilience framework and the ICO Accountability Framework and is presented to each meeting of the IG&SSG. Whilst we commend this approach, further development is required as only three of the 10 categories reported have fully defined performance metrics defined and only one of the 10 categories includes cross reference to the risks associated with it. The IG&SSG has been informed that work is underway to address these issues, but no definitive timeline has been communicated.

The Terms of Reference for both the IG&SSG and D&I Board require papers to be issued at least 5 clear days before the meetings but this has not been happening. Some papers have been delivered as presentations at the meeting without having been sent to members in advance. This should be remedied to ensure compliance with the ToR.

Risk Management – IG&SSG and D&I

The management of IG&S risks is reported to each IG&SSG meeting within the IGS Accountability and Assurance Framework Report and is included in the updates to CGC twice a year. A risk report is also presented to each D&IB and there is some commonality of risks in the reports presented to IG&SSG and D&IB.

The latest risk reporting to IG&SSG and D&IB shows that there are a total of 48 risks with 11 scored as high, 27 as medium and 10 scored as low. The graphical representations showed that 23 risks had improved scores since the last report, 24 had remained static and 1 had deteriorated.

Summary information is also provided indicating the total number of risks in each category across D&I with the number within (35%) and outwith (65%) the risk appetite highlighted. The report does not currently include commentary on whether the actions underway and planned will be sufficient to bring these risks within the risk appetite in an acceptable timescale.

Corporate Risks

The two Information Governance corporate risks have been aligned to the CGC for scrutiny and Deep Dives are reported. A deep dive into risk 18 – D&I Strategy was presented to CGC on 3 November 2023 and a deep dive into risk 17 Cyber Resilience is to be presented to the 12 January 2024 meeting. In common with other areas of risk management the format of the deep dives should be improved to address our annual report (B06/24) recommendations.

Although the scores on the corporate risks associated with IG&S have remained static in the year to date, there is evidence of actions being progressed to reduce these towards their target scores and the latest reporting includes a timescale for reaching the target level.

Digital and Information Strategy

The D&I Strategy update to the CGC on 3 November 2023 included analysis of delivery and clearly shows items partially or not delivered. It also identified themes for the next iteration of the strategy and confirmed that this will be supported by a financial framework.

The regular portfolio and project updates provided to the D&IB outline the status of projects and their strategic alignment.

Information Governance Responsibilities

An NHS Fife Senior Information Risk Owner (SIRO) and Data Protection Officer (DPO) are in place and the SIRO is an Executive member of the Board.

Information Governance Policies and Procedures

The status of IG related policies is reported to IG&SSG in the IGS Accountability and Assurance Framework Report with the most recent report presented in October 2023 indicating that all 7 of the 8 policies were within their review date (87.5%). The exception being GP/D3 – NHS Fife Information Governance and Data Protection Core Policy which has a review date August 2023. The IGS Accountability and Assurance Framework Report states that this policy has been reviewed and is available for consultation.

Information Governance Incidents and Reporting

Updates on IG&S incident management are reported to each IG&SSG meeting and to the CGC twice per year. The most recent update to CGC on 3 November 2023 included:

- the number of IG&S incidents reported via DATIX
- the number of IG&S incidents reported to the ICO or Competent Authority, the number of these reported within the required 72-hour timescale and the number that required follow-up by the ICO.

At its meeting on 10 October 2023 the IG&SSG received an update on an incident where an imposter obtained personal identifiable information. This resulted in a reprimand from the ICO, which is the tier of ICO enforcement action below monetary penalties and can include publication of the reprimand on the ICO website. The IG&SSG agreed that the reports from the SAER would be provided to the IG&SSG for consideration before this incident would be highlighted to CGC outlining the issue would warrant disclosure in the Board's Governance Statement.

Action Point Reference 4 – Assurance Reporting to IG&SSG

Finding:

The IGS Accountability and Assurance Framework Report includes ten categories but while the IG&SSG have been advised that performance metrics are being developed for these, the group have not been informed of a timescale for completion of this and to date only three of the categories have fully established performance metrics defined.

Papers to the IG&SSG and the D&I Board has not always been timely and some papers have been delivered as presentations at the meeting without being distributed. The terms of reference for both IG&SSG and D&I Board state that the papers will be issued at least 5 clear days before the meetings, but this has not been happening in practice.

Audit Recommendation:

IG&SSG should be provided with a timescale by which the IGS Accountability and Assurance Framework Report will be improved to include:

- fully established performance measures for each category reported in the framework
- completed risk sections for each category in framework report including cross referencing to the ID of risk in DATIX and to the improvement actions that will reduce the risk score.

The timing of the issue of papers to IG&SSG and D&I Board members should be monitored, and action taken to ensure that the papers are provided to members at least 5 days before the meeting dates.

Assessment of Risk:

Merits attention		There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**

Management Response/Action:

The performance measures will be established throughout the remainder of 2023-24. While the measures can be developed the ability to report on these in a consistent and efficient manner will need to be established.

The IG&S Accountability Framework will be updated to include the relevant risk summary.

The timing of the issue of papers will be monitored.

Action by:	Date of expected completion:
Associate Director of Digital and Information	**30 April 2024**

Action Point Reference 5 – IG&S Incident Management Assurance

Finding:

At its meeting on 10 October 2023 the IG&SSG received an update on an incident where an imposter obtained personal identifiable information. This resulted in a reprimand from the ICO, which is the tier of ICO enforcement action below monetary penalties and can include publication of the reprimand on the ICO website. The IG&SSG agreed that this incident would warrant disclosure in the Board's Governance Statement, however, the report and findings from the SAER group would need to be issued to the IG&SSG prior to the item being highlighted to the CGC.

Audit Recommendation:

Our existing recommendation in ICE 2022-23 (B08/23 point 10) relates to including a conclusion in the incident management part of the update report to CGC from IG&SSG regarding whether any of the incidents being managed are likely to require a disclosure in the Board's Governance Statement. Having considered the breach referred to above the approach to reporting on information governance and security breaches should be strengthened to ensure that:

- The IG&SSG consider whether any of the breaches being reported are likely to require to be disclosed in the Board's Governance statement
- CGC are informed at the earliest opportunity regarding any breaches that are likely to require a disclosure in the Board's Governance Statement
- These steps are reflected in the relevant policies and procedures.

Assessment of Risk:

Merits attention		There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**

Management Response/Action:

The Incident reporting element to the IG&SSG will consider if any of the breaches are likely to require disclosure in the Board's Governance statement.

Through identification of these breaches the IG&SSG will consider the necessary escalation to the CGC.

Action by:	Date of expected completion:
Associate Director of Digital and Information	**30 April 2024**

Assessment of Risk

To assist management in assessing each audit finding and recommendation, we have assessed the risk of each of the weaknesses identified and categorised each finding according to the following criteria:

Fundamental		Non Compliance with key controls or evidence of material loss or error. **Action is imperative to ensure that the objectives for the area under review are met.**	**None**
Significant		Weaknesses in design or implementation of key controls i.e. those which individually reduce the risk scores. **Requires action to avoid exposure to significant risks to achieving the objectives for area under review.**	**None**
Moderate		Weaknesses in design or implementation of controls which contribute to risk mitigation. **Requires action to avoid exposure to moderate risks to achieving the objectives for area under review.**	**One**
Merits attention		There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**	**Four**

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**12 January 2024**
Title:	**Update on Corporate Risks Aligned to the Clinical Governance Committee including Deep Dives: Covid-19 and Cyber Resilience**
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 12 November 2023, along with the scheduled Deep Dive reviews.

The Committee is invited to:

- note the corporate risks as at 21/12/23 set out at Appendix No. 1;
- consider the SBAR and Closing Deep Dive Review - COVID 19 Pandemic - provided at Appendix No. 2;
- consider the SBAR and Deep Dive Review - Cyber Resilience - provided at Appendix No. 3;
- review all information provided against the Assurance Principles at Appendix No. 4; and the Risk Matrix at Appendix No. 5;
- conclude and comment on the assurance derived from the report

2.2 Background

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

- relevance
- proportionality
- reliability
- sufficiency

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

Table 1

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

2.3 Assessment

Since the last report to the Committee on 12 November 2023:

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

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

Strategic Risk Profile

Table 2

Strategic Priori	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	6	5	1	-	-	◄►	Moderate
To improve staff experience and wellbeing	2	2	-	-	-	◄►	Moderate
To deliver value and sustainability	6	4	2	-	-	◄►	Moderate
Total	**19**	**13**	**6**	**0**	**0**		

Summary Statement on Risk Profile

On 28/11/23, the Board approved the addition to the Corporate Risk Register of the corporate risk associated with **Preparation for the Implementation of the Health and Care (Staffing) (Scotland) Act 2019**
This risk is assessed as Moderate level.
It is mapped to Strategic Priority 'To improve the quality of health and care services' and will be reported for assurance purposes to the Staff Governance Committee.

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.

Risk Key		Movement Key	
High Risk	15 - 25	▲	Improved - Risk Decreased
Moderate Risk	8 - 12	◄►	No Change
Low Risk	4 - 6	▼	Deteriorated - Risk Increased
Very Low Risk	1 - 3		

Updates

Risk 3 - COVID 19

At the last meeting of the Committee on 12 November 2023, members expressed support for closing this as a corporate risk, pending its review by the Public Health Assurance Committee (PHAC) on 6 December 2023. The PHAC endorsed de-escalation to the Public Health Directorate risk register. A closing deep dive is provided at Appendix No. 2.

Risk 4 - Optimal Clinical Outcomes

Following the Development Session on 23 October 2023, a revised risk will be prepared for consideration by EDG before presenting to the Committee in March 2024.

Risk 9 - Quality and Safety
The risk level is to remain at high pending the outcome of the review commissioned by the Chief Executive into the governance arrangements around the triangulation of data associated with quality and safety. Feedback is expected in January 2024.

Risk 17- Cyber Resilience
A deep dive review of this risk is provided at Appendix 3.

Potential Corporate Risk:

Future Biological Threats including Pandemics
Work to prepare the new risk is going through the Pandemic Flu Group, with a working timeline of March 2024. This is to ensure alignment with national pandemic preparedness guidance; it is anticipated this will be published by the end of February 2024.

Deep Dive Reviews
Deep dives continue to form an important component of our assurance arrangements. All 6 corporate risks aligned to this Committee have undergone at least one deep dive.

Based on our experience and learning over the last year, and following discussion at the Audit and Risk Committee Development Session held on 12 October 2023, the Risks and Opportunities Group (ROG) made recommendations to EDG on 2 November 2023 on the role of the 'deep dive' and triggers for reviews during the life - cycle of a corporate risk.
In summary the triggers are:

Proposal of a New Corporate Risk:
A potential risk is identified to the delivery of strategic priorities

Deteriorating Corporate Risk:
A risk has deteriorated i.e. current risk level increased from when initially identified/ risk level causes risk to exceed risk appetite

Static Risk:
There is stasis in a corporate risk beyond the target date for achieving the target risk rating

Proposed De- escalation or Closure of Corporate Risk:
A risk has achieved or surpassed its planned risk target

Following EDG's approval of the recommendations, the Audit and Risk Committee endorsed this development at its meeting on 13 December 2023. It is proposed the refreshed approach will take effect from 1 April 2024. Arrangements for implementation will be communicated to the Committee in due course.

Next Steps
The format and content of the Corporate Risk Register, and risk reports, including deep dives, will continue to evolve in response to feedback from this Committee and other stakeholders. This will inform decisions on further development and/ or improvements.

The ROG will continue to promote and support the further development of risk management, and explore enhancements in this area. These include the frequency of reporting on corporate risks to Committees, as the ability to mitigate a number of risks is dependent on a range of external factors, including performance & finance.

In the operational risks space, a notable development has been the creation of a Risk Summary Dashboard using a reporting tool (Micro Strategy), to maximise the value of the information in the Datix Risk Register. The Audit and Risk Committee and EDG received a live demonstration of the Dashboard on 12 October and 2 November 2023 respectively, with a recommendation from the ROG that the Dashboard is made available and its use promoted to support and enhance our operational risk management approach. At its meeting on 13 December, the Audit and Risk Committee endorsed the recommendation that the ROG should support the development and implementation approach for the Dashboard, and progress this work in the first quarter of 2024.

At the Audit and Risk Committee Development Session mentioned above, there was thoughtful discussion around the Committee's system responsibilities across all aspects of risk, including how other Committees evidence their challenges to provide additional assurance to the Audit & Risk Committee. Specific actions will be developed and form part of the Committee's work plan for 2024-25.

2.3.1 Quality, Patient and Value-Based Health & Care

Effective management of risks will support delivery of all strategic priorities. Applying realistic medicine principles will ensure a more holistic focus on patients' needs, and the outcomes and experiences that matter to them, and their families and carers.

2.3.2 Workforce

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

2.3.3 Financial

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

2.3.4 Risk Assessment / Management

Management of the corporate risks aligned to this Committee continues to be maintained, including through close monitoring of agenda, work- plans, and clear governance through appropriate groups and committees. These fora allow for due diligence on the risks, which should inform decision making and contribute to good governance.

50 % of the risks remain above risk appetite, which reflects the ongoing level of delivery challenge across the services.

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 with stakeholders.

2.3.8 Route to the Meeting

- NHS Fife Clinical Governance Oversight Group on 12 December 2023
- Alistair Graham, Associate Director of Digital & Information on 15 December 2023
- Neil McCormick, Director of Property & Asset Management on 15 December 2023
- Dr Chris McKenna, Medical Director, on 15 December 2023
- Dr Shirley- Anne Savage, Associate Director of Quality & Clinical Governance on 15 December 2023
- Dr Joy Tomlinson Director of Public Health on 15 December 2023

2.4 Recommendation

- **Assurance** - Members are asked to take a **"reasonable"** level of assurance that, all actions, within the control of the organisation, are being taken to mitigate these risks as far as is possible to do so.
- Members are also asked to note the intended developments on the:
  - Content and process associated with Deep Dive reviews;
  - Risk Summary Dashboard

3 List of appendices

The following appendices are included with this report:

Appendix No. 1, NHS Fife Corporate Risks aligned to the CGC as at 21/12/23
Appendix No. 2, SBAR and Closing Deep Dive Review: COVID 19 Pandemic risk
Appendix, No. 3, SBAR and Deep Dive Review: Cyber Resilience risk
Appendix No.4, Assurance Principles
Appendix No.5, Risk Matrix

Report Contact
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Risk Manager
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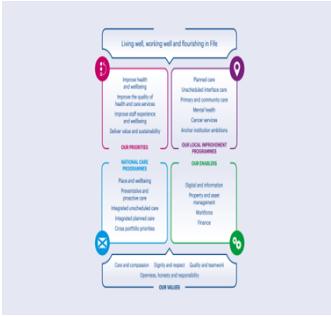
NHS Fife Corporate Risks Aligned to the Clinical Governance Committee as at 21 December 2023

To improve health and wellbeing

	Risk	Mitigation	Current Risk Level / Rating	Target Risk Level & Rating by date	Current Risk Level Trend	Appetite (High)	Risk Owner
3	**COVID 19 Pandemic** There is an ongoing risk to the health of the population, particularly the clinically vulnerable, the elderly and those living in care homes, that if we are unable to protect people through vaccination and other public health control measures to break the chain of transmission or to respond to a new variant, this will result in mild-to-moderate illness in the majority of the population, but complications requiring hospital care and severe disease ,including death in a minority of the population.	A range of indicators together provide an assessment that overall numbers of people affected by COVID19 in Scotland remain low. Population immunity to COVID-19 has increased through combination of immunisation and exposure to infection. The infection prevention and control measures which protect the most vulnerable are understood and used within healthcare settings. Treatments are available for individuals at higher risk of adverse outcomes. Tailored support continues to be provided to Care Homes with positive	Mod 9 (3x3)	Mod 12 (4x3) by October 2023	◀▶	Below	Director of Public Health

		staff or resident cases. The risk is regularly reviewed by the Public Health Assurance Committee (PHAC). An update on the deep dive review presented to CGC on 03/03/23 was provided to the PHAC in December 2023. It was agreed that this risk is now considered for closure as a Corporate Risk and a closing Deep Dive will be tabled to consider this at the next CGC meeting in January 2024.					
5	**Optimal Clinical Outcomes** There is a risk that recovering from the legacy impact of the ongoing pandemic, combined with the impact of the cost-of-living crisis on citizens, will increase the level of challenge in meeting the health and care needs of the population both in the immediate and medium-term.	The Board has agreed a suite of local improvement programmes, as detailed in the diagram below to frame and plan our approach to meeting the challenges associated with this risk. The governance arrangements supporting this work will inform the level of risk associated with delivering against these key programmes and reduce the level of risk over time. 	High 15 (5x3)	Mod 10 (5x2) by 31/03/24	◀▶	Within	Medical Director

		Following the Development Session on 23 October 2023, a revised risk will be prepared for EDG consideration, before presenting to the Committee in March 2024.					

To improve the quality of health and care services

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

		2023, members requested that the risk and the risk scores be reviewed. This was given that the likelihood of occurrence was scored very high, despite the governance arrangements in place, and the number of completed mitigating actions. A review of the risk scores has been carried out which indicates the potential to reduce the current and target risk ratings and levels. This would bring the risk within its risk appetite. This exercise has been undertaken during a period in which the Board is considering its response to events at the Countess of Chester Hospital. This includes the NHS Fife Board Chief Executive, commissioning a review of our governance arrangements, including systems for organisational learning. The review will allow an objective opinion to be formed on the adequacy and effectiveness of our systems and processes, provide evidence of positive assurance, and where indicated, recommend improvement actions. The risk scores are unchanged pending the outcome of the above review. Feedback is expected in January 2024.					

To deliver value and sustainability

	Risk	Mitigation	Current Risk Level / Rating	Target Risk Level & Rating by date	Current Risk Level Trend	Appetite (Moderate)	Risk Owner
16	**Off-Site Area Sterilisation and Disinfection Unit Service** There is a risk that by continuing to use a single off-site service Area Sterilisation Disinfection Unit (ASDU), our ability to control the supply and standard of equipment required to deliver a safe and effective service will deteriorate.	Monitoring and review continues through the NHS Fife Decontamination Group. Establishment of local SSD for robotics is progressing with an indicative date of 31/12/23. Health Facilities Scotland (HFS) has agreed the design and the unit at St Andrews Community Hospital (SACH); the timescale to become operational has been revised from December 2023 to possibly June 2024. Work is underway to meet this target. An option appraisal for delivery of the service is being explored. 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	Mod 12 (4x3)	Low 6 (2x3) by 01/04/2026 at next SG funding review	◄►	Within	Director of Property & Asset Management

		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 purchased in early 2022 costing £29,000 in use to protect our heavy trauma and orthopaedic trays. A trial of foam corners has been instigated by Tayside. 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 Consideration being given to increasing stock to 7 days for Trauma and Obstetric trays. Manage the SLA appropriately and consider changes to allow quality issues to be identified and treated seriously and in a timely manner. 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). Considering alternative providers to determine whether value for money is being provided and whether increased resilience can be provided (work 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. Work with Regional partners to identify synergies in service delivery including the developing business plan for re-provision of CDU capacity within NHS Lothian. 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.					

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

Risk Movement Key

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

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**12 January 2024**
Title:	**Covid-19 Pandemic: Corporate Risk Closure**
Responsible Executive:	**Joy Tomlinson, Director of Public Health**
Report Author:	**Joy Tomlinson, Director of Public Health**

1 Purpose

This report is presented for:

- Assurance
- Decision

This report relates to:

- 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

2 Report summary

2.1 Situation

An overarching COVID19 pandemic risk is retained and managed on the Corporate Risk Register. A Deep Dive review of the risk is attached (**Appendix 1**). There is reasonable assurance that the necessary management actions are in place to ensure this risk can now be managed as business as usual. The Committee is asked to endorse the recommendation that this risk is closed on the Corporate Risk Register.

2.2 Background

The COVID19 pandemic is a global outbreak caused by SARS-CoV-2 coronavirus. This novel coronavirus was initially identified in China in December 2019 and the World Health Organisation declared it a Public Health Emergency of International Concern on 30th January 2020. It was confirmed as a pandemic on 11th March 2020.

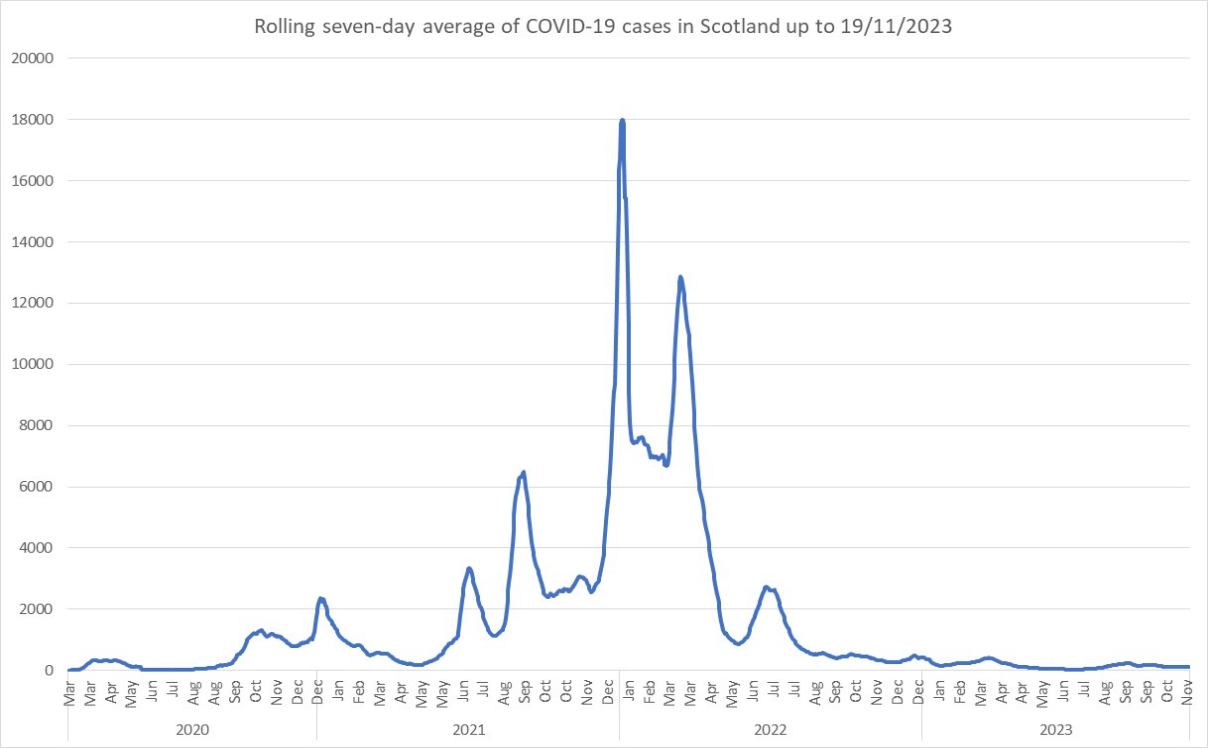
An overarching COVID19 pandemic risk is retained and managed on the Corporate Risk Register of NHS Fife. The risk descriptor is set out below:

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.

The World Health Organisation declared an end to the public health emergency on 5th May 2023. This decision was reached after the WHO Emergency Committee had examined the wider trends and concluded that the pandemic had been on a downward trend for the preceding 12 months. The increase in immunity from effective vaccines and from the number of infections across the world, mean that the threat of severe disease and death has reduced over time.

A reduction in case numbers has also been tracked in Scotland (see **Figure 1** below). The method of case ascertainment has changed over time, with reduction in asymptomatic testing from July 2022. A range of indicators including test positivity, hospital admissions, ICU admissions, wastewater sampling and outbreaks in specific settings are used to monitor COVID19 activity levels across the population.

Figure 1: COVID19 cases in Scotland March 2020 to November 2023



The response to the pandemic required coordinated local and national responses for the whole population. These included development of testing pathways, contact tracing, isolation of individuals during their infectious period, social distancing and specific directions about travel and mixing of the population. Following development and roll-out of vaccination the population has benefitted from protection from the most severe consequences of infection.

Within healthcare settings additional actions were required, including development of care pathways specifically for people with suspected COVID19, rapid digital developments to support remote consultation, enhanced infection prevention control approaches across all areas, widespread testing of the workforce and significant disruption to planned and unplanned care.

The impacts of the pandemic on the wider population of Fife and the healthcare system were reported regularly to the Executive Directors' Group (EDG) during 2020 to 2022. The enhanced monitoring of trends through national surveys has reduced significantly since 2022 and reporting of COVID19 infection is included within a wider suite of monitoring for respiratory infections.

2.3 Assessment

A Deep Dive review into the COVID19 pandemic risk was carried out most recently in November 2023 and discussed at the Public Health Assurance Committee meeting on 6th December 2023. There is reasonable confidence that the necessary management actions are in place to ensure this risk can now be managed as business as usual.

Within Fife, testing pathways were established as directed by Scottish Government in their Test, Trace, Isolate and Support (TTIS) Strategy, published in May 2020. These pathways were extensive initially and required rapid expansion of high volumes of testing capacity. The pathways were in place for many months and were used to disrupt community transmission of COVID19. During 2022, these pathways were reduced and stepped back in line with national expectations.

The Test and Protect approach also included building capacity to undertake complex contact tracing for confirmed cases of COVID19. This involved testing, then tracing people who may have become infected by spending time in close contact with the case. Contacts were identified and then steps were put in place making it less likely they would transmit it to others.

Contact tracing was delivered directly by health protection professionals in teams in NHS Fife and across Scotland. Contact tracing for the whole population stopped on 1st May 2022. From this point, the majority of the population have received advice on steps to take if they had a positive test from NHS Inform.

On 28th August 2023, all Scottish Government COVID19 routine testing guidance in health, social care and prison settings was paused. Routine testing remains in place for individuals in hospital, prior to being discharged to a care home or a hospice.

The introduction of an effective vaccination for COVID19 has resulted in significant protection to the population. The primary aim of the programme remains the prevention of severe illness (hospitalisations and deaths) arising from COVID19.

The third autumn/winter programme of vaccination is underway across Fife as of Autumn 2023 and the vaccine provides effective protection against severe illness.

Other protections in place include effective infection prevention and control across healthcare and other vulnerable settings. Training is available for all staff and this has been revised and refined over the course of the pandemic. There are also effective anti-COVID treatments, which provide additional protection for people at highest risk of severe illness.

The course of the pandemic continues to be tracked both nationally and locally using a range of different indicators in the population. This risk is now below target level and has been maintained below target level for several months.

The assessment from the Deep Dive, is that this risk can now be closed on the Corporate Risk Register, placed on the Public Health Directorate risk register, and continue to be monitored through the Public Health Assurance Committee. The risk will continue to be regularly reviewed and management actions assessed. Although it is possible a new variant of concern could emerge, the expectation is existing management actions would provide sufficient protection from the most severe elements of COVID19 infection.

2.3.1 Quality / Patient and Value - Based Health & Care

Maintaining whole system focus on the risks associated with the COVID19 pandemic has been beneficial. The quality of patient care is protected by the management actions which have been put in place to manage the pandemic within a healthcare environment.

2.3.2 Workforce

The workforce have been provided with direct protection through the offer of vaccination and training in Infection Prevention Control procedures. There are not anticipated to be any disadvantages to staff by removing this risk from the Corporate Risk Register as the management actions to protect staff are well embedded.

2.3.3 Financial

No direct financial impacts are anticipated as a result of closure of this risk. There is the potential for new pressures to arise if a new variant occurs which ‘escapes’ the protection of immunity from vaccination. If this was to occur, the risk could quickly be reintroduced to the Corporate Risk register.

2.3.4 Risk Assessment / Management

The management actions to mitigate this risk are set out in the Deep Dive review attached as **Appendix 1**. The target risk level was achieved in October 2022 and exceeded in October 2023, reducing to 9, moderate. National surveillance has not identified any new emerging variants of concern. The root causes for the pandemic do however remain

significant risks worldwide. A new Corporate Risk is being prepared for inclusion on the Corporate Risk Register. This will incorporate preparations for wider biological threats and the potential impacts on the healthcare system.

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

It is not anticipated that there will be any adverse outcomes in terms of equality and diversity as a result of this proposal. The management actions in place are protective of the whole population and subgroups with greater vulnerabilities. People in our population who are more affected by health inequalities have faced a worsening of these harms because of the pandemic. The wider disruption to employment and education have resulted in harms to children, young people and those who are most disadvantaged.

Anchor ambitions can be strengthened utilising some experiences from the pandemic, particularly considering some of the opportunities to purchase locally and put in place direct assistance to individuals so they can access healthcare.

2.3.6 Climate Emergency & Sustainability Impact

There are no direct impacts from this proposal on the targets outlined within NHS Scotland's Climate Emergency and Sustainability Strategy. The closure of the risk could support further discussion about single-use items in some areas.

2.3.7 Communication, involvement, engagement and consultation

Management actions for this risk have been reviewed and considered by the Board Immunisation Coordinator, Lead Consultant in Health Protection, Deputy Director of Pharmacy and the Executive Director of Nursing. The Deep Dive review has utilised national surveillance materials.

The Public Health Assurance Committee have considered this risk regularly over the course of the pandemic. The most recent discussion of this risk was on 6th December 2023. The group recommended that this risk is considered for closure as a Corporate Risk. The legacy risk will continue to be monitored on the Public Health risk register.

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.

- Public Health Assurance Committee 6th December 2023
- Executive Directors' Group on 21st December 2023

2.4 Recommendation

Members are asked to consider the content of the Deep Dive, the assessment that reasonable assurance should be taken from management actions in place and recommended decision.

- **Assurance**
- **Decision** – Recommend COVID19 Pandemic risk is closed on the Corporate Risk Register and oversight is transferred to the Public Health Assurance Committee.

3 List of appendices

The following appendices are included with this report:

- Appendix No. 1, Deep Dive COVID19 Pandemic Risk

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

Deep Dive Review – COVID 19 Pandemic for Clinical Governance Committee on 12th January 2024

Corporate Risk Title	**3 - COVID 19 Pandemic**			
Strategic Priority	To improve health and wellbeing			
Risk Appetite	**High**			
Level of Risk Assurance	**Substantial Assurance** 	**Reasonable Assurance** 	**Limited Assurance** 	**No Assurance** 
Confirm Assurance Level (Add a Yes)		**Yes**		
Risk Description	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 respond to a new variant, this will result in mild to moderate illness in the majority of the population, but complications will require hospital care and cause severe disease and death in a minority. The potential impacts for NHS Fife include increased deaths, increased pressure on healthcare and support services affecting recovery, reduced capacity for non-urgent services, disruption to supply chains, impacts from treatments deferred during the pandemic and increased levels of employee absence due to personal illness and caring responsibilities.			
Root Cause (s)	The international spread of disease is a global threat with serious consequences for public health, human lives and economies that calls for an effective, appropriate and comprehensive response. The number of high-threat infectious hazards continues to rise; some of these are re-emerging and others are new. The COVID 19 pandemic has directly impacted the health of individual citizens, healthcare staff and the ability of the healthcare system to deliver core services to the population. The Global Preparedness Monitoring Board, co-convened by WHO and the World Bank, recognised a lack of preparedness for future respiratory pandemics in their 2019 annual report A World at Risk. In their 2020 report they noted "the COVID-19 pandemic has revealed a collective failure to take pandemic preparedness and response seriously and prioritise it accordingly….it has exploited inequalities, reminding us in no uncertain terms that there is no health security without social security." The GPMB 2023 annual report: A Fragile State of Preparedness, recognises some areas of improvement following COVID19. However, the report highlights significant weaknesses in future preparedness and ongoing threats from outbreaks of infectious disease. Risk of a pandemic happening increased due to a combination of factors. The likelihood of animal to human spill-over infection was increased as a result of deforestation, wet markets and close proximity to large density of people. Population movement, mixing and international travel further increased the likelihood of infection spreading quickly in the population. The impacts from the COVID19 pandemic were not evenly distributed in the population across Fife and Scotland. Older people and particularly those residents in care homes experienced more severe illness and higher mortality rates. A rapid review recognised that the Care Home environments posed particular risks for rapid transmission Care Home Review 2020. Pandemic prevention and preparedness require sufficient financial and technical			

	resources. Early assessments of preparedness such as the one published by Audit Scotland: lessons to be learned in Pandemic response highlighted that there were areas which should be strengthened. Not all actions identified from earlier pandemic preparedness exercises were fully implemented. Demand for personal protective equipment was significant and there were shortages early in the pandemic. Pressure on staff was unprecedented. The Scottish and UK COVID Inquiries are in progress and will identify what lessons there are for the future within their respective scope. The COVID19 response required additional programmes of work to be put in place by NHS Fife, including testing, contact tracing, enhanced support for vulnerable settings and restrictions on population movement. These remained in place until the national immunisation programme was fully established. National directions were given about the level of restrictions which required to be in place across the population. The pandemic has required multiple management actions, which have changed over time. Scotland's Strategic Framework sets out the strategic approach to the response and associated longer term harms. The target risk level has been achieved. This can be attributed to the range of management actions cited above and below. It is important to note that this could change quickly. A new variant or mutation with significant vaccine escape would result in a rapid escalation of the risk to the Executive Directors' Group (EDG) and the NHS Fife Clinical Governance Committee.		
Current Risk Rating ([LxC] & Level (e.g. High Moderate, Low)	**Likelihood -** 3 - Possible	**Consequence -** 3 - Moderate	**Level** Moderate 9
Target Risk Rating([LxC] & Level (e.g. High, Moderate, Low)	**Likelihood –** 4 - Likely	**Consequence -** 3 - Moderate	**Level** Moderate 12 **Target Date 31/03/24**

Management Actions (current)

Action	Status	Impact on Likelihood/ Consequence
Population immunity to COVID-19 continues to increase, and the JCVI have stated that should population immunity to SARS-CoV-2 continue to increase over time, it is anticipated that most people will experience relatively mild symptomatic or asymptomatic infection when exposed to the virus. In such a scenario, future routine COVID-19 immunisation (beyond the Winter 23/24 programme) may be a cost effective intervention for only a relatively small population group who remain at high risk from more severe COVID-19. • The Spring 23 booster programme achieved 84% uptake among 75+ cohort in Fife and 89% uptake among care home residents. • The UK COVID-19 vaccination programme entered its third autumn season in 2023. The primary aim of the programme remains the prevention of severe illness (hospitalisations and deaths). A CMO direction on 01/09/23 led to a re-phasing of the winter 23/24 booster programme, with delivery to care home residents and the 75+ population brought-forward as a precaution in view of detection of BA.2.86 variant. • Delivery commenced 04/09/23, with all COVID eligible adult groups (65+ and at-risk) issued a co-administration flu/COVID appointment or prompt letter. Whilst the winter booster offer will remain open until 31/03/24, the key delivery period runs until mid-December. • The COVID vaccine in use in Fife switched from bivalent BA.4/5 to monovalent XBB.1.5 on 27/09/23. More recent risk assessment of BA.2.86 have not raised evidence of future concern, and direction from JCVI to expand or revaccinate is	**On track**	**Reduced consequence**

not anticipated this season.		
Population advice is available about travel, workplaces, ventilation, testing and staying at home and immunisation Coronavirus in Scotland. Advice is available for individuals on NHS Inform.	**Completed**	**Reduced likelihood**
Surveillance, contribution from GP surgeries across Fife contribute to the community surveillance programme, (Community Acute Respiratory Infections: CARI) as well as information gathered from hospital cases (Secondary Care Acute Respiratory Infections: SARI).	**On track**	**Reduced consequence**
Support for vulnerable settings is in place with range of guidance for healthcare and non-healthcare settings. National Infection Prevention and Control Manual (NIPCM) and Fife specific advice is available on Blink Coronavirus (COVID19). Infection Prevention and Control (IPC) training has been promoted in Fife's care homes for staff. This has included both practical and theoretical training using the evidence base derived from the National Infection Prevention and Control Manual (NIPCM). The Care Home IPC team delivered face to face training to 776 care home staff in 2022 and 643 in 2023 thus far. Fundamental IPC training and education is also offered to NHS community teams, such as Health Protection Team (HPT), Community Treatment and Care (CTAC) nurse team, other visiting health professionals and the Care Home Liaison Nurses (CHLNs).	**Complete and ongoing**	**Reduced likelihood**
Anti- COVID Treatments: There are currently several COVID-19 treatments available in Scotland which are designed to treat the symptoms of the disease. The National Infection Prevention and Control Manual (NIPCM) targets those higher risk individuals who are deemed to be at highest risk of disease progression, hospitalisation and death. There is currently an out-patient and in-patient pathway for deployment of these treatments across NHS Fife. Consultation is underway, regarding draft NICE guidance to expand eligible cohorts of patients, which may include the frail and elderly population. Planning for a revised pathway, should this be approved, is underway to ensure implementation within the required 90 days' timescale.	**On track**	**Reduced consequence**
NHS Fife continues to offer covid testing in line with national recommendations to support clinical diagnosis and for outbreak management per the NIPCM, and on advice from local Infection Prevention and Control Teams or local Health Protection Teams. Testing for care home residents and those who are eligible for COVID-19 treatments will also continue to be available.	**On track**	**Reduced consequence**

Completed
On track
Significant level of delivery challenge
At risk of non delivery
Not started

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**12 January 2024**
Title:	**Deep Dive: Cyber Resilience**
Responsible Executive:	**Dr Chris McKenna, Medical Director**
Report Author:	**Alistair Graham, Associate Director of Digital and Information**

1 Purpose

This report is presented for:

- Assurance

This report relates to:

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

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

As part of the Clinical Governance Committee workplan a series of deep dives into the committee's associated corporate risks was agreed. The report provides the deep dive associated with risk 17 – Cyber Resilience.

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

2.2 Background

The corporate risk associated with Cyber Resilience is described as:-

"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"

This risk is identified through the requirement to provide compliance to the Security of Network and Information Systems (NIS) Directive and align with the key wider cyber-related requirements under the General Data Protection Regulation (GDPR), along with other standards.

To support consistency, the Scottish Government (SG) published the Scottish Public Sector Cyber Resilience Framework (SPSCRF) in January 2020, which allowed Scottish public sector organisations to:

- assess their cyber resilience arrangements.
- identify areas of strength and weakness.
- gain reasonable confidence that they are adhering to minimum cyber resilience requirements.
- make informed decisions on how/whether to achieve higher levels of cyber resilience on a risk-based and proportionate basis.

NHS Fife undergoes an annual audit under the NIS Directive, with the most recent report being made available in August 2023. This is the fourth annual report NHS Fife has received.

The assurance and monitoring of progress relating to the SPSCRF remains with the Information Governance and Security Steering Group, with many of the operational elements and initiatives reported via the Digital and Information Board. The NIS Audit report becomes the key route to considering the next set of action plans that are then incorporated into the Information Governance Accountability and Assurance Framework.

The lead role in supporting NHS Fife's NIS Audit cycle is the Information Security Manager. This individual is supported by a wide range of Operational teams who impact on the safety and security of all our digital systems along with the continued education and communication to our staff and those teams that consider the physical security of buildings and key areas.

The summary compliance scores from all the NISD audits are shown below in Table 1.

Table 1 - NISD Compliance Score

Annual Measures	2020	2021	2022	2023
NISD Compliance Score	53%	69%	76%	87%

The Key Messages contained within the report are:-

NHS Fife is a high-performing board with well-defined security policies and procedures in place.

This is reflected in the data analysis summarised below, which shows:

- an overall compliance status of 77%;
- 10 categories and 41 sub-categories rated at 80% compliance or above
- 16 categories and 55 sub-categories rated at 60% compliance or above
- 290 controls achieved.

The only area with compliance below 30% is:

- Security in Cloud Services – which is dependent upon receipt of evidence from National Services Scotland (NSS)

Since the initial SPSCRF was developed, there have been significant changes to Information and communications technology (ICT) operational practices and standards. These reflect a greater use of cloud-based services, outsourced ICT provisions and expansion of home/remote working in response to the pandemic; all of which introduce a changed risk profile to organisations.

These new standards and their associated controls were included in the new edition of the SPSCRF.

Based on the revised standards, the NHS Fife baseline score was 77%.

While every effort is made to influence and manage the risk in an effective manner, external influences play a key role in the underlying risk level that NHS Fife is exposed to. An example of this is the geopolitical landscape. The National Cyber Security Centre (NCSC) operated by GCHQ, continues to keep organisations on high alert following the conflict within Ukraine and the levels of cyber activity observed and in the main defended.

Another example of external influences is within the NHS supply chain. In recent years we have seen several external suppliers being impacted by successful cyber-attacks, which by their nature, increase the threat to NHS Boards. This example can also be extended to NSS, who is a key supplier and contractor of services used by the NHS and so have additional responsibilities in ensuring compliance, on our behalf, for systems and services procured and operated.

This overarching risk, reported via the Corporate Risk Register, is linked and supported by 4 linked risks aligned to the main objectives of NISD, Manage, Protect, Detect and Respond and Recover.

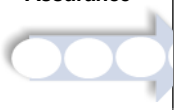
In this dynamic situation and recognising the influence of the external factors, there will be continual assessment on the ability to reach the target score for this risk. This is also influenced by the level of compliance requirements and controls continuing to increase, and the availability of funding to resource or procure technologies or services to meet the new levels.

2.3 Assessment

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

Deep Dive Review

Corporate Risk Title	**Digital & Information** Cyber Resilience Risk
Strategic Priority	

Risk Appetite	**Moderate**			
Level of Risk Assurance	**Substantial Assurance** 	**Reasonable Assurance** 	**Limited Assurance** 	**No Assurance** 
Confirm Assurance Level (Add a Yes)		**Yes**		
Risk Description	There is a risk that 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.			
Root Cause (s)	The scale and complexity of our digital infrastructure and number of users makes us more susceptible to different types of cyber-attacks via multiple routes, increasing the risk of a successful intrusion. The number of legacy systems operated, that are considered critical to supporting services, continues to present vulnerability to attack and exploitation. Health organisations have experienced successful attacks within the last 3 years. Attacks on the Scottish Environment Protection Agency (SEPA), HSE Ireland and other public agencies suggest the sustained targeting of public sector organisations by cyber criminals. The current geopolitical landscape is resulting in increased cyber activity and so increases the risk associated with successful cyber-attacks. Increased levels of activity have been reported by the National Cyber Security Centre (NCSC). It is challenging to recruit and retain cyber and security specialists within the public sector to allow progress against additional and more challenging Network and Information Systems (NIS) Directive (NISD) controls and be responsive to emerging threats. The cyber team experiences significant turnover given the competitive nature of the Cyber and Security market. With large differences in pay and terms and conditions between the public and private sector and a limited pool of talent, the ability to retain resource is limited. Progress against NISD is inconsistent.			
Current Risk Rating ([LxC] & Level (e.g. High Moderate, Low)	**Likelihood -** **4 - Likely**	**Consequence -** **4 - Major**	**Level** **High - 16**	
Target Risk Rating([LxC] & Level (e.g. High, Moderate, Low)	**Likelihood -** **4 - Likely**	**Consequence -** **3 - Moderate**	**Level** **Moderate - 12** **Target Date: September 2024**	

Management Actions

Action	Status	Impact on Likelihood/ Consequence
Undertake the NIS Audit in 2023 and on the provision of the report analysis and develop and Cyber Resilience Framework action plan. Complete	Completed	**No impact**
Progress the Cyber Resilience Framework action plan providing regular updates to the Information Governance and Security Steering Group Target completion – July 2024 (Prior to next audit)	On track	**Reduce Consequence**

Action	Status	Impact on Likelihood/ Consequence
Progress specific risk mitigation activity relating to **Manage** Introduction of Architecture Review Board for legislative and technical assessment of all new and existing technologies introduced and operated by NHS Fife. Work with National Services Scotland (NSS) to develop improved visibility and evidence of their own and their supplier's compliance with the Cyber Resilience Framework. Work with NSS to create a HEAT map of the current national system and supplier landscape. Create a policy Target completion – July 2024 (Prior to next audit)	Significant level of delivery challenge	**Reduced Likelihood**
Progress specific risk mitigation activity relating to **Protect** Conduct and implement action plan from Penetration Test Plan. Continued revision and update to policies and procedures associated with staff awareness and behaviour. Continue to review and enhance technical and access controls where finance allows. Target completion – July 2024 (Prior to next audit)	On track	**Reduced Likelihood**
Progress specific risk mitigation activity relating to **Detect** Conduct and implement action plan from "Red Team" exercise, which simulated a logical and physical cyber-attack. Proactive security event discovery, detecting anomalous events in relevant network and information systems or reports from staff. Development of plans to respond to events and remediate issues in a timely manner. (Average 25 per month) Work with NSS to help improve the services offered by the National Cyber Centre of Excellence. Target completion – July 2024 (Prior to next audit)	On track	**Reduced Likelihood**
Progress specific risk mitigation activity relating to **Respond and Recover** Continued development of Business Continuity and Disaster Recovery planning and exercising, to demonstrate and practice effective recover options. Conduct a market assessment for specialist skills associated with Respond and Recover, following lessons learnt from another NHS Board. Conduct and implement action plan from "Red Team" exercise, which simulated a logical and physical cyber-attack.	Significant level of delivery challenge	**Reduced Likelihood**

Target completion – July 2024 (Prior to next audit)		
Progress specific risk mitigation activity relating to the operation of **legacy technologies**. A more robust approach to the replacement and decommission of legacy technology and infrastructure is in development and will be considered. Target completion – July 2024 (Prior to next audit)	On track	**Reduced Likelihood**
Revised communication plan to help inform and educate staff on the role they play in preventing and identifying cyber-attacks. Target completion – July 2024	Not started	**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 and Value-Based Health & Care

The impact to clinical activities, if the victim of a successful cyber-attack, would be significant through the unavailability of key clinical systems. These systems would be unavailable for lengthy periods of time and the quality of care would be reliant on the robustness of services' resilience plans.

2.3.2 Workforce

We continue to balance the requirement for additional controls and policies, with the staff requirement to conduct their roles effectively. The highest risk of vulnerability remains staff members being subjected to and falling foul of phishing attacks and cyber criminals remain skilled and able in ensuring social engineering allows for the best opportunity to identify and exploit a vulnerability. We continue to support our staff members through impacting and regular communications that are also responsive to emerging threats.

2.3.3 Financial

The scale of compliance required through the SPSCRF continues to grow and results in a challenge to being able to resource and procure the technologies and services to be able to demonstrate compliance. Where possible, national investment or collaborative working opportunities with other NHS Boards are sought to limit the impact of the current financial situation.

2.3.4 Risk Assessment / Management

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

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

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

An Equality Impact Assessment is not conducted over the Cyber Resilience risk, but is undertaken for any technology introduced in this area.

2.3.6 Climate Emergency & Sustainability Impact

Consideration of the Scottish Public Sector Green ICT Strategy forms part of the approach to Cyber Resilience.

2.3.7 Communication, involvement, engagement and consultation

- The Information Governance and Security Steering Group is consistently updated on the issues identified in this report.
- The Digital and Information Board is consistently updated on the issues identified in this report.

2.3.8 Route to the Meeting

This paper is presented directly to Clinical Governance Committee.

2.4 Recommendation

This paper is provided to members for:

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

3 List of appendices

None.

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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

ASSURANCE SUMMARY
NHS FIFE CLINICAL GOVERNANCE OVERSIGHT GROUP
24th OCTOBER 2023

1. Purpose

1.1 To provide the NHS Fife Clinical Governance Committee with an assurance summary from the Clinical Governance Oversight Group (CGOG) held on the 24th October 2023. This assurance statement summarises the key aspects of business covered.

2. Governance

2.1 Deteriorating Patient

The following was highlighted:

- The Welch Allyn test phase funding is in place, and this will allow testing in Wards 43, 44 and Admissions Unit 1 (AU1).
- Following the workshop in August, a wide range of potential ways to support improvement has been identified. These are being reviewed and the Deteriorating Patient Group will consider how to best progress these.
- Work has started with the AU1 team to explore what can be done to support them with the improvement work. A range of proposals for tests of change have been identified.
- The Resuscitation Team are now delivering Know the Score education as an online webinar. In addition, the Advanced Nurse Practitioner is delivering 'pop up' face to face teaching sessions across the wards. Feedback is very positive with particularly good engagement at the pop-up sessions.
- Know the Score boxes (containing a range of materials to make it easier to implement) are being distributed to wards.
- Planning for further engagement specifically around the community inpatient areas is being explored.

The following were noted by the group:

- August highlight report for Deteriorating Patient
- September highlight report for Deteriorating Patient
- NHS Fife Deteriorating Patient Flash Report Workshop 23 August 2023

2.2 Independent Review of Audiology Services in NHS Scotland

A review of the paediatric audiology services was commissioned after there had been adverse outcomes in the NHS Lothian Paediatric Audiology Service documented through the complaint process. The review details a number of areas for improvement which prompted NHS Fife to develop a local action plan. Subsequently, an Independent National Audiology Review has delivered 55 recommendations to the Scottish Government to improve the quality of Audiology services and provide the

structure, governance and leadership required to bring sustained improvement to services.

The overarching aims across the findings and recommendations are:

- To reduce variation and ensure the delivery of safe, high-quality, patient-centred care across Scotland, with clear accountability.
- To build a sustainable pipeline of talent and ensure that patients are cared for by professionals with the right knowledge and specialist skills, within services with effective, skilled leadership.
- To ensure a culture of continuous improvement of quality and outcomes of care across the patient journey, with external assurance of patient safety, clinical effectiveness and patient experience.
- To ensure that national structures are in place to provide strategic oversight and assurance of audiology services.

As NHS Fife had pre-empted this report, they have already undertaken work to up-skill their audiology workforce to ensure there is now a more robust team.

A response from Scottish Government (SG) is awaited from the review. This will shape how implementation and governance of these recommendations takes place. NHS Fife will endeavour to engage with any 'task force' compiled to support implementation of the recommendations. The recommendations are weighted towards the SG taking ownership for audiology services within which there are significant resource implications.

It is known that accommodation within Victoria Hospital for audiology services is a significant risk. This is something which any inspection or deep dive would highlight. Investigation work is currently being undertaken by the Estates department and it is hoped that the response from SG to the audiology review could be an opportunity to highlight this further.

The work currently being undertaken in Victoria Hospital phase one with regards to the ENT department may provide accommodation for audiology services. Accommodation within Queen Margaret Hospital for paediatric audiology services and St Andrews Community Hospital are currently compliant.

2.3 Hospital Standard Mortality Report

This was report was noted and assurance taken.

2.4 NHS Fife Clinical Governance Strategic Framework Delivery Plan 2023/24 Mid-Year Review

The update demonstrated how well many areas of work were progressing. Currently NHS Fife are in a very good position to give assurance around our clinical governance activity following questions at a national level as there is the published framework and workplan which can evidence our governance processes.

2.5 NHS Fife Clinical Policy & Procedure Update

There is a 98% compliance rate for all clinical policies and procedures for NHS Fife.

There were two new procedures approved at the NHS Fife Clinical Policy & Procedure Co-ordination & Authorisation Group:

- Fife Wide Procedure for Nova StatStrip Xpress2 Professional Blood Glucose Meter Point of Care Testing (Poct)
- FWP-FNP-01 - NHS Fife Wide Procedure for Fit Note Provision by Advanced and Specialist Nurses

There are currently two Fife wide procedures past their review date:

- FWP-HIV-01 - NHS Fife Wide Procedure for Human Immunodeficiency Virus (HIV) Testing Procedure (01/08/2023)
- RB-01 - NHS Fife Policy on Caring for Patients who refuse blood including Jehovah's Witness (19/07/2023)

2.6 NHS Fife Activity Tracker

An update was given of:

- One new Annual Report - Health Improvement Scotland Annual Delivery Plan issued 25 September 2023
- One new standard issued - Bowel Screening Standards published 31st August 2023

2.7 NHS Fife Corporate Risk Register

It has been agreed the Clinical Governance Oversight Group (CGOG) was the appropriate place to take the Clinical Risks prior to being updated for CGC to decide whether there were any additional risk mitigations which could alter the risk rating.

A summary was given of the corporate risks which aligned to Clinical Governance Committee and their status.

Since the last report to this Group on 22 August 2023:

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

Further to the reduction in the rating of the Covid-19 Risk, the Public Health Assurance Committee will review the risk at its meeting in October 2023. Based on that assessment, a recommendation will be taken through EDG and the appropriate governance routes to retain or close as a corporate risk. An update will be provided to the CGC on 12 January 2024.

A development session took place in October around the Optimal Clinical Outcomes Risk to provide further information and assurance.

After the deep dive completed in July for the risk around Quality and Safety, there was a view that this risk should be rescored however due to events in the “wider healthcare” a decision was taken that this would remain unchanged for now.

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

This was report was noted and assurance taken.

2.9 NHS Fife Health & Social Care Partnership Inspection Update

The appendices were shared to provide an update on the external inspection processes in place within Fife Health and Social Care Partnership. A draft SOP along with flowcharts have been developed to support a standardised approach for external inspections from initial notification to completion of actions. Within the workplan there was guidance to ensure that there was compliance around the papers being reported to the correct places at the correct times.

It was suggested that within the flowchart the process for feedback/reports after CGOG should be highlighted as this would be expected by the Internal Audit Team.

2.10 NHS Fife Acute Services Healthcare Improvement Scotland Inspection

An update was provided from the unannounced inspection to Victoria Hospital on Monday 31 July to Wednesday 2 August 2023. During the inspection, Healthcare Improvement Scotland:

- inspected the ward and hospital environment.
- observed staff practice and interactions with patients, such as during patient mealtimes.
- spoke with patients, visitors and ward staff (where appropriate).
- accessed patients' health records, monitoring reports, policies and procedures.

The action plan will be published on 26th October 2023.

3. Adverse Events & Duty of Candour Update

3.1 NHS Fife Adverse Events

A meeting took place to discuss overdue actions and consideration given to those that were no longer relevant and therefore could be closed off. A plan was made on how to progress the open actions. It was agreed that a report on overdue actions will be sent out to the services to give them an overview of their open actions, advise on management of these and provide guidance to support closure.

The Themes and Trends Report identified a significant increase in the incidences (21 reported) for unavailability of Urgent Care Mental Health Assessment Team (UCAT). It was queried how the group would receive an update from the mental health team. This would be discussed at the December meeting. A meeting would be organised with HSCP regarding escalation and be brought back to this group.

A staff support pathway has been developed by a SLWG, led by the Adverse Events Lead and included representation from Spiritual Care, Psychology and Peer Support. The pathway has been presented to, and approved at the Staff Health and Wellbeing Group and is now ready to move into the second phase.

There have been 3 areas identified to pilot the support pathway, ED, AU1 and labour areas. The pilot will commence on 1st November and will run for 3 months. There will

be an evaluation at the end of the pilot. Sessions will be held for senior staff/managers who have utilised the pathway and staff who have received support to feedback on their experience. The questionnaire that initiated this project, where staff identified a lack of structured support following an adverse event and an uncertainty about the support services that were available, will be repeated to allow a measure of improvement.

Training for senior staff/managers on how to implement and use the pathway is underway with a further 2 sessions planned. Further information including the pathway and supporting documents have been added to BLINK.

3.2 Duty of Candour Process

Feedback was sought on the Duty of Candour Process.

4. Patient Experience

4.1 Patient Experience Flashcard

The patient experience team were still working with other services in order to streamline processes. It was reported that there was an increase in complaints of 15% from last year which was made challenging due to staffing pressures. However, there was an improvement in compliance from last year's figures.

The draft version of the dashboard is now ready for group members to look at and provide feedback on any additional data they would like to see.

It was pointed out that these figures appeared to show HSCP as less compliant than Acute services. This will be investigated further.

5. Linked Meeting Minutes

There were no escalations from the linked meeting minutes.

6. NHS Fife Clinical Governance Oversight Group Terms of Reference

Noted by the group.

7. NHS Fife Clinical Governance Oversight Group Workplan 2023 – 2024

Nothing to highlight from the workplan.

8. AOCB

8.1 CMO (2023) 17 – Anticipatory Care Planning and Future Care Planning

Noted by the group and comments and feedback requested.

8.2 Unconfirmed dates for future CGOG meetings 2024-2025

Noted by the group.

Appendix 1 – Attendance

Member	Designation	24th October 2023
Lynn Barker	Associate Director of Nursing, Health Social Care Partnership	✓
Norma Beveridge	Interim Associate Director of Nursing, Acute	✓
Dr Sue Blair	Consultant in Occupational Medicine	x
Andy Brown	Principal Auditor - Finance	x
Gemma Couser	Associate Director of Quality & Clinical Governance	x
Pauline Cumming	Risk Manager	✓
Fiona Forrest	Deputy Director of Pharmacy & Medicines	✓
Claire Fulton	Adverse Events Lead	✓
Cathy Gilvear	Quality, Clinical & Care Governance Lead, HSCP	✓
Ben Hannan	Director of Pharmacy and Medicines	x
Dr Helen Hellewell	Associate Medical Director, HSCP	x
Janette Keenan	Director of Nursing	✓
Aileen Lawrie	Associate Director of Midwifery	x
Dr Sally McCormack	Associate Medical Director for Emergency Care & Planned Care	x
Dr Chris McKenna (Chair)	Medical Director, NHS Fife	✓
Dr Iain MacLeod	Deputy Medical Director, Acute	✓
Siobhan McIlroy	Head of Patient Experience	✓
John Morrice	Associate Medical Director for Women and Children's Services	✓
Elizabeth Muir	NHS Fife Clinical Effectiveness Manager	✓
Sally O'Brien	Head of Nursing	x
Victoria Robb	Lead Pharmacist, Medicines Safety	✓
Nicola Robertson	Assistant Director of Nursing, Corporate Division	✓
Shirley-Anne Savage	Associate Director of Quality & Clinical Governance	✓
Geraldine Smith	Lead Pharmacist, Medicines Governance & Education Training	x
Prof Morwenna Wood	Associate Medical Director for Emergency and Planned Care	x
Amanda Wong	Associate Director of Allied Health Professionals	✓
In Attendance	**Designation**	
Claire Berry	Quality improvement Project Manager	✓
David Comiskey	Head of Audiology Services	✓
Nicola Maher	Programme Manager – Digital and Information	✓
April Robertson	Clinical Governance Administrator (Minute Taker)	✓
Dr Gavin Simpson	Consultant Anaesthetics	✓

ASSURANCE SUMMARY
NHS FIFE CLINICAL GOVERNANCE OVERSIGHT GROUP
12th DECEMBER 2023

1. Purpose

1.1 To provide the NHS Fife Clinical Governance Committee with an assurance summary from the Clinical Governance Oversight Group (CGOG) held on the 12th December 2023. This assurance statement summarises the key aspects of business covered.

2. Matters Arising

2.1 Escalation of increased incidences reported for unavailability of Urgent Care Mental Health Assessment Team (UCAT)

The group were informed that there was an overall plan which the Head of Complex & Clinical Care Services H&SCP and her team were leading on. It was reported that:

- Absences from work have reduced and the vacancies have reduced by around half with further staff being recruited.
- There is a short life working group which meets fortnightly with clinical and service management representation looking at those who attend UCAT frequently.
- There are complex case reviews of these clients, ensuring there is a robust safety plan.
- There is good engagement between Acute Services and H&SCP on the long-term plan for UCAT.

This information will be presented at the next meeting in the form of an SBAR.

2.2 Patient Experience - Compliance from H&SCP

To improve compliance, the Head of Patient Experience has been having weekly meetings with the Community Care Directorate and with the Senior Manager, H&SCP, Child / Adult Mental Health & Addiction as well as meetings with the Heads of Service. She also presents a report to the Quality Matters Assurance Group (QMAG).

It was agreed that it is good practice to ensure there is clinical input when responding to complaints as this allows ownership, lessons to be learned and any further actions to be taken. The Deputy Medical Director for H&SC felt the ideal response was a joint one between Service Managers and clinicians showing who was taking ownership of each part, giving a flowing response instead of separate statements. The ultimate goal was to give a response that showed that we as an organisation were taking ownership.

It was noted that there are some complaints which are incredibly complex and have multiple aspects to the patient's experience. The Group were reminded by the that a complexity scoring for complaints has been developed (negligible, minor, moderate, major or extreme). Using this scoring system, it is hoped that where the complaint is deemed to be negligible, minor or even moderate, that these can be quickly dealt with. Where a complaint is more complex, this would enable the Patient Experience

team to inform complainants that it may take significantly longer to conclude the response.

2.3 CMO (2023) 17 - Anticipatory Care Planning and Future Care Planning

The Group were invited to give their response to this CMO letter.

A blanket change on the use of terminology from “anticipatory care planning” to “future care planning” could cause confusion on the use of the current tools. Communication around any change would be key and the change should gradually evolve and be staged.

3. NHS Fife Corporate Risks

3.1 Update on Corporate Risks Aligned to the NHS Fife Clinical Governance Committee

Since the last report to this Group on 19 October 2023, there have been no changes to the risk profile.

- Six risks continue to be aligned to the CGC.
- The risk level breakdown is unchanged - 4 High and 2 Moderate.

Risk 3 - COVID 19
Proposed de- escalation as a corporate risk. The CGC supports closing the risk and moving to develop one that addresses the wider biohazard threat. The Public Health Assurance Committee (PHAC) will review the risk on 6 December 2023. Thereafter, a recommendation will be made to EDG and then CGC on 12 January 2024, to retain or close as a corporate risk.

Risk 4 - Optimal Clinical Outcomes
Following a deep dive review in May 2023 and a focused CGC Development Session on 23 October 2023, an update on the risk will be provided to the CGC following feedback from the session.

Risk 9 - Quality and Safety
The risk level will remain high pending the outcome of the review of the governance arrangements associated with quality and safety data commissioned by the Chief Executive. The CGC accepted this position on 3 November 2023.

Risk 16 - Off-Site Area Sterilisation and Disinfection Unit Service
Following the deep dive review presented to the CGC in September 2023, the risk was escalated to the September Board. It was agreed to consider the risk at a future Board Development Session on the prioritisation of capital resources more generally. The CGC had asked that the risk scoring be reviewed. The NHS Fife Decontamination Group reviewed on 10 November 2023. After examining the risk, it was agreed to maintain the current risk score.

Risk 17- Cyber Resilience
Given improved performance in this year’s Network and Information Systems (NIS) audit, the potential to reduce this risk’s rating will be considered.

Risk 18 - Digital & Information
The Associate Director of Digital & Information presented a deep dive on this risk to the CGC on 3 November 2023. This set out the activities associated with the creation

of a future Digital Strategy, and alignment to current strategic ambitions and programmes. The creation of a future strategy allows for specific consideration of the financial plan required to underpin the outcomes required by NHS Fife.

Potential Corporate Risk:

Future Biological Threats including Pandemics - risk in development
It is anticipated the Director of Public Health will present a draft risk and an initial deep dive review, to the PHAC on 6 December 2023, EDG thereafter, and CGC on 12 January 2024.If agreed it poses a corporate risk, it will be proposed for Board approval in January 2024.

Deep Dive Reviews
Five of the six corporate risks aligned to the CGC have now undergone at least one deep dive. Based on our experience and learning over the last year and following discussion at the Audit and Risk Committee Development Session on 12 October 2023, the Risks and Opportunities Group (ROG) made recommendations to EDG on 2 November 2023 on the role of the 'deep dive' and triggers for reviews during the life-cycle of a corporate risk. Following EDG approval, these will be submitted to the Audit and Risk Committee (ARC) to endorse on 13 December 2023.

3.2 Risk Presentation

The Board approved the updated Risk Management Framework (RMF) in September 2023. The intention was to update the related Risk Register / Risk Assessment Policy. In re-drafting the policy, there was considerable duplication with the RMF. Following consultation with Internal Audit (IA) and the ROG, it has been determined that a separate policy is not required if the content is covered in the RMF. The approach now being taken forward is:

- Proposal to ARC on 13/12/23 to endorse an approach to:
- Expand Framework to capture essential policy content; subject to refinement and iteration
- Prioritise training and development of learning resources; align with existing materials
- Develop delivery plan and training programme being developed to enable and support individuals, departments, services, directorates and management & leadership teams to:
- Review and manage risks in a consistent and time effective manner

PC summarised the status of the overall corporate risk profile, provided an update on the ROG key areas for focus and the areas for future focus. A copy of the presentation was provided to the members.

4. Adverse Events & Duty of Candour Update

4.1 NHS Fife Adverse Events

The Themes and Trends Report was shared with the Group. In October a total of 66 incidents were reported with outcome severity recorded as major or extreme. This is the highest monthly total recorded over the last 24 months and an increase of 20 events in direct comparison to October 2022. The major / extreme events represent 3% of the total number of events reported in October.

Tissue Viability (TV) events are consistenty the highest reported category of events coded as major harm. On average 12.6 TV incidents are reported as major / extreme per month. With October having a record high of 23 incidents. TV events make up 43% (140) of the total number of SAERs / LAERs that have been commissioned in 2023 to date.

Reviews of Major Adverse Events; 235 LAERS and 49 SAERs

Overdue in Acute Services Division
SAERs 23 of 40 open
LAERs 45 of 80 open

Overdue in Helath & Social Care Partnership
SAERs 7 of 12 open
LAERs 69 of 116 open

In the last 12 months the average closure time for a LAER is 240 days and a SAER is 313 days. The national target for both of these categories is 90 days.

Next steps

- Consider National Framework for Learning from Adverse Events and define local trigger list for reporting of adverse events by categories – workshops early 2024.
- Review current types of reviews for commonly reported major events and explore the possibility to manage differently going forward – workshops early 2024.

Tthe consequence ratings were shared and it was explained that these would be discussed at the workshops to ensure staff understood how to grade appropriately. A trigger list was also shared which is still a work in progress. These will be explored further within the workshops looking at each speciality area to agree the local direction for these types of events.

The Medical Director thought it would be advantageous for other ways of managing LAERs to be considered, explaining that they can appear as a ‘second rate’ review to relatives. It was felt that sometimes comments or complaints from the family lead to something being comissioned which may be unnecessary. This would be in line with some other boards who only carry out SAERs and no LAERs (or equivalent). It would be good if a decision could be made backed up by a matrix on how we manage events that do not meet the national definition for a SAER.

A meeting with key stakeholders from CGOG would be organised in the New Year to rationalise the matrix of decision making commisioning SAERs. The group should also consider if there is a simplified approach that can be taken to allow for a prompt response and indentify whether there is a need for escalation of the adverse event.

5. Patient Experience

5.1 Patient Experience Flashcard

- The total number of stage 2 complaints open is currently 82.
- For the last 2 years these have never been below 145.

- The creation of the dashboard has allowed the officers to focus on clearing the backlog of complaints.
- Using the dashboard, complaints can be filtered by Acute, H&SCP and directorate level as well as demonstrating where the complaints are in the process e.g. awaiting statements, sign off, drafting etc.
- It also shows the detail of each complaint and has transformed the way the patient experience teamwork.

The huge amount of work was acknowledged. The dashboard has been immensely helpful in looking at the data and Digital & Information (D&I) have been asked to produce something similar for adverse events.

6. Governance

6.1 Mortality in Nosocomial COVID-19 Cases

This report had been commissioned over a year ago and has been in progress for this time. It has been a difficult report to write as it had to be very clear and transparent to the board and ensure that it comprehensively described the learning that has occurred as a result of the pandemic.

The report goes into the detail in relation to the numbers of patients who died after acquiring Covid in hospital. The group were asked to take time to fully read the report and provide feedback. This is primarily an infection prevention report which relates to our response to outbreaks, the cohorting of patients and our compliance with the guidance available at the time. It also outlines the challenges experienced and the learning taken should this kind of situation ever be faced again in the future. It is important for this information to be shared.

There is a comprehensive section within the appendix around the lessons learned which the group were encouraged to comment on.

6.2 NHS Fife Health & Social Care Partnership Clinical Governance Assurance Update SBAR

6.3 NHS Fife H&SCP Integrated Joint Board 10, Risk Register

This report relates to Fife HSCP Quality Matters Assurance Group Clinical Quality (QMAG) meeting on 6th October and an overview of the 3 Quality Matters Assurance Safety Huddles (QMASH) held between 11th August and 6th October.

The QMASH meetings are held every two weeks and is chaired by the Director of Nursing. The aim is to look at the live data, themes and trends, to ask questions and try to get ahead of matters arising instead of waiting for any issues to appear in other data sources.

It was agreed that future Inspections would be part of this assurance statement instead of a separate item on the agenda. This was noted to be acceptable to internal audit.

It was explained the provision of the Risk Register was at the request of Internal Controls Evaluation (ICE) with regard to adult and child protection. Further information will be provided at the next CGOG (February) meeting.

There was an expectation that Acute Services provided a similar assurance update to this group.

6.4 Fife Health & Social Care Partnership Clinical Governance Inspection Update SBAR

Comments from the Mental Welfare Commission (MWC) around Ward 1, Queen Margaret Hospital, Dunfermline were very positive with no further recommendations this year. Areas commended by MWC included leadership, MDT Recording, Multidisciplinary Working, Equipment, impact of Activity co-ordinators and ward environment.

The inspectors commented regarding the environmental improvements within the ward and explained that on entering the ward it feels calm, organised and recognised the effort that has been put into changing the ward environment over this short time. They also thought the leadership team were motivated, energetic and determined.

Cairnie Ward, Stratheden Hospital, **Cupar** had also received favourable feedback. The MWC were complimentary regarding the care provided and shared the positive feedback they had received from patients and relatives.

Recommendations will again focus on the environment. The inspectors referenced Ward 1 and the changes made there and acknowledged that financial investment that would be required.

The following reports were noted by the group:

- Mental Welfare Commission for Scotland, draft report on unannounced visit to Radernie Unit, Stratheden Hospital 15th May 2023
- Mental Welfare Commission for Scotland, draft report on announced visit to Elmview and Muirview Wards, Stratheden Hospital 20 July 2023
- Mental Welfare Commission for Scotland, draft report on announced visit to Hollyview Ward, IPCU, Stratheden Hospital, 27th July 2023
- Mental Welfare Commission for Scotland, report on announced visit to Lomond Ward, Stratheden Hospital 2nd March 2023

6.5 Deteriorating Patient November Highlight Report

There was a visit from Professor Jason Leitch (Scottish Government's National Clinical Director) where the combined work of the Deteriorating Patient within the Acute and H&SCP was presented.

The work / learning of the Deteriorating Patient was also presented at the Organisational Learning Group (OLG).

The cascade training of the deteriorating patient work had not reached its full potential. Secondment posts out to advert to help support this.

6.6 NHS Fife Clinical Policy & Procedure Update

One new procedure was approved at the October meeting of the NHS Fife Clinical Policy & Procedure Co-ordination & Authorisation Group:

- FWP-PBIARD-01 – NHS Fife Pre-Birth Inter-Agency Referral Discussion

It was reported that there are **five** Fife wide procedures past their review date:

- FWP-AHPNMSPP-01 - NHS Fife Wide Procedure for the Management of Nursing, Midwifery and Allied Health Professional Students within the Practice Learning Environment (01/10/2023)
- FWP-ARTHROP-01 - NHS Fife Wide Procedure Management of Patients with BMI>40 being considered for Lower Limb Arthroplasty (primary and revision surgery) (16/10/2023)
- RB-01 - NHS Fife Policy on Caring for Patients who refuse blood including Jehovah's Witness (19/07/2023)
- FWP-HP-01 - NHS Fife Wide Adult In-patient Hydration Procedure (08/10/2023)
- FWP-BBMHB-01 Fife Wide Procedure for Babies Born to Mothers with Hepatitis B Infection and/or Babies Born into a household where a member (other than the mother) is known to be infected with Hepatitis B (01/04/2023)

These procedures are on the agenda for NHS Fife Clinical Policy & Procedure Co-ordination & Authorisation Group, Monday 18th December 2023 for discussion.

The group were given assurance that they have a 95% compliance rate for all clinical policies and procedures for NHS Fife

6.7 NHS Fife Activity Tracker

One new Inspection Report:
- Victoria Hospital - safe delivery of care inspection report: October 2023

One new Annual Report:
- Death Certification Review Service Annual Report 2022-2023 issued 10 October 2023

New standards issued:
- Bowel Screening Standards issued 31 August 2023
- Healthcare Improvement Scotland Annual Delivery Plan issued 25 September 2023
- Core Screening Standards issued 28 September 2023
- Congenital heart disease (CHD) standards issued 29 November 2023

7. Linked Meeting Minutes

There were no escalations from the linked meeting minutes.

8. AOCB

8.1 Confirmed dates for future CGOG meetings 2024-2025

Noted by the group.

Appendix 1 – Attendance

Member	Designation	12th December 2023
Lynn Barker	Associate Director of Nursing, Health Social Care Partnership	✓
Norma Beveridge	Interim Associate Director of Nursing, Acute	✓
Dr Sue Blair	Consultant in Occupational Medicine	x
Andy Brown	Principal Auditor - Finance	x
Gemma Couser	Associate Director of Quality & Clinical Governance	x
Pauline Cumming	Risk Manager	✓
Fiona Forrest	Deputy Director of Pharmacy & Medicines	x
Claire Fulton	Adverse Events Lead	✓
Cathy Gilvear	Quality, Clinical & Care Governance Lead, HSCP	✓
Robyn Gunn	Head of Laboratory Services	✓
Ben Hannan	Director of Pharmacy and Medicines	x
Dr Helen Hellewell	Associate Medical Director, HSCP	✓
Janette Keenan	Director of Nursing	✓
Aileen Lawrie	Associate Director of Midwifery	✓
Dr Sally McCormack	Associate Medical Director for Emergency Care & Planned Care	✓
Dr Chris McKenna (Chair)	Medical Director, NHS Fife	✓
Dr Iain MacLeod	Deputy Medical Director, Acute	✓
Siobhan McIlroy	Head of Patient Experience	x
John Morrice	Associate Medical Director for Women and Children's Services	x
Elizabeth Muir	NHS Fife Clinical Effectiveness Manager	✓
Sally O'Brien	Head of Nursing	x
Victoria Robb	Lead Pharmacist, Medicines Safety	x
Nicola Robertson	Assistant Director of Nursing, Corporate Division	✓
Shirley-Anne Savage	Associate Director of Quality & Clinical Governance	✓
Geraldine Smith	Lead Pharmacist, Medicines Governance & Education Training	x
Prof Morwenna Wood	Associate Medical Director for Emergency and Planned Care	x
Amanda Wong	Associate Director of Allied Health Professionals	x
In Attendance	**Designation**	
Lee Cowie	Senior Manager, H&SCP, Child/Adult Mental Health & Addiction Services	✓
Kate Gaunt	Deteriorating Patient & Resuscitation Lead	✓
April Robertson	Clinical Governance Administrator (Minute Taker)	✓

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**12 January 2024**
Title:	**Review of Draft Annual Workplan 2024/25**
Responsible Executive:	**Dr Chris McKenna, Medical Director**
Report Author:	**Shirley-Anne Savage, Associate Director of Quality and Clinical Governance**

1 Purpose

This is presented for:

- Decision

This report relates to a:

- Annual Operational Plan

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This paper sets out the proposed Clinical Governance Committee (CGC) workplan for 2024/25 and summarises the approach adopted to ensure there is a regular review of the workplan to enable the CGC to fulfil its remit.

2.2 Background

The CGC is a Standing Committee of the Board. In order to provide effective scrutiny, assurance and escalation of key issues the CGC adheres to the Committee Assurance Principles. To support the effective delivery of the Committee an annual workplan is developed to ensure clarity of priorities and focused agendas.

2.3 Assessment

The 2024/25 proposed CGC workplan is attached in appendix 1 for consideration of the Committee. Updates to the workplan reflect the additional Annual Assurance Statements from Subcommittees. Please note, there are some dates still to be added in relation to Annual Reports and Linked Committee Minutes, and these have been highlighted.

Given the dynamic nature of our organisation the workplan is included as a standing agenda item at each Committee meeting. This regular review will ensure the workplan reflects new and emerging risks or areas of focus. To support this a tracker of the workplan is maintained to monitor the business of the Committee.

2.3.1 Quality/ Patient Care

The Clinical Governance Committee's responsibility is to oversee the delivery of Clinical Governance agenda and will seek to assure the Board and the public of Fife that appropriate systems of control are in place to continuously improve and safeguard the quality and safety of care. An effective workplan is required to ensure that this responsibility is delivered.

2.3.2 Workforce

N/A

2.3.3 Financial

N/A

2.3.4 Risk Assessment/Management

The workplan will be reviewed at each Committee meeting and updated to ensure that emerging risks or concerns are reflected in the workplan.

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

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

2.3.6 Climate Emergency & Sustainability Impact

N/A

2.3.7 Communication, involvement, engagement and consultation

N/A

2.3.8 Route to the Meeting

The proposed workplan for 2024/25 has been developed in collaboration with Directors.

2.4 Recommendation

The Clinical Governance Committee is recommended to:

- Consider and approve the proposed workplan for 2024/2025; and
- Approve the approach to ensure that the workplan remains current

3 List of appendices

The following appendices are included with this report:

- Appendix 1- Clinical Governance Committee Workplan 2024/25

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

DRAFT CLINICAL GOVERNANCE COMMITTEE
ANNUAL WORKPLAN 2024 / 2025

Governance - General							
	Lead	**03/05/24**	**08/07/24**	**06/09/24**	**04/11/24**	**06/01/25**	**07/03/25**
Minutes of Previous Meeting	**Chair**	✓	✓	✓	✓	✓	✓
Action list	**Chair**	✓	✓	✓	✓	✓	✓
Escalation of Issues to Fife NHS Board	**Chair**	✓	✓	✓	✓	✓	✓
Active or Emerging Issues							
	Lead	**03/05/24**	**08/07/24**	**06/09/24**	**04/11/24**	**06/01/25**	**07/03/25**
Governance Matters							
	Lead	**03/05/24**	**08/07/24**	**06/09/24**	**04/11/24**	**06/01/25**	**07/03/25**
Annual Assurance Statements from Subcommittees (D&I Board, H&S Subcommittee, IG&S Steering Group, IJB Q&C Committee, Resilience Forum, Medical Devices, CGOG, ICC)	**Board Secretary**	✓					
Annual Committee Assurance Statement (inc. best value report)	**Board Secretary**	✓					
Annual Internal Audit Report	**Director of Finance & Strategy**		✓				
Committee Self-Assessment Report	**Board Secretary**						✓
Corporate Calendar / Committee Dates	**Board Secretary**			✓			
Corporate Risks Aligned to CGC, and Deep Dives	**Medical Director/Director of Nursing**	✓	✓	✓	✓	✓	✓
Review of Terms of Reference	**Board Secretary**						✓ Approval
Review of Annual Workplan	**Associate Director of Quality & Clinical Governance**	✓	✓	✓	✓	✓	✓ Approval

Strategy / Planning							
	Lead	**03/05/24**	**08/07/24**	**06/09/24**	**04/11/24**	**06/01/25**	**07/03/25**
Advanced Practitioners Review Update	**Director of Nursing**			✓			
Annual Delivery Plan Quarterly Performance Report 2024/25 *(also goes to FP&R, PH&W & SGC)*	**Director of Finance & Strategy / Associate Director of Planning & Performance**	✓ **Q4**	✓ **Q1**		✓ **Q2**		✓ **Q3**
Cancer Strategic Framework & Delivery Plan	**Medical Director**				✓		
Clinical Governance & Strategic Framework Delivery Plan 2023/24	**Medical Director / Associate Director of Quality & Clinical Governance**		✓		✓ **Mid-year update**		
Corporate Objectives	**Director of Finance & Strategy / Associate Director of Planning & Performance**	✓					
Scottish Healthcare Associated Infection (HCAI) Strategy 2023-25	**Director of Nursing**			✓			
Quality / Performance							
	Lead	**03/05/24**	**08/07/24**	**06/09/24**	**04/11/24**	**06/01/25**	**07/03/25**
Integrated Performance and Quality Report	**Medical Director / Director of Nursing**	✓	✓	✓	✓	✓	✓
Healthcare Associated Infection Report (HAIRT)	**Director of Nursing**	✓	✓	✓	✓	✓	✓
Nursing & Midwifery Professional Assurance Framework	**Director of Nursing**			✓			
Public Protection, Accountability & Assurance Framework	**Director of Nursing**	✓					
Digital / Information							
	Lead	**03/05/24**	**08/07/24**	**06/09/24**	**04/11/24**	**06/01/25**	**07/03/25**
Digital and Information Strategy 2019-24 Update	**Medical Director / Associate Director of Digital & Information**		✓		✓		

Digital / Information (cont.)							
	Lead	**03/05/24**	**08/07/24**	**06/09/24**	**04/11/24**	**06/01/25**	**07/03/25**
Hospital Electronic Prescribing and Medicines Administration (HEPMA) Programme	**Medical Director**			✓			
Information Governance and Security Steering Group Update	**Associate Director of Digital & Information**			✓			✓
Person Centred Care / Participation / Engagement							
	Lead	**03/05/24**	**08/07/24**	**06/09/24**	**04/11/24**	**06/01/25**	**07/03/25**
Equalities Outcome Report *(also goes to PHWC)*	**Director of Nursing**						✓ **2025 report**
Patient Experience & Feedback	**Director of Nursing**	✓	✓	✓	✓	✓	✓
Annual Reports / Other Reports							
	Lead	**03/05/24**	**08/07/24**	**06/09/24**	**04/11/24**	**06/01/25**	**07/03/25**
Adult Support & Protection Annual Report 2020-22 *(also goes to PHWC)*	**Director of Nursing**		✓				
Allied Health Professional Assurance Framework [date]	**Director of Nursing**			✓ **Update**			
Annual Resilience Report 2023/24	**Director of Public Health**						✓
Care Opinion Annual Report 2023/24	**Director of Nursing**			✓			
Clinical Advisory Panel Annual Report 2023/24	**Medical Director**		✓				
Controlled Drug Accountable Officer Annual Report [date]	**Director of Pharmacy & Medicines**			✓			
Director of Public Health Annual Report 2024 *(also goes to PHWC)*	**Director of Public Health**			✓			
Fife Child Protection Annual Report 2023/24 *(also goes to PHWC)*	**Director of Nursing**		✓				
Hospital Standardised Mortality Ratio (HSMR) Update Report [date]	**Medical Director**				✓		

Annual Reports / Other Reports (cont.)							
	Lead	**03/05/24**	**08/07/24**	**06/09/24**	**04/11/24**	**06/01/25**	**07/03/25**
Medical Education Report [date]	**Medical Director**					✓	
Medical Appraisal and Revalidation Annual Report [date]	**Medical Director**				✓		
Occupational Health Annual Report 2023/24	**Director of Workforce**			✓			
Organisational Duty of Candour Annual Report [date]	**Medical Director**						✓
Participation & Engagement Report and Quality Framework for Participation & Engagement Self-Evaluation [date]	**Director of Nursing**					✓	
Prevention & Control of Infection Annual Report [date]	**Director of Nursing**				✓		
Radiation Protection Annual Report 2023/24	**Medical Director**	✓					
Research & Development Progress Report & Strategy Review [date]	**Medical Director**					✓	
Research, Innovation and Knowledge Annual Report [date]	**Medical Director**					✓	
Review of Deaths of Children & Young People [date]	**Director of Nursing**						✓
Linked Committee Minutes							
	Lead	**03/05/24**	**08/07/24**	**06/09/24**	**04/11/24**	**06/01/25**	**07/03/25**
Area Clinical Forum	**Chair of Forum**	04/04	06/06	01/08	03/10	05/12	06/02
Area Medical Committee	**Medical Director**	13/02	09/04	11/06	13/08	08/10	10/12
Area Radiation Protection Committee	**Medical Director**	TBC					
Cancer Governance & Strategy Group	**Medical Director**	21/03	30/05	-	15/08	-	31/10
Clinical Governance Oversight Group	**Medical Director**	TBC					
Digital & Information Board	**Medical Director**	-	23/04	23/07	-	15/10	-
Fife Area Drugs & Therapeutic Committee	**Medical Director**	07/02	17/04	19/06	21/08	23/10	18/12

Linked Committee Minutes (cont.)							
	Lead	**03/05/24**	**08/07/24**	**06/09/24**	**04/11/24**	**06/01/25**	**07/03/25**
Fife IJB Quality & Communities Committee	**Associate Medical Director**	08/03	10/05	05/07	04/09	08/11	10/01
Health & Safety Subcommittee	**Chair of Subcommittee**	08/03	07/06	-	06/09	06/12	-
Infection Control Committee	**Director of Nursing**	07/02	03/04	05/06	07/08	02/10	04/12
Ionising Radiation Medical Examination Regulations Board (IRMER)	**Medical Director**	Ad-hoc					
Information Governance & Security Steering Group	**Director of Finance & Strategy**	16/04	-	17/07	-	21/10	29/01
Medical Devices Group	**Medical Director**	13/05	12/06	-	11/09	11/12	-
Research, Innovation & Knowledge Oversight Group	**Medical Director**	TBC					
Resilience Forum	**Director of Public Health**	13/03	-	13/06	11/09	12/12	-
Ad-hoc Items							
	Lead	**03/05/24**	**08/07/24**	**06/09/24**	**04/11/24**	**06/01/25**	**07/03/25**
Matters Arising							
	Lead	**03/05/24**	**08/07/24**	**06/09/24**	**04/11/24**	**06/01/25**	**07/03/25**
Development Sessions							
	Lead						

CLINICAL GOVERNANCE COMMITTEE
ANNUAL WORKPLAN 2023 / 2024

Governance - General							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Minutes of Previous Meeting	**Chair**	✓	✓	✓	✓	✓	✓
Action list	**Chair**	✓	✓	✓	✓	✓	✓
Escalation of Issues to Fife NHS Board	**Chair**	✓	✓	✓	✓	✓	✓
Active or Emerging Issues							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Health Improvement Scotland (HIS) Inspection Update	**Director of Nursing**			✓			
Computerised Tomography (CT) Scanner Update and Next Steps	**Director of Acute Services**			✓			
Letter to Cabinet Secretary re. Countess of Chester Hospital Inquiry	**Medical Director**				✓		
Letter from Chief Medical Officer re. Report of the Transvaginal Mesh Case Record Review	**Medical Director**				✓		
Reinforced Autoclaved Aerated Concrete	**Director of Property & Asset Management**					✓	
Notification to Health & Safety Executive (HSE) of Work in Atmosphere Containing Radon	**Medical Director**					✓	
Governance Matters							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Annual Assurance Statements from Subcommittees (D&I Board, H&S Subcommittee, IG&S Steering Group, IJB Q&C Committee, Resilience Forum, Medical Devices)	**Board Secretary**	✓					

Governance Matters (cont.)							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
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**		✓		✓ **Summary from Aug '23 mtg**	✓ **Summary from Oct '23 & Dec' 23 mtgs**	**To be included in Ass. Statements in May 2024**
Committee Self-Assessment Report	**Board Secretary**						✓
Corporate Calendar / Committee Dates	**Board Secretary**			✓			
Corporate Risks Aligned to CGC, and Deep Dives	**Medical Director/Director of Nursing**	✓ **Optimal Clinical Outcomes**	✓ **Quality & Safety**	✓ **Off-Site Area Sterilisation and Disinfection Unit Service**	✓ **Digital & Information**	✓ **Covid-19 and Cyber Resilience**	✓
Review of Terms of Reference	**Board Secretary**						✓ Approval
Delivery of Annual Workplan 2023/24	**Associate Director of Quality & Clinical Governance**	✓	✓	✓	✓	✓	✓
Review of Annual Workplan 2024/25	**Associate Director of Quality & Clinical Governance**	✓	✓	✓	✓	✓ Draft	✓ Approval
Strategy / Planning							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Advanced Practitioners Review	**Director of Nursing**	✓					
Annual Delivery Plan Quarterly Performance Report 2023/24 *(also goes to FP&R, PH&W & SGC)*	**Director of Finance & Strategy / Associate Director of Planning & Performance**	**Deferred to July**	✓	✓	✓ **Q2**		✓ **Q3**
Cancer Strategic Framework & Delivery Plan	**Medical Director**				✓		

Strategy / Planning (cont.)							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Clinical Governance & Strategic Framework Delivery Plan 2023/24	**Medical Director / Associate Director of Quality & Clinical Governance**	**Deferred to July**	✓		✓ **Mid-year update**		
Corporate Objectives	**Director of Finance & Strategy / Associate Director of Planning & Performance**	✓					
Data Loch	**Medical Director**	**Removed from workplan - this item is being replaced, and once ready, will be brought back**					
Development Assistant Practitioner Role	**Director of Nursing**	✓					
Integrated Unscheduled Care	**Medical Director**	✓					
Quality / Performance							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Breast Screening Adverse Event Paper	**Director of Public Health**		**Removed – July PHWC only**				
Integrated Performance and Quality Report	**Medical Director / Director of Nursing**	✓	✓	✓	✓	✓	✓
Healthcare Associated Infection Report (HAIRT)	**Director of Nursing**	✓	✓	✓	✓	✓	✓
National Cervical Exclusion Audit	**Director of Public Health**		**Removed – covered at PHWC in May**				
Nursing & Midwifery Professional Assurance Framework	**Director of Nursing**	**2 yearly report – due September 2024**					
Hospital Acquired Covid Report	**Medical Director**					**Deferred to next mtg**	✓
Digital / Information							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Digital and Information Strategy 2019-24 Update	**Medical Director / Associate Director of Digital & Information**		✓		✓		
Laboratory Information Management System Update	**Associate Director of Digital & Information**			✓ **Private Session**			

Digital / Information (cont.)							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Hospital Electronic Prescribing and Medicines Administration (HEPMA) Programme	**Medical Director**			✓ **Private Session**			✓
Information Governance and Security Steering Group Update	**Associate Director of Digital & Information**			✓			✓
Person Centred Care / Participation / Engagement							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Equalities Outcome Report *(also goes to PHWC)*	**Director of Nursing**						✓
Patient Experience & Feedback	**Director of Nursing**	✓	✓	✓	✓	✓	✓
Annual Reports / Other Reports							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Adult Support & Protection Annual Report 2020-22 *(also goes to PHWC)*	**Director of Nursing**	✓					
Allied Health Professional Assurance Framework	**Director of Nursing**	**Deferred to July**	**Deferred to Sept.**	✓			
Annual Resilience Report 2022/23	**Director of Public Health**	**Partial Assurance Statement**			✓ **Mid-year Assurance Report**		✓ **Annual Report**
Clinical Advisory Panel Annual Report 2022/23	**Medical Director**		✓				
Controlled Drug Accountable Officer Annual Report August 2023	**Director of Pharmacy & Medicines**			✓			
Director of Public Health Annual Report 2023 *(also goes to PHWC)*	**Director of Public Health**		✓				
Equality Outcomes Progress Report 2021-25	**Director of Nursing**	**Presented in 2023, and will be next presented in 2025, along with the 2026-29 report**					

Annual Reports / Other Reports (cont.)							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Fife Child Protection Annual Report 2022/23 *(also goes to PHWC)*	**Director of Nursing**	**Deferred to July**	✓				
Hospital Standardised Mortality Ratio (HSMR) Update Report 2022/23	**Medical Director**				✓		
Integrated Screening Annual Report	**Director of Public Health**	**Will be presented to the Public Health & Wellbeing Committee only**					
Medical Education Report 2022/23	**Medical Director**				**Deferred to January**	**Deferred to March**	✓
Medical Appraisal and Revalidation Annual Report 2022/23	**Medical Director**				**Deferred to January**	✓	
Occupational Health Annual Report 2022/23	**Director of Workforce**			✓			
Organisational Duty of Candour Annual Report 2022/23	**Medical Director**						✓
Participation & Engagement Report and Quality Framework for Participation & Engagement Self-Evaluation 2022/23	**Director of Nursing**				**Deferred to January**	✓	
Prevention & Control of Infection Annual Report 2022/23	**Director of Nursing**				✓		
Radiation Protection Annual Report 2022/23	**Medical Director**	✓					
Research & Development Progress Report & Strategy Review 2023-25	**Medical Director**					✓	
Research, Innovation and Knowledge Annual Report 2022/23	**Medical Director**					✓	
Review of Deaths of Children & Young People Date to added	**Director of Nursing**						✓
Volunteering Annual Report 2022/23	**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

Linked Committee Minutes (cont.)							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Area Medical Committee	**Medical Director**	✓ 14/02	✓ ~~11/04~~ 02/05	✓ ~~13/06~~ 27/06	✓ 08/08	✓ 10/10	✓ 12/12
Area Radiation Protection Committee	**Medical Director**	✓ 31/08			✓ 10/05	✓ 14/11	TBC
Cancer Governance & Strategy Group	**Medical Director**	✓ 30/03	✓ 31/05		✓ 17/08	✓ 02/11	✓ 11/01
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		✓ 19/10	
Fife Area Drugs & Therapeutic Committee	**Medical Director**		✓ 26/04	✓ 21/06	✓ 16/08	21/10 **Mtg Cancelled**	✓ 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
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 **Mtg Cancelled**

Linked Committee Minutes (cont.)							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Research, Innovation & Knowledge Oversight Group	**Medical Director**	✓ 27/03		✓ 21/06	✓ 19/09	✓ 11/12	
Resilience Forum	**Director of Public Health**	✓ 01/03		✓ 08/06	07/10 **rescheduled to 10/10**	✓ 10/10	✓ 07/12
Ad Hoc Items							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Mental Health Estates Initial Agreement	**Medical Director**	**Deferred on 5 May, 7 July & 3 November, due to financial constraints. Initial Agreement is part of a larger business plan for mental health. Removed from workplan.**					
Medical Devices	**Director of Property & Asset Management**	✓					
Public Protection, Accountability & Assurance Framework	**Director of Nursing**	✓					
Fatal Accident Enquiry	**Medical Director**	✓	✓				
Excellence in Care Presentation	**Director of Nursing**		✓				
Infection Control Inspection by Health Improvement Scotland Report	**Director of Nursing**		✓				
Medical Devices Update	**Medical Director**			**Ad Hoc**			
Deteriorating Patient Cardiac Arrest Update	**Director of Nursing**			✓			
Incident Management Framework	**Director of Public Health**				✓		
Scottish Healthcare Associated Infection (HCAI) Strategy 2023-25	**Director of Nursing**			✓			
The Infection Prevention Workforce: Strategic Plan 2022-24	**Director of Nursing**			✓			
Care Opinion Report	**Director of Nursing**			✓			
High Risk Pain Medicines - Patient Safety Programme, End of Year 1 Report	**Director of Pharmacy & Medicines**			✓			
Medicines Safety Review and Improvement Report	**Director of Pharmacy & Medicines**				✓		

Ad Hoc Items (cont.)							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Alignment of NHS Fife Cancer Framework and the National Cancer Strategy 2023-2033 and Cancer Action Plan for Scotland 2023-2026	**Medical Director**				✓		
Medical Appraisal and Revalidation Framework	**Medical Director**					✓	
Internal Controls Evaluation Report 2022/23	**Director of Finance & Strategy**					✓	
Strategy Mid-Year Review	**Director of Finance & Strategy**					✓	
Patient Story	**Director of Nursing**					✓	
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**			**23/10/23**			

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**12 January 2024**
Title:	**Population Health and Wellbeing Strategy Mid-Year Report**
Responsible Executive:	**Margo McGurk, Deputy Chief Executive and Director of Finance & Strategy**
Report Author:	**Susan Fraser, Associate Director of Planning and Performance**

1 Purpose

This report is presented for:

- Assurance
- Decision

This report relates to:

- NHS Board Strategy or Direction

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

Following the publication of the NHS Fife Population Health and Wellbeing Strategy in March 2023, it was agreed that a mid-year report providing an update on the implementation of the strategy would be presented to the NHS Fife Board. The first Mid-Year report provides an update on progress on actions (April 2023-September 2023) and plans for the remainder of 2023-24 (October 2023-March 2024).

This SBAR also outlines the planned approach for the development of an annual report and an updated strategy delivery plan for financial year 2024-25. This work is expected to be presented to the NHS Fife Board in May 2024.

2.2 Background

During summer 2023, a deep dive was undertaken of the corporate risk associated with the implementation of the Population Health and Wellbeing Strategy. The deep dive focused on providing assurance on implementation progress to the NHS Fife Board.

It was agreed to produce a mid year report and an annual report reflecting progress of the actions over the financial year with key achievements and impact. It will also look ahead and outline plans for the forthcoming period.

The draft mid-year report was presented at the Public Health and Wellbeing Committee in November 2023. After extensive discussion, a range of changes were agreed:

- The PHW Committee asked for updates against the 'what will do' statements described in the strategy rather than the strategic priority ambitions. For each action, there is both a summary of what has been achieved in the period April-September 2023 and the plans for October 2023- March 2024 period.

- A suite of impact indicators to support the strategy had been planned to be included. This work has been paused pending the imminent publication of the Scottish Government Care and Wellbeing Portfolio Analytical Insights Pack. It is expected that the impact indicators will be included as part of the annual report.

2.3 Assessment

This first mid-year update covers the period April-September 2023 and has been developed with extensive input from the Executive Directors Group.

The report is structured around the 'what will do' statements described in the strategy with achievements in the first 6 months of 2023/24 and the plans for the October 2023- March 2024 period.

The table below outlines proposed changes to the wording of the 'what will do' actions between the strategy and mid-year report. These were agreed in consultation with the relevant directors and reflects the changing landscape of the NHS.

	Original Action	Proposed Action	Reason
Strategic Priority 1: Action 1.2	'*Ensuring universal access to immunisations including influenza and COVID-19'*	*'Ensuring equitable access to routine, seasonal & selective immunisation programmes throughout the life course'.*	This change reflects the breadth of all immunisation work.
Strategic Priority 4: Action 4.2 (pg	'*Develop new buildings to support service delivery, such as new Health and Wellbeing Centres in Kincardine and Lochgelly'*	*'Develop buildings to support service delivery, such as new Health and Wellbeing Centres in Kincardine and Lochgelly'.*	This change reflects updated Scottish Government guidance which places more emphasis on utilising, refurbishing and repurposing our existing estate and a presumption away from new builds as part our climate emergency response.
Strategic Priority 4: Action 4.4 (pg	'*Reduce our energy usage by adopting zero carbon technology, such as increased usage of solar panels and redesigning how we heat our buildings'*	*'Reduce our carbon footprint by adopting zero carbon technology, such as increased usage of solar panels and redesigning how we heat our buildings'.*	This change reflects that reducing energy usage is just one change we need to make to support sustainability.

Given the early stage of strategy implementation, it is not possible to show achievement of key outcomes, but the report does provide assurance on the breadth of work underway at the present time.

In tandem with updating the Mid-Year Review report, work is now commencing on the preparation of the annual report planned to be produced in Quarter 1 2024/25. It is proposed that the annual report will include:

- Updates on the activities undertaken between October 2023 and March 2024.
- A summary of the proposed suite of impact indicators with baselines and measurement plans.
- Refreshed deliverables (the 'what we will do' section) for 2024-25 to ensure that our work remains aligned to the priorities of the organisation.
- Description of any changes in policy that will affect NHS Fife and changes in local priorities

2.3.1 Quality, Patient and Value-Based Health & Care

The mid-year review provides a high-level progress update on the work being undertaken to improve quality and patient care in the current financial year in line with the commitments and vision outlined in the Population Health and Wellbeing Strategy.

2.3.2 Workforce

The mid-year review provides a high-level progress update on the work on the work being undertaken to improve staff experience and wellbeing in the current financial year in line with the commitments and vision outlined in the Population Health and Wellbeing Strategy.

2.3.3 Financial

The implementation of the Population Health and Wellbeing strategy is central to the achievement of our medium-term financial plan. In the longer term it is anticipated that it will support reduced demand on our healthcare system through preventive actions which will improve the physical and mental health of the population.

2.3.4 Risk Assessment / Management

A deep dive of the corporate risk associated with implementation of the Population Health and Wellbeing Strategy was undertaken in summer 2023. This considered how we provide assurance that the strategy is being implemented and is creating impact for our patients, staff and communities. Following the deep dive reporting mechanisms have been agreed which included production of this mid-year report.

The mid-year report includes a summary of the corporate risks in appendix one. It also shows the risk score in April 2023 and the status in September 2023. This enables a comparison of the overall risk level. This shows that our risk profile has not materially

changed since the beginning of the financial year and reflects that many of these risks require sustainable system change over a longer time period to affect a meaningful reduction in the risk level.

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

An Equality Impact Assessment (EQIA) was completed as part of the development of the PHW Strategy and will be reviewed annually as part of the governance process.

2.3.6 Climate Emergency & Sustainability Impact

The Mid-year Report does not raise, directly, issues relating to climate emergency and sustainability. However, these items do form important parts of our strategy. This update does make reference to key aspects of the work that has been taken forward, for example how we are reducing our energy usage and carbon emissions.

2.3.7 Communication, involvement, engagement and consultation

This paper reflects a range of communication, involvement, engagement and consultation with the PHW Strategy Core Team.

2.3.8 Route to the Meeting

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

- Executive Directors Group (EDG), Thursday 2 November
- Population Health and Wellbeing Committee, Monday 6 November
- 1-1 Discussions with EDG members and Senior Managers across NHS Fife, Nov/Dec
- Executive Directors Group (EDG), (virtually), Thursday 21 December
- Staff Governance Committee, 11 January

2.4 Recommendation

This paper is provided for:

- **Assurance** – the committee is invited to take assurance from the Mid-Year Report and the first 6 months of work to implement the NHS Fife Population Health and Wellbeing Strategy.
- **Decision** – the committee is invited to discuss and agree to the changes in the 'what we will do' actions in the mid-year report.

3 List of appendices

The following appendices are included with this report:

- Appendix 1: Living well, working well and flourishing in Fife, Population Health and Wellbeing Strategy 2023-2028, Mid-Year Report April-September 2023

Report Contacts

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NHS Fife

Living well, working well and flourishing in Fife

Population health and wellbeing mid-year report 2023-2024

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Contents

Introduction

NHS Fife Board approved *Living Well, Working Well and Flourishing in Fife*, our Population Health and Wellbeing Strategy, in March 2023. It outlines our vision to support population health and wellbeing. In this update, our first since the strategy was approved, we provide a progress update on all the work taken forward during the first 6 months of implementation. We also outline our future plans and describe how the impact and risks of the strategy are monitored.

Our aim is to deliver value-based health and care and we know this will be achieved by driving better outcomes and experiences for the people we care for through equitable, sustainable, appropriate and transparent use of resources.

Delivering over the longer term

The Population Health and Wellbeing Strategy 2023-28 covers a 5-year period. We are currently developing our plans based on what we know. Delivery of the vision and ambitions is being supported through implementation of a range of strategies and delivery of strategic programmes.

We know that our plans will need to be updated in response to a changing health and social care landscape. We are already responding to new opportunities and challenges as they emerge, by adapting our plans and updating our assumptions.

Looking ahead over the longer term (5-10 years), we anticipate that there will be many opportunities for service change and innovation as well as challenges we are not yet aware of. As these become clearer, we will use our flexibility and agility to ensure that we respond appropriately.

Engagement

Engagement with the public and staff is fundamental when there are changes being made in health and care. From a strong foundation during the development of the strategy, we are continuing to engage with people using our services and staff in the delivery of the strategy, for example through hosting workshops and open events. We are also developing our engagement strategy which will be completed by March 2024.

Monitoring our progress

This update provides a summary of progress in the first 6 months of the implementation of the strategy and where appropriate it references work of both NHS Fife and Fife HSCP.

Monitoring our impact and risks

Impact indicators are being developed and will assist in the assessment of the difference the strategy is making to the people of Fife. These will be reported regularly.

The corporate risk collectively outlines the organisational risks associated with the delivery of our strategy.

The Foundations of our strategy

This strategy has set ambitious objectives to improve healthy life expectancy and reduce health inequalities. We acknowledge that successfully achieving this for the population of Fife is largely outside the direct control and influence of NHS Fife. People's health and wellbeing is determined by the conditions in which we grow up, live and work, which includes our education, employment, income, social networks, housing, and broader socio-economic, cultural and environmental factors.

Nonetheless, access to health and care services still plays a significant role. The Marmot Review (2010) identifies that health and social care services contribute 20% of the modifiable determinants of health. Strong healthcare systems across the world improve health outcomes, population health, and health equity.

Health and care services make an important contribution to improving health outcomes and reducing health inequalities by enabling inclusive, high quality, and patient-centred care; supporting action-focused work on prevention; improving early detection; supporting early intervention and treatment; and delivering sustainable services. All of these factors are closely aligned to the 4 strategic priorities of NHS Fife.

Supporting the strategy is our Annual Delivery Plan (ADP) which is our Scottish Government commissioned plan for 2023/24. In the ADP, NHS Fife outlines the work being undertaken against the Scottish Government's recovery drivers.

Delivering the strategy

Strategies and programmes

Supporting the implementation of the strategy are strategies and strategic plans that are at various stages of development and delivery. The strategies have implementation plans and high-level progress is included in progress updates.

Impact indicators

Work is continuing to agree the outcome-level measures which contribute to our overall desired impact. A framework is being developed to monitor progress against delivery of the strategy. This has been paused until the Scottish Government Care and Wellbeing Portfolio Analytical Insights Pack is in place, to ensure our measures are aligned to national standards. Definitions will be developed for each of these measures and baseline data gathered. These will be reported as part of the annual report of the Population Health and Wellbeing Strategy.

Risk management

Although there is a corporate risk relating directly to the implementation of the Population Health and Wellbeing Strategy, it was recognised through the deep dive process undertaken in summer 2023 that all risks on the corporate risk register are impacted by, and are aligned to the strategy. All corporate risks are reviewed regularly and reported via the governance committees to the NHS Fife Board.

Appendix One provides a summary of the risks, their score in April 2023 and their current status (September 2023) and allows a comparison of the overall risk level and should be considered against progress of the strategy.

This analysis shows that our risk profile has not materially changed since the beginning of the financial year and reflects that many of these risks require sustainable system change over a longer time period to affect a meaningful reduction in the risk level.

Progress updates by strategic priority and ambitions

Progress has been assessed against each of the 4 strategic priorities, ambitions and the 'What we are going to do' sections in the Strategy. There has been more progress made against some actions than others but that should be expected in the delivery of a 5-year strategy. Further engagement activities such as workshops have been captured as part of progress made.


Improve health and wellbeing
Improve staff experience and wellbeing
OUR STRATEGIC PRIORITIES
Improve the quality of health and care services
Deliver value and sustainability

Priority 1: Improve health and wellbeing

Ambitions

A Fife where we:

1. live in flourishing, healthy and safe places and communities.
2. thrive in our early years.
3. have good mental wellbeing.
4. reduce the use of and harm from alcohol, tobacco, and other drugs.
5. have a sustainable, inclusive economy with quality of outcomes for all.
6. eat well, have a healthy weight and are physically active.

Progress update

SP1.1 **What we said we would do:** Through training and upskilling our staff we will scale up the work supporting people to access benefits advice so that more people, where appropriate, can access financial and benefits support.

Progress to 30 September 2023

- Promotion of a range of Poverty Awareness Training supported and coordinated through our multi-agency Poverty Awareness Training Group. Training reflects current issues such as the cost-of-living crisis and supports key areas of work including income maximisation, no wrong door approach and addressing child poverty. Training courses are open to all public and voluntary sector workers in Fife.
- Face to face and virtual workshops were delivered with a number of local and national partners across all sectors. For example, Citizens Advice and Rights Fife (CARF) and Child Poverty Action Group (CPAG). Some of the training delivered includes:
  - Fife Benefit Checker and Our Fife Toolkit workshops.
  - Money Talk workshops (specifically targeting Health Visitors, Family Nurse Partnership and Midwives as part of the Financial Inclusion Referral Pathway).
  - Poverty Awareness Information Session.
- Further information on all poverty awareness training is available via the Fife Health Promotion Training website.

Planned Activity to 31st March 2024

- Planned activities by the multi-agency Poverty Awareness Training Group include:
  - Building capacity of all our Poverty Awareness training programmes through growing our Train the Trainer Workshops (T4T) and ensure all training is accessible, innovative, and supports all learning styles.
  - Developing a tiered approach to Poverty Awareness Training to showcase the level of training needed depending on the workers role and remit and the service they provide.
  - Creating a series of Learning Bytes demonstrating explicit links between Poverty and Mental Health recognising that poverty is both a cause and a consequence of poor mental health.
  - Collaborate with Health Promotion Localities Team to support the roll out of Poverty Awareness training across all 7 localities.
  - Continue to support campaigns such as Challenge Poverty week.
- Embed the eHNA to increase referrals from Cancer Services to the Macmillan ICJ pathway to ensure patients with a cancer diagnosis have access to financial and benefits advice.
- Explore how we embed the eHNA process with patients diagnosed via the Rapid Cancer Diagnosis Service.

SP 1.2 **What we said we would do:** Ensuring equitable access to routine, seasonal **and** selective immunisation programmes throughout the life course.

Progress to 30 September 2023

- Immunisation Inclusion Group established to explore a community champions model.
- Final report presented to Fife Community Immunisation Services Programme Board of the Strategic Review of Childhood Immunisation Services in Fife.
- Quality improvement working group established focused on improving pre-school MMR2 uptake.
- Refreshed measles elimination action plan.
- Engagement with locality groups with locality-specific data.

Planned Activity to 31st March 2024

- Agree Equality Impact Assessment action plan.
- Establish processes to oversee implementation of activities proposed within the 'Strategic Review of Childhood Immunisation Services in Fife' report.
- Report to Public Health & Wellbeing Committee at February 2024 development session on progress against short-term activities proposed within the Strategic Review of Childhood Immunisation Services in Fife.

SP1.3 **What we said we would do:** In line with the UN Convention on the Rights of the Child, we will support every child to have the best possible health. Examples include promoting breast-feeding and helping to address child poverty.

Progress to 30 September 2023

- Publication of the 2023 Director of Public Health (DPH) Annual Report which includes a focus on children and young people in Fife with a formal launch event in September in conjunction with Fife Council's Education Service.
- Working with community planning partners through Plan4Fife, we have published our 2022-23 Tackling Poverty and Preventing Crisis Annual Report which includes the Fife Annual Local Child Poverty Action Report.
- Children's Services Plan 2023-2026 published.
- Raised awareness at Board level of The Promise and Corporate Parenting responsibilities.
- Accepted as a Getting it Right for Everybody (GIRFE) pathfinder with a focus on transition from child to adult services.

Planned Activity to 31st March 2024

- Continued implementation of UNICEF Baby Friendly Standards in maternity, neonatal and community care
- Dissemination of DPH Report to Fife localities to inform development of local plans.
- Early Years will be a core aspect of the Prevention and Early Intervention Strategy as part of the life course approach that underpins the strategy.

- NHS Fife has been selected as a pathfinder site to test the implementation of the Bairn's Hoose standards seeking to provide holistic, child-centred support to those who have been victims or witness of abuse and to children under the age of criminal responsibility whose behaviour has caused harm.
- Connecting on Place based work and No Wrong Door with Fife Council.
- Developing and enhancing services that support the most vulnerable children in our communities including:
- development of a CAMHS Kinship Team.
- Expanding CAMHS Looked after Children's services.
- Introducing a transitions specialist to support young people.

SP 1.4 **What we said we would do:** Improving awareness of the range of mental health and wellbeing support across Fife amongst NHS staff and the public.

Progress to 30 September 2023

For the public:

- HSCP Locality groups are functioning in all 7 localities with connections into Area Committees. Funding being made available for a Test of Change (ToC) to support Mental Health wellbeing and distress in the localities by mental health practitioners, ambulance services and police.
- Developed, launched and evaluated a new mental health and wellbeing resource 'Jobseekers Wellbeing Toolkit' designed as a self-management prevention and early intervention resource issued by employability partners to support client wellbeing.

For staff:

- Promotion of Access Therapies Fife, Step on Stress and other resources to support staff in addition to Counselling, Occupational Health, Peer Support, Spiritual Care and Staff Psychology Support.
- Pilot of Health and Safety Executive Stress Talking Toolkit undertaken within Mental Health and Learning Disability service, with positive results and excellent staff engagement.

Planned Activity to 31st March 2024

For the public:

- The NICE mapping exercise undertaken by the HSCP Wellbeing Strategy Group will be taken forward.
- Conclusion of the test of change for the mental health and wellbeing in localities work.

For staff:

- Focus on early intervention by the Occupational Health Mental Health Nursing service and retaining staff at work.
- Expansion of Stress Talking Toolkit activity to other areas on a planned basis including: Acute, Domestic Services and Pharmacy Services.

SP 1.5 **What we said we would do:** Improving mental health services for individuals struggling with substance misuse through closer working with the community alcohol and drug partnership.

Progress to 30 September 2023

- Concluding implementation of the 2020-23 Alcohol and Drug Partnership Strategy.
- Commenced work on an updated Alcohol and Drugs Strategy for 2024 onwards. Fife Alcohol and Drug Partnership (ADP) event held with stakeholders which identified priorities for new strategy.
- Drug Harms Assessment Group in place providing rapid assessment of potential risks to the population of Fife.
- Submission of evidence-based response by NHS Fife to Fife Licensing Board consultation on licencing policy in relation to local implementation of alcohol licensing legislation.

Planned Activity to 31st March 2024

- Developing a performance framework for all Medication Assisted Treatment (MAT) standards to inform Scottish Government returns and board performance reporting.
- Finalising the new Alcohol and Drugs Strategy by March 2024, focus groups with people with lived/living experience, staff from our commissioned services and Service Committee.
- Following publication of national guidance on Rapid Access Detox Acute Referral (RADAR) system (early notification of substances that cause harm), work will be carried out to embed in NHS Fife services.

SP 1.6 What we said we would do: We will encourage people to make healthier food choices

Progress to 30 September 2023

- Workshop taken place with a range of stakeholders to develop the Food4Fife strategy.
- An event focusing on Public Health Priority 6 (PHP6) was held on 19th September. This event aimed to focus on the 3 strands of PHP6 (food, weight, and physical activity) to identify priority areas for action and aligns with our work around type 2 diabetes prevention.
- Engagement with partnership Active Fifers Groups in 7 locality areas.

Planned Activity to 31st March 2024

- The Food4Fife strategy is expected to be published by the end of 2023 and will cover the period to 2030.
- Priority areas and actions to be agreed and approach developed to build on PHP 6 event.

SP 1.7 What we said we would do: We will support increased access to physical activity, particularly in older age, enabling people to stay independent and healthier for longer.

Progress to 30 September 2023

- Finalised the 2024- 2029 Fife Musculoskeletal Physiotherapy Service Strategic Plan which has a focus on supporting physical activity for patients.
- Recently published a range of health and physical activity resources on the NHS Fife website. A tool has been developed which has links for staff to signpost patients, supporting them to increase their physical activity, linked to their personal outcomes and good conversation work. Further research is currently underway.

Planned Activity to 31st March 2024

- Commencement of a strategic plan.
- The impact of published resources will be monitored and refined as necessary.

SP 1.8 **What we said we would do:** We will use NHS Fife's buildings and land to support communities to improve health and wellbeing. For example, making our buildings and land more accessible to support third sector activities.

Progress to 30 September 2023

- NHS Fife's draft Anchor Strategic Plan has been submitted to Scottish Government. This outlines how NHS Fife will maximise local employment, local procurement and also seek to build the potential future use of our land and buildings.
- The Community Benefits Portal is in place for procurement activities and will be evaluated against uptake.

Planned Activity to 31st March 2024

- The baseline assessment for Anchor Strategic Plan will be completed and submitted to Scottish Government by 29th March 2024. The final version of the Anchors Strategic Plan will be presented to NHS Fife Board. finalised
- .
- Further locality stakeholder engagement planned through HSCP.

SP 1.9 **What we said we would do:** Collaborating in regeneration projects like the River Leven programme.

Progress to 30 September 2023

- Identified from the River Leven Programme, the Green Health Partnership has been established to support development of Green Prescribing and Social Prescribing.

Planned Activity to 31st March 2024

- The Green Health Partnership is holding its first steering group meeting in November 2023. The Steering Group will be focused on securing funding for a GHP co-ordinator role and clarifying strategic and operational pathways for the project.

SP 1.10 Other relevant areas of work linked to priority 1 ambitions

Progress to 30 September 2023

- A workshop was held to explore both why communities living in more deprived parts of Fife are less likely to participate in our screening programmes and how this can be addressed.
- Prevention and Early Intervention Strategy has been drafted.

Planned Activity to 31st March 2024

- Contribute to refreshed Plan for Fife and agreed priority areas
- Create an action plan to reduce inequalities in screening uptake.
- Finalise and develop plans for implementation of the Prevention and Early Intervention Strategy in early 2024.

Priority 2: Improve the quality of health and care services

Ambitions

1. Provide high-quality person-centred care.
2. Deliver services as close to home as possible.
3. Reduce reliance on inpatient beds by providing alternatives to admission to hospital.
4. Ensure timely access to services based on clinical need.
5. Prevent and identify disease earlier.
6. Support the delivery of seamless, integrated care and services across health and social care

Progress update

SP 2.1 **What we said we would do:** Redesign urgent and emergency care to reduce our reliance on the Emergency Department and in-patient care.

Progress to 30 September 2023

- Priority areas identified by Planned Care Programme Board:
  - Flow and Navigation Centre (FNC)
  - Interface and Complex Care
  - Scottish Ambulance Service interface
  - Front Door/Rapid Triage Unit
  - Ambulatory Care pathways
  - Crisis Management
- Improved timely discharge from hospital by increasing the number of patient discharges taking place at the weekend.
- Employed a solicitor to assist patients who require welfare guardianship.
- Testing the delivery of rapid access or 'hot' clinics to avoid attendance or admission to hospital.
- 2023-26 Home First Strategy published with Action Plan
- Expansion of the ED medical workforce agreed to support system resilience and delivery of timely effective patient care.
- Primary care improvements including the activity in Community Treatment and Access Centres (CTAC).

Planned Activity to 31st March 2024

- Review and update the work plan for the Unscheduled Care Programme ahead of the winter period. We have an interim performance target to achieve 85% against the four-hour standard by March 2024.
- Monitor and report on the impact of the expansion of the ED medical workforce.
- Identify next steps following the FNC review.
- Review the learning from the Hot Clinics with a view to scaling this way of working for more specialties in Fife.
- Ensure actions from the Home First Strategy are progressed to reduce demand for acute hospital care. Examples of work include ensuring that those who do not need an admitted to an acute hospital bed (for example in the Victoria Hospital) are redirected and supported to be cared for in the right place. When patients do need to be admitted, planning for discharge begins as soon as possible following admission. This will reduce the amount of time patients need to spend in hospital.

SP 2.2 **What we said we would do:** Improve cancer care, for example by continuing to develop our Rapid Cancer Diagnostic Service.

Progress to 30 September 2023

- The Single Point of Contact Hub (SPOCH) is working collaboratively with Rapid Cancer Diagnosis Service (RCDS) to implement the optimal colorectal cancer diagnostic pathway.
- Expansion of the SPOCH to manage urgent suspected lung cancer referrals and parts of the bowel screening pathway.
- Initial findings show that the SPOCH has improved patient experience at the beginning of the pathway and has reduced the number of administrative calls received by the Clinical Nurse Specialists.
- Cancer Research UK funding was awarded to NHS Fife to test and evaluate a Nurse led Rapid Access Diagnostic Clinic (RADC) over a period of 18 months. This service began in August 2023 for suspected prostate cancer referrals, with the aim to improve patient experience from triage, diagnostics, and decision to treat. Evaluation of the project is underway by Stirling University.

- Work ongoing to improve and implement the Optimal Lung Cancer Pathway. Key achievements include same day/ next day chest x-ray, introduction of enhanced vetting of referrals, and reduced waits for CT scan and MDT discussion.

Planned Activity to 31st March 2024

- The Cancer Framework Action Plan has identified actions for delivery by March 2024 which focuses on improvement of cancer care from prevention, treatment, end of life and survivorship.
- Continuing to test the Prostate Rapid Access Diagnostic Nurse-led Clinic and taking forward the evaluation of this approach.
- Implementation of optimal diagnostic pathways- with a focus on lung cancer and head of neck cancers as developed by the Centre for Sustainable Delivery (CFSD):
  - Lung: Increase outpatient bronchoscopy capacity, introduction of frailty scoring prior to the first outpatient appointment to ensure patients are provided with tailored information relevant to their condition and exploring ways to provide timely good news for patients who do not have a lung cancer diagnosis.
  - Head and Neck: plans are dependent on a funding bid to Scottish Government.
- Working with the national Scottish Cancer Network on the development of end-to-end pathways for prostate and head and neck cancers.
- Evaluation of the effectiveness of lifestyle interventions that can improve health and wellbeing for example, advice around sleep, nutrition, exercise and relaxation for patients referred RCDS who are not found to have any definitive diagnosis for their symptoms.
- Explore how we can reduce waiting times for systemic anti-cancer therapies in our oncology and haematology day unit.

SP 2.3 **What we said we would do:** Provide a world class elective orthopaedic service through the National Treatment Centre – Fife Orthopaedics.

Progress to 30 September 2023

- Embedded the new facilities provided by the opening of the National Treatment Centre - Fife Orthopaedics.
- Commenced a review of our orthopaedics services which aims to deliver a patient centred, safe, flexible, and sustainable orthopaedic-trauma model which can positively manage the changes in demand over the next 15-20 years.

Planned Activity to 31st March 2024

- Redesign orthopaedic pathways to improve patient experience and fully embed the opportunities for new ways of working.
- Continue the work of the orthopaedics review so that by summer 2024 we are firmly on our way to delivering a gold standard, 24/7 orthopaedic-trauma service with and for the people of Fife.

SP 2.4 **What we said we would do:** Further develop our day surgery service at Queen Margaret Hospital.

Progress to 30 September 2023

- Opened a Procedure Unit at Queen Margaret Hospital (QMH).
- Delivered the final stages of the project to improve and expand Day Surgery facilities at QMH which has provided additional capacity and improved patient experience.

Planned Activity to 31st March 2024

- Increase utilisation of day surgery space at QMH and continue to support clinical innovation for the benefit of patients.

SP 2.5 **What we said we would do:** Increase the level of ambulatory services (care provided without being admitted to hospital) across Fife.

Progress to 30 September 2023

- Commenced scoping work to expand ambulatory care services to enable more patients to be treated without an unnecessary in-patient hospital admission. There are challenges to delivery of this due to availability of space and resources for this work.

Planned Activity to 31st March 2024

- Prepare the business case for the ambulatory care service to be considered as part of the medium-term financial plan and ADP for 2024/25.

SP 2.6 **What we said we would do:** Increase the level of ambulatory services (care provided without being admitted to hospital) across Fife.

Progress to 30 September 2023

- Local strategic leadership for the implementation of the Women's Health Plan is now confirmed. This is supporting an increasing focus on a women's life course approach to service planning across services in NHS Fife.
- An assessment covering a range of women's health services has been undertaken. This has considered access to contraception, termination of pregnancy, menopause care, promoting positive approaches to menstrual health and pregnancy. This has highlighted good practice and areas for further development.
- Plans for future focus have been informed by scoping, feedback, and review of progress to date.

Planned Activity to 31st March 2024

- Review provision of abortion services to ensure optimal geographical access.
- Work with primary care to develop guidelines and prescribing pathway for women experiencing early pregnancy bleeding.
- Explore with the Cardiac Rehab team, including staff and people using our services, to understand how services can be developed in response to women's needs.
- Identify local best practice, understand outcomes and potential local priorities for further work.

SP 2.7 **What we said we would do:** Implement Best Start for maternity and neonatal services.

Progress to 30 September 2023

- Increasing uptake of each 'place of birth' option as appropriate for those giving birth. This includes provision of midwife only care through home births and in the NHS Fife's Midwife led Unit which is part of the Victoria Hospital Birthing Unit.
- Systems and processes are being further developed to implement the Maternity and Neonatal (Perinatal) Adverse Review Process for Scotland. NHS Fife is a path finder site for this work.

Planned Activity to 31st March 2024

- Continue remodelling services to work towards ensuring continuity of care by a primary midwife for those using our services.
- Submission of evidence and application for the Baby Bliss Charter Silver Award before the end of 2023.

SP 2.8 **What we said we would do:** Focus on waiting times and support people, where appropriate, to wait well for their procedure.

Progress to 30 September 2023

- Primary care improvements including the activity in Community Treatment and Access Centres (CTAC).
- Efforts continue to identify opportunities to maximise use of planned care capacity including utilising on Active Clinical Referral Triage and Patient Initiated Review. We are also seeking to increase the use of day surgery where possible.
- Outpatient communications have been updated to provide information on the availability of The Well which can provide people with a range of support as they are waiting for treatment.
- A Waiting Well service is being tested in Orthopaedics. This service can refer people to The Well. For patients who have had longer waits, a waiting well appointment with an Advanced Nurse Practitioner is being tested to provide a review of patients waiting for treatment.

Planned Activity to 31st March 2024

- Expand the waiting well service to other specialities where patients are experiencing long waits.
- Share our experiences with other Health boards and learn from practice elsewhere.

SP 2.9 **What we said we would do:** Continue to invest and develop in new technologies such as robot assisted surgery to provide high quality care.

Progress to 30 September 2023

- Completed 500 cases using Robotically Assisted Surgery to support better outcomes for people including shorter length of stay.
- Pioneering developments in surgery such as the use of an innovative new device (iTind) to treat lower urinary tract symptoms associated with an enlarged prostate has been introduced. This is less invasive than traditional interventions with patients being treated as day-cases and returning home the same day.

Planned Activity to 31st March 2024

- Continue to embed provision of robot assisted surgical procedures for Colorectal, Gynaecology and Urology patients.
- Explore availability of funding for a second robot to continue to grow the provision of robot assisted surgery in NHS Fife.

SP 2.10 Other relevant areas of work linked to priority 2 ambitions

Progress to 30 September 2023

- Launched a project to improve the care and management of deteriorating patients in our hospitals.
- Testing approaches to improve safety and reduce the harm associated with usage of high-risk pain medicines.
- Commenced work to improve our approach to how we respond to patient complaints, including improving our response times.
- NHS Fife Charity funding support received to enhance a number of staff and patient areas.
- Fife HSCP is developing a Prevention and Early Intervention Strategy to support overall health improvement and reduce the burden of disease in the population of Fife.

Planned Activity to 31st March 2024

- Progress plans for the deteriorating patient work.
- Spread improvement as part of the High-Risk Pain Medicines project.
- Agree and implement a new approach to patient complaint responses and reduce the number of outstanding complaints by March 2024.

Priority 3: Improve staff experience and wellbeing

Ambitions

Our workforce:

1. is inclusive and diverse, reflecting Fife's communities.
2. is supported to develop new skills that help improve care for patients.
3. is heard and at the heart of transforming services.
4. works in partnership across health and social care, recognising interdependencies.
5. experiences compassionate leadership in a culture that supports wellbeing.

Progress update

SP 3.1 Promote a range of career pathways with a focus on developing our workforce.

Progress to 30 September 2023

- Agreement on the Career Development Framework for Healthcare Support Workers and Assistant Practitioners (band 2-4) to support the development of the nursing workforce.
- Block recruitment event in June.
- Unregistered staff pools created within Acute Services to support underlying long-term vacancies.
- Investment in Gateway doctors to replace junior locum spend.
- Additional ward administration staff in post to mitigate the workload associated with non-clinical clerical tasks for nursing staff.
- Reducing use of agency staffing by working towards a more substantive workforce and use of our own in-house staff bank.

Planned Activity to 31st March 2024

- Consider the strategic framework for nursing and midwifery by NHS Fife Board by March 2024.
- Undertake a further recruitment campaign for our Mental Health Service.
- Scope opportunity to expand our international recruitment programme using existing vacancies across NHS Fife.
- Continue work on reducing agency staff usage and increase scope of this work to include the medical workforce.

SP 3.2 Expand and enhance our employability programmes across Fife including a range of foundation and modern apprenticeships.

Progress to 30 September 2023

- Showcased a wide range of NHS careers at schools and careers fairs through in-person and virtual platforms, with a #TeamNHSFife approach.
- Scoped opportunities and strengthened relationships with a variety of key partners, charities, and educational establishments, such as the MCR Pathways Mentoring Scheme, which we plan to support.
- Through working closely with colleagues and local education providers, internship, and apprenticeship programmes are being established. These will support both development and progression of existing staff as well as recruitment of new staff to posts including Graduate Apprenticeships.
- Our collaborative efforts with Fife Council's Employability team resulted in the establishment of employability pathways, such as the Kickstart Scheme. This scheme has seen recruitment and development of 12 young people in a variety of entry-level roles. 7 of these individuals remain employed within NHS Fife.
- A Graduate Information Analyst was recruited through the Graduate Career Advantage Scotland (GCAS) paid work experience scheme, in collaboration with NES.
- There has been significant work with Fife College and partners to provide mentorships for students.

Planned Activity to 31st March 2024

- Increase engagement with those considering careers in healthcare through strengthened links with the Developing the Young Workforce Fife Regional Board and the Schools Co-ordinators.
- Participate in the Fife Council led recruitment initiative 'Progressive Life Chances', aimed at supporting disadvantaged individuals into employment.
- Enhance links with local educational providers to promote careers in NHS Fife. For example, offering internship placements for Dundee University students across NHS Fife and Fife HSCP and considering Graduate Apprenticeship opportunities with Heriot Watt University.
- Create opportunities for young people to engage with NHS Fife as part of the Young Person's Guarantee.

- Recruit an Employability Officer to support all our work and deliver against the Board's ambitions.
- In partnership with Fife College provide a Foundation Apprenticeship in Health.
- Continue working with Fife College to offer MA Level 2 and 3 opportunities for NHS Fife Healthcare Support Workers.

SP 3.3 Continue to support our staff with their practical health and mental wellbeing.

Progress to 30 September 2023

- NHS Fife's Occupational Health Service has developed a new mental health nursing service for staff, building on the fatigue management service introduced during the Covid-19 pandemic.
- The Chaplaincy team has worked with around 40 teams utilising values based reflective practice to help staff with their mental wellbeing in the workplace. This is in addition to existing staff spiritual care support.
- The 'Boost your Income' initiative has been delivered and evaluated. This programme supported staff with financial concerns and provided benefits advice to ensure staff are accessing all the benefits they are entitled too. Over the reporting period, 69 people have been supported and received an increase in their household income. This equated to over £160k. Uptake of this support has been lower than expected and next steps are being considered how staff with financial concerns can be supported.
- There has been a focus on Menopause support for staff as one of the key requests, with monthly sessions at Victoria and Queen Margaret Hospitals which are well attended and received by staff.
- Compassionate Connected Teams – the Staff Psychology Support team have delivered multiple Leading with Compassion sessions to managers and senior leaders.
- Since December 2022, EnergyPods have been available which give staff the opportunity to boost their energy and take time out with a personalised guided power nap in comfortable surroundings. Permanent locations for the EnergyPods on the Victoria Hospital site have now been secured.

Planned Activity to 31st March 2024

- Review existing wellbeing activity and prepare an updated staff health and wellbeing action plan to ensure maximisation of resources to support staff wellbeing.
- Develop the mental health support offered to staff.
- Open a refurbished Staff Hub in Whyteman's Brae hospital in November 2023 and refurbish staff rest areas on the Cameron, Lynebank and Stratheden Hospital sites before the end of March 2024.
- Develop further plans to refurbish and create staff hubs within clinics and health centres.
- Launch a new Cycle to Work scheme to support active travel and low carbon commuting.
- Seek investment support for Second Nature Weight Management App for staff from the East Region Programme Board
- Increase opportunities for staff to be more physically active through working with the Fife Active Communities Officer and with Fife Sports and Leisure Trust.
- Scope how opportunities for staff to access Menopause support can be expanded for those who work out with Victoria Hospital and Queen Margaret Hospital.
- Identify how staff can be supported who have experienced adverse events in the workplace.

SP 3.4 Continue to support our staff with their practical health and mental wellbeing.

Progress to 30 September 2023

- The international recruitment programme for 2023-24 is complete with 17 posts successfully recruited to.

Planned Activity to 31st March 2024

- Work with Scottish Government and other stakeholders to identify plans for further international recruitment beyond March 2024, noting that no additional funding has been confirmed for 2024-25.
- Participate in the pilot for the NHS Scotland Pastoral Care Quality Award (PCQA) and will undertake the International Recruitment Pastoral Care Quality Charter.

SP 3.5 Develop and launch a new Leadership Framework focussed on compassionate leadership and an open, transparent and nurturing culture.

Progress to 30 September 2023

- Plans agreed to recruit a new senior manager within the workforce team to accelerate our work around leadership, organisational culture, and wellbeing.
- *Compassionate, connected and effective teams* sessions led by the NHS Fife Psychology Service continued during 2023. This workshop is delivered in person with established teams, on-line for individual participants and as part of the Foundation Management Training.

Planned Activity to 31st March 2024

- Finalise the Leadership Framework in conjunction with colleagues across NHS Fife by Spring 2024.
- Hold the first meeting of the newly created Systems Leadership Group in October 2023. The focus will be on engaging with senior teams to explore how we support delivering improvements in our culture and how we collectively plan for the future.
- Commence a programme of compassionate leadership development for the Acute Senior Leadership Team and the Executive Directors' Group (EDG).

SP 3.6 Other relevant areas of work linked to priority 3 ambitions

Progress to 30 September 2023

- Relaunch of Diverse Ethnicity Network with Coffee Connect session held in May 2023.
- Ethnically Diverse Staff Experience Survey launched in September and will be open till 31 October 2023.
- Through the #SpeakingUp project, a further 21 confidential contacts were recruited and trained to offer support to staff who wish to speak up and raise concerns.
- Improved performance on iMatter: 78% of teams in NHS Fife now have an action plan. This reflects the best performance from a territorial Board.
- NHS Fife Board has continued to engage with a programme of visits to a range of locations across Fife for Board Members and Executive Directors. Our Interim Chair has promoted the work of the board through a new Bitesize Briefing and regular updates to staff.

Planned Activity to 31st March 2024

- Complete analysis of the Ethnically Diverse Staff Experience survey.
- Establish a LGBTQ+ staff network.
- Finalise our Corporate Communication and Participation and Engagement strategies.

Recognising excellence and recognising staff achievements

Across NHS Fife, there are many talented colleagues who provide fantastic care for the population of Fife. It is not possible to share everyone's achievements, but examples include:

- Vicki Bennett and Simon Fevre were both recognised at the annual British Dietetic Association Awards celebrating outstanding individuals working within the dietetic profession from across the UK. Vicki was recognised with the Mary Turner Award for her outstanding work as a trade union representative, which Vicki combines with her role in Public Health. Simon was awarded with a Fellowship, the British Dietetic Association's highest honour, given in recognition of Simon's many years of committed and inspirational service to the dietetic profession.
- Debs Steven, Lead Pharmacist Pain Management, was awarded a Fellowship of the Royal Pharmaceutical Society for Distinction in the Profession of Pharmacy. Being appointed as a Fellow is one of the highest accolades that can be paid, as it recognises the distinction members have attained in their pharmacy career. As fellowship awards are based on nominations from members, it also signifies the high esteem in which colleagues are held by their peers.
- NHS Fife Children's community nursing team won the prestigious Children's Nursing & Midwifery Award at the Royal College of Nursing Nurse of the Year Awards. The team were recognised for the incredible support and care they provide to families whose children are diagnosed with complex and severe health conditions.

A Celebrating Success event was held in the summer 2023 where the fantastic work of all the medical trainees across NHS Fife was recognised. In September 2023, the NHS Fife Staff Awards was held acknowledging all of the outstanding work of NHS Fife staff.

Priority 4: Deliver value and sustainability

Ambitions

1. Provide the right services in the right places with the right facilities.
2. Ensure the best use of our buildings and land.
3. Reduce energy usage and carbon emissions, working toward carbon neutral by 2040.
4. Deliver our capital programmes for primary care, mental health, and acute services creating high quality environments for patients and staff.
5. Deliver sustainable and effective resource allocation that supports value-based healthcare.

Progress update

SP 4.1 **What we said we would do:** Maximise the use of our buildings and land in line with service and community needs.

Progress to 30 September 2023

- A primary care premises review has been undertaken to understand the future requirements for space and facilities across GP Practices. The review identified 17 immediate, short, and medium-term recommendations. The immediate recommendations have now been completed with support of £2 million funding from Fife HSCP. This has resulted in the creation of an additional 61 consulting rooms across NHS Fife's primary care estate.
- The Property and Asset Management Strategy (PAMS) was submitted to Scottish Government. This outlined the investment required to address the challenges presented by the ageing estate.
- Analysis of the estate has shown that 62% of the estate is classed as green space. NHS Fife Greenspace Strategy was approved by the NHS Fife Board. The vision is to maximise the health promoting potential of the land and support a response to the climate emergency.
- An improved Day Surgery Unit Queen Margaret Hospital was opened as well as an improved A&E department with new signage and web pages.
- NHS Fife are working with Lucky Ewe to explore a potential Community Asset Transfer (CAT) of land at Stratheden Hospital.

Planned Activity to 31st March 2024

- Complete the short- and medium-term actions from the primary care premises review in conjunction with the delivery of the NHS Fife primary care strategy.
- In conjunction with Fife Climate Hub, planning will commence for a stakeholder event in early 2024/25. This event will bring together a range of communities and groups with an interest in climate change across Fife and support the implementation of our Greenspace Strategy.

SP 4.2 **What we said we would do:** Develop buildings to support service delivery, such as new Health and Wellbeing Centres in Kincardine and Lochgelly.

Progress to 30 September 2023

- Scottish Government has requested NHS Boards develop plans for the NHS estate as a whole system to support prioritisation and allocation of resource in a joined-up way. Supporting the development of the NHS Fife plan, a masterplan for the Victoria Hospital site has been drafted which will improve the experience of the site, build a green corridor supporting biodiversity, and support active travel.
- Ward 5 (VHK) upgrade is underway to develop the ward into a fit for purpose clinical area. This highlights the commitment to refurbishing the existing estate as this is one of the oldest parts of the Victoria Hospital.

Planned Activity to 31st March 2024

- Complete the refurbishment of Ward 5 by the end of this financial year.
- Deliver additional capacity for the delivery of education within Cameron and Whyteman's Brae hospitals.
- Continue to retrofit existing buildings to improve energy efficiency (see action 30 for more detail on our plans) in line with commitments to reduce carbon emissions.
- Review the existing PAMS to ensure the focus on the refurbishment of the existing estate is in line with publication of new guidance expected by March 2024.
- Continue to update and develop the whole system plan for NHS Fife to support prioritisation and allocation of resources.

SP 4.3 **What we said we would do:** Redesign and develop mental health services in Fife, including fit-for-purpose inpatient and community-based services.

Progress to 30 September 2023

- Following publication of the NHS Scotland Mental Health and Wellbeing Strategy in summer 2023, Fife HSCP is developing an aligned strategic statement and associated delivery plan which responds to priorities for the population of Fife.
- Initial agreement has been prepared for the Mental Health Estates Project and is now progressing through internal governance.
- There has been commitment to funding for the next 3 years to improve the Mental Health estate across NHS Fife. Work has commenced to refurbish ward 3 at Queen Margaret Hospital.

Planned Activity to 31st March 2024

- Complete the refurbishment of Ward 5 by the end of this financial year.
- Deliver additional capacity for the delivery of education within Cameron and Whyteman's Brae hospitals.
- Continue to retrofit existing buildings to improve energy efficiency (see action 30 for more detail on our plans) in line with commitments to reduce carbon emissions.
- Review the existing PAMS to ensure the focus on the refurbishment of the existing estate is in line with publication of new guidance expected by March 2024.
- Continue to update and develop the whole system plan for NHS Fife to support prioritisation and allocation of resources.

SP 4.4 **What we said we would do:** Reduce our carbon footprint by adopting zero carbon technology, such as increased usage of solar panels and redesigning how we heat our buildings.

Progress to 30 September 2023

- Investment of £1.8 million has been secured as part of a low carbon infrastructure programme. This has seen installation of solar panels, improvements to hot water systems, more accurate automated heating controls and optimisation of our fridge-freezers. This will make buildings more comfortable, reliable, and reduce carbon emissions.
- Reduction in use of medical gases and working with pharmacy colleagues to prepare to transition inhalers to non-greenhouse gas propellant inhalers.
- Published our 2021/22 Climate Emergency and Sustainability annual report which outlines work towards achieving net-zero. The Climate Emergency and Sustainability annual report 2022/23 is being drafted. This suggests that since 2021/22, there has been reductions in Greenhouse Emissions of over 2%, reductions in medical gases of over 12% and a reduction in water usage of around 15%.

Planned Activity to 31st March 2024

- Complete the low carbon infrastructure investment programme with upgrades to windows at Whytemans Brae and Stratheden Hospitals.
- Secure funding for installation of LED lighting across the NHS Fife estates, a heat recovery system in the NHS Fife laundry and further funding for windows and insulation in the Fife college of nursing.
- Finalise and publish of the Climate Emergency and Sustainability Report for 2022/23.

SP 4.5 **What we said we would do:** Lower the environmental impact of travel by adapting the use of technology (virtual appointments and virtual working), supporting sustainable travel (walking, cycling and public transport) and investing in electric and low emissions vehicles.

Progress to 30 September 2023

To support delivery of the 2025 target to decarbonise vehicles, plans are now agreed to increase the availability and usage of electric vehicles. Currently 44% of light vehicles and 6% of cars are electric. This number is expected to rise substantially between now and 2025.

Planned Activity to 31st March 2024

- Increase corporate electric vehicle charging infrastructure to support the transition to electric vehicles. Across Fife, there are already 61 charging points for corporate electric vehicles, and this will increase to 77 charging points by March 2024.
- Explore how to increase the availability of charging points for private vehicles (for example those belonging to staff, patients and other visitors to NHS Fife) through collaborating with commercial companies.
- Encourage low carbon commuting through provision of a salary sacrifice scheme for staff to lease electric cars and expansion of the cycle to work scheme.

SP 4.6 **What we said we would do:** Become an organisation providing more responsive care using technology, developing digital solutions such as virtual appointments, electronic access to test results and growing our use of data to support planning and delivery of care.

Progress to 30 September 2023

- Established the Electronic Health Record (EHR) Group to provide oversight to digital adoption in clinical settings.
- Conducted prioritisation workshop with Digital and Information (D&I) Board and EHR Group members.
- Extended data sharing arrangements with Scottish Ambulance Service to support sharing of electronic summaries.
- Appointment notifications being received by patients within Patient Hub for Pain Management and Vasectomy.
- Scanning of active health records for Cohort 1 complete.
- Federation between NHS Fife and Fife Council established on M365 platform to ease sharing of calendars and MS Teams.
- Other highlights of the work of the Digital Strategic Delivery Team are available in our November 2023 Update.

Planned Activity to 31st March 2024

- Review the progress in delivering the existing Digital Strategy and present findings to the Clinical Governance Committee.
- Commence development of the future Digital Strategy and ensure alignment to national and local strategic priorities.
- Complete of the prioritisation and planning to finalise our 2024-25 delivery plan via EHR Group and Digital and Information Board.
- Implement Phase 1 and Phase 2 concurrently of the Laboratory Information Management System (LIMS).
- Begin the Hospital Electronic Prescribing Management Administration (HEPMA) project with replacement of Pharmacy Stock Control system.
- Finalise the Business Case for GP IT replacement programme.

SP 4.7 **What we said we would do:** Use a structured approach to identify financial efficiencies, for example, through careful procurement of supplies and optimising the use of medicines.

Progress to 30 September 2023

- A £15.8m revenue overspend is reported for the first six months of the financial year for Health Board retained services. Despite the receipt of additional financial sustainability allocations for NRAC and New Medicines Funding from Scottish Government during June, the Board financial position continues to track beyond the agreed Board risk appetite in relation to delivering value and sustainability.

Planned Activity to 31st March 2024

- Assess and progress options to support financial recovery and minimise the overspend before the end of the financial year following the mid-year review.

Emergent opportunities and challenges

A range of opportunities and challenges are emerging as we consider longer term planning horizons. Below are some areas that we will be considering as we undertake our planning work.

1. Anchor Institution

We are producing an Anchor Strategic Plan that will be implemented over the next few years. This work represents a significant opportunity to achieve many of our ambitions in the Population Health and Wellbeing Strategy.

2. Changing risks associated with Covid-19

The risks associated with Covid-19 are changing. The success of the vaccination programme and increasing immunity means that the associated risk in the risk register will be reduced. Sustained reductions in this risk means that there are more options in how services are delivered and the focus can move to other strategic challenges.

3. Embedding Realistic Medicine and Value Based Healthcare learning

We are continuing to take forward work to help us to deliver more person-centred and responsive care that meets the needs of the population of Fife and considering how we can do things differently. Central to our approach is embedding the values and principles of Realistic Medicine and Values Based Healthcare which will help us deliver quality care designed around the needs of people and lead to an improved experience.

4. Health and Care Staffing (Scotland) Act 2019 (HCSA /Safe Staffing)

Full implementation of the Health and Care Staffing (Scotland) Act will take place on 1 April 2024. This includes the commencement of monitoring and governance. Board reports are due to the Scottish Government by 31 March 2025. NHS Fife must demonstrate how we have met the specific duties of the Act and provide information to the Scottish Ministers on the steps taken to comply with the legislation. The first Ministerial reports to Parliament are expected in April 2026.

The Common Staffing Methodology, as part of the Act, includes using the outputs of the staffing level tools and professional judgment to inform and ensure appropriate staffing in place for all staff covered within the scope of the Act.

5. New and Emerging Legislation

The Scottish Parliament continues to enact a range of legislation that will impact NHS Fife and the wider health and social care sector. For example, the creation of a Patient Safety Commissioner with a remit to ensure the safety of healthcare; a Housing Bill which may include a duty on the wider public sector (including NHS Scotland) to prevent homelessness; and the National Care Service. As legislation is enacted we will continually seek to improve care for those using our services.

Appendix one: NHS Fife corporate risk register

Risk title (taken from risk register)	Score April 2023	Score Sept 2023	Target Risk Level	Trend[1]
1. Population Health and Wellbeing Strategy	Mod 12	Mod 12	Mod 12 by 31/03/24	=
2. Health Inequalities	High 20	High 20	Mod 10 by 31/03/24	=
3. COVID 19 Pandemic	Mod 12	Mod 9	Mod 12 by October 2023	↓
4. Policy obligations in relation to environmental management and climate change	Mod 12	Mod 12	Mod 10 by 01/04/25	=
5. Optimal Clinical Outcomes	High 15	High 15	Mod 10 by 31/03/24	=
6. Whole System Capacity	High 20	High 20	Mod 9 by 30/04/24	=
7. Access to outpatient, diagnostic and treatment services	High 20	High 20	- [2]	=
8. Cancer Waiting Times (CWT)	High 15	High 15	Mod 12 by 30/04/24	=
9. Quality & Safety	High 15	High 15	Mod 10 by 31/03/24	=
10. Primary Care Services	High 16	High 16	Mod 12 by 31/03/24	=
11. Workforce Planning and Delivery	High 16	High 16	Mod 8 by	=
12. Staff Health and Wellbeing	High 16	High 16	Mod 8 by 31/03/25	=
13. Delivery of a balanced in-year financial position	High 16	High 16	Mod 12 by 31/03/24	=
14. Delivery of recurring financial balance over the medium-term	High 16	High 16	Mod 12by 31/03/24	=
15. Prioritisation & Management of Capital funding	Mod 12	Mod 12	Mod 8 by 1/04/26	=
16. Off-Site Area Sterilisation and Disinfection Unit Service	Mod 12	Mod 12	Low 6 by 01/04/26	=
17. Cyber Resilience	High 16	High 16	Mod12 by	=
18. Digital & Information	High 15	High 15	Mod 8 by April 2025	=

[1] = risk stayed the same, ↓ risk falling, ↑ risk increasing

[2] It is not possible to provide a target risk and date given the uncertainty over future availability of funding.

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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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NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**12 January 2024**
Title:	**Medical Appraisal & Revalidation Strategic Framework 2024-27**
Responsible Executive:	**Dr Chris McKenna, Medical Director, NHS Fife**
Report Author:	**Dr Shirley-Anne Savage, Associate Director of Quality & Clinical Governance**

1 Purpose

This is presented for:

- Assurance
- Discussion
- Decision

This report relates to a:

- Annual Delivery Plan
- Government policy / directive
- Local policy
- National Health & Wellbeing Outcomes / Care & Wellbeing Portfolio

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

A Medical Appraisal and Revalidation Strategic Framework (Appendix 1) has been developed for NHS Fife.

The Framework is being brought for assurance, discussion and a decision on publication.

2.2 Background

Our aim as an organisation is to deliver safe, effective, person-centred care. Medical Appraisal and Revalidation and in turn the Medical Appraisal and Revalidation Framework is part of the process to ensure this, encouraging a meaningful and supportive appraisal available to all doctors. This in turn provides assurance to us as the employing Health Board and our patients that our doctors are up to date and fit to practise.

2.3 Assessment

The aim of the Medical Appraisal and Revalidation Framework is to:

- Ensure that NHS Fife has the capacity and capability to deliver high quality appraisals to eligible doctors in Fife.
- Create a faculty of enthusiastic and competent appraisers.
- Develop an appraiser recruitment and retention plan that meets the needs of the organisation.
- Ensure all the employed and contracted doctors in NHS Fife are aware of the importance, value and benefits of medical appraisal.
- Maximise the number of doctors able to revalidate successfully on their given date by the GMC.
- Give assurance to the organisation and public that our employed and contracted doctors are professionally up to date and fit to practice medicine.
- Ensure doctors are supported appropriately when any issues are raised in connection with appraisal activity.

2.3.1 Quality/ Patient and Value-Based Health &Care

Quality and patient care is at the heart of this framework. Medical appraisal and revalidation ensure that licensed doctors are up-to-date and are practising to the appropriate professional standards.

2.3.2 Workforce

The wellbeing and contribution of doctors is a key to this framework.

2.3.3 Financial

- Not applicable

2.3.4 Risk Assessment/Management

This framework aims to mitigate the Quality and Safety corporate risk.

2.3.5 Equality and Diversity, including health inequalities

- Not applicable

2.3.6 Climate Emergency & Sustainability Impact

- Not applicable

2.3.7 Communication, involvement, engagement and consultation

Dr Christopher McKenna, Medical Director

Medical and Appraisal Revalidation Group 10th January 2024

Staff Governance Group 11th January 2024

2.3.8 Route to the Meeting

- Not applicable.

2.4 Recommendation

- Framework: Assurance, discussion and decision on publication

3 List of appendices

The following appendices are included with this report:

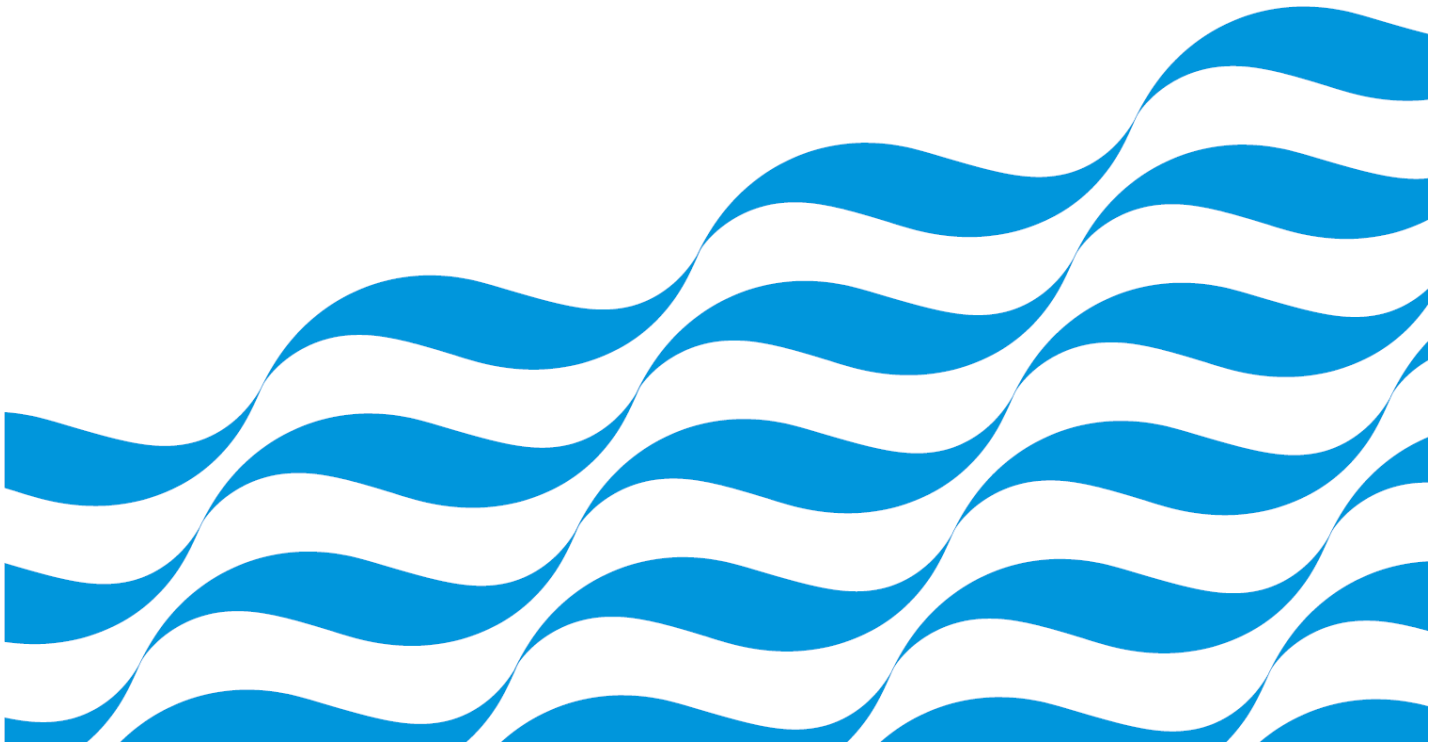
- Appendix 1: Medical Appraisal and Revalidation Strategic Framework 2024-2027

Report Contact

Dr Shirley-Anne Savage
Associate Director of quality & Clinical Governance
Email shirley-anne.savage@nhs.scot

Medical Appraisal & Revalidation Strategic Framework

2024-2027



Contents

1. Executive Introduction

Our aim as an organisation is to deliver safe, effective, person-centred care. Medical Appraisal and Revalidation is part of the process to ensure this, encouraging a meaningful and supportive appraisal available to all doctors. This in turn provides assurance to us as the employing Health Board and our patients that our doctors are up to date and fit to practise.

Appraisal is a supportive, formative and developmental process. It should be a positive process, providing doctors with feedback and allow reflection on their past and to plan their future progress.

Appraisal and revalidation will support and equip our medical staff ensuring their health and wellbeing as well as providing the appropriate information and support to deliver excellent care.

Dr Christopher McKenna
Executive Medical Director and Responsible Officer, NHS Fife

2. Purpose

The aim of the Framework is to:

- Ensure that NHS Fife has the capacity and capability to deliver high quality appraisals to eligible doctors in Fife.
- Create a faculty of enthusiastic and competent appraisers.
- Develop an appraiser recruitment and retention plan that meets the needs of the organisation.
- Ensure all the employed and contracted doctors in NHS Fife are aware of the importance, value and benefits of medical appraisal.
- Maximise the number of doctors able to revalidate successfully on their given date by the GMC.
- Give assurance to the organisation and public that our employed and contracted doctors are professionally up to date and fit to practice medicine.
- Ensure doctors are supported appropriately when any issues are raised in connection with appraisal activity.

3. What is Medical Appraisal and Revalidation?

3.1 Appraisal

Medical appraisal in Scotland is managed in the NHS designated bodies at Board level by Executive Medical Directors who are also Responsible Officers (ROs). They appoint appraisal leads and appraisers. NHS Fife has two deputy ROs- the Deputy Medical Directors for Acute Services and the Health and Social Care Partnership. The Medical Director for NHS Education Scotland (NES) is the RO for all doctors in training.

Annual appraisal is a contractual obligation for all Consultants, Specialty Doctors and Associate Specialists (SAS doctors), Career Grade doctors and General Practitioners (GPs) contracted by NHS Boards. It is an opportunity for reflection and learning of a doctor's whole practice. It should be a supportive process, providing doctors with feedback and to allow reflection and plan their future professional development.

The appraisal is based on the General Medical Council (GMC) Good Medical Practice Framework for Appraisal and Revalidation (March 2013) which describes the principles of good medical practice and standards of competence, care and conduct expected of doctors in all aspects of their professional work. It consists of four domains:

- Knowledge, skills and performance.
- Safety and quality.
- Communication, partnership and teamwork.
- Maintaining trust.

and gives the doctor the opportunity to:

- Reflect on their clinical and non-clinical practice.

- Reflect on the supporting information they have gathered and what that information demonstrates about their practice.
- Reflect on and discuss their health and wellbeing.
- Identify areas where they could make improvements or undertake further development and produce a Personal Development Plan (PDP) for the coming year.
- Demonstrate that they are up to date.

3.2 Revalidation

Medical Revalidation has been a legal requirement in the UK since December 2012 and is the process by which doctors demonstrate to the General Medical Council (GMC) and reassure patients and employers that they are up to date and fit to practise.

The Medical Profession (Responsible Officers) Regulations 2010(1) and the Medical Profession (Responsible Officers) (Amendment) Regulations 2013(2) require each body designated under the regulations to appoint a Responsible Officer (RO) who must monitor and evaluate the fitness to practise of doctors with whom the designated body has a prescribed connection. A designated body is a doctor's principal employer that will provide a regular appraisal and support them with revalidation.

Under current legislation, every 5 years, the RO is responsible for making recommendation to the GMC regarding a doctor's suitability for licence renewal (revalidation). This is based on the satisfactory completion of annual appraisals undertaken in the workplace and any other governance information available to the RO.

The process:

- Supports doctors in regularly reflecting on how they can develop or improve their practice.
- Gives patients confidence doctors are up to date with their practice.
- Promotes improved quality of care by driving improvements in clinical governance.

4. Framework Overview

Our Aims

- Deliver high quality appraisals to the senior doctors in Fife.
- Create a faculty of appraisers.
- Develop an appraiser recruitment and retention plan.
- Support doctors to appreciate the importance, value and benefits of medical appraisal.
- Give assurance our doctors are 'up to date and fit to practise'.

Our Values

- Care and compassion.
- Dignity and respect.
- Quality and teamwork.
- Openness, honesty and responsibilty.

Medical Appraisal and Revalidation Activities

- Medical appraisal for all employed and contracted medical staff.
- Ensuring robust appraisal procedures in place to allow annual appraisal for all trained medical stall.
- Support and training for appraisers.
- Support for all trained medical staff to enable them to meet appraisal and revalidation requirements.
- Responsible Officer revalidation recommendations.

Enablers

- Effective policies and procedures.
- Scottish Online Appraisal Resource (SOAR).
- NES Training.
- Appraisers.
- Strong senior medical leadership.
- Medical Appraisal & Revalidation team.
- Medical Appraisal & Revalidation Group (MARG).

Our Values

We will:

- Lead with compassion.
- Ensure that the wellbeing of our medical workforce is a priority.
- Ensure that we are visible, approachable and supportive.
- Ensure that learning is shared.

Medical Appraisal and Revalidation Activities

We will:

- Maintain robust medical appraisal policies and procedures.
- Develop an appraiser and recruitment and retention plan.
- Support all doctors to appreciate the importance, value and benefits of medical appraisal.
- Ensure annual appraisal is available for all employed and contracted medical staff.
- Ensure that employed and contracted doctors have access to supporting information for their appraisal.
- Provide training and support in relation to appraisal for both appraisers and appraisees.
- Ensure that doctors who find the process challenging are supported appropriately to avoid the requirement for GMC non-engagement action.
- Ensure that our medical workforce understands the requirements to remain up to date.
- Ensure the employed and contracted doctors continue to have a licence to practise through timely revalidation recommendations.

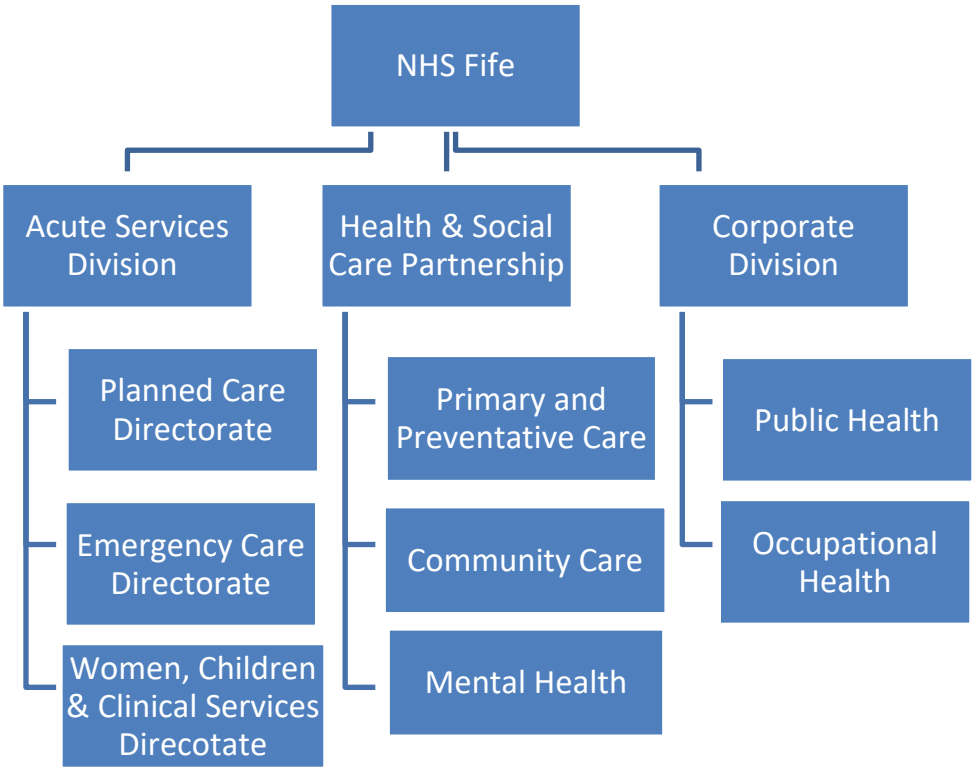
Enablers

We will:

- Adhere to national guidance.
- Update all local appraisal policies and procedures.
- Maintain and ensure NHS Fife data on the Scottish Online Appraisal Resource (SOAR) is kept up to date and any issues are raised regarding the platform.
- Provide support, training and advice in relation to the use of SOAR.
- Actively promote NES appraiser training on a regular basis to encourage and direct potential appraisers to the course.
- Support the Responsible Officer with the revalidation process.
- Provide support, training and advice around the appraisal and revalidation process.
- Develop a delivery plan that will support the delivery of this framework.
- Ensure that MARG meetings are supported by focussed agendas, action plans, monitoring of the appraisal process and any issues that may arise.

5. Scope

This framework applies to all employed doctors (GP's, Consultants, SAS Doctors and Career Grade Doctors) contracted to NHS Fife.



6. Strategic Context

This framework aligns to our strategic priorities:

- To improve health and wellbeing.
- To improve the quality of health and care services.
- To improve staff experience and wellbeing.
- To deliver value and sustainability.

Below are the national documents which influence our approach to medical appraisal and revalidation and the local policies and procedures which align to this Framework.

National Documents

- The Good Medical Practice Framework for Appraisal and Revalidation GMC March 2013.
- Medical Appraisal Guidance Scotland (MAGS) December 2021.
- Preparing for Appraisal for Revalidation Purposes – produced by Short Life Working Group of the Revalidation Delivery Board for Scotland (RDBS), November 2022.
- Medical Profession (Responsible Officers) Regulations 2010(1).
- Medical Profession (Responsible Officers) (Amendment) Regulations 2013(2).

Local policies and procedures

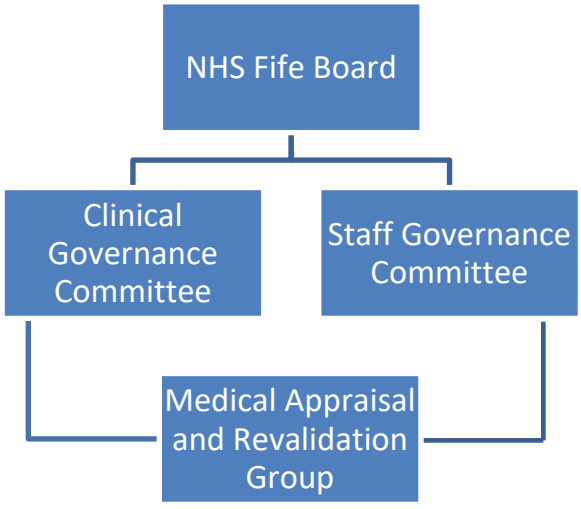
- Medical Appraisal and Revalidation Policy and Procedure 2018.

7. Governance Structures

The Revalidation Delivery Board for Scotland (RDBS) was convened by the Scottish Government to oversee the development and implementation of revalidation. It is the main policy making body for appraisal and revalidation in Scotland. The Board is chaired by the Senior Medical Officer, lead for Medical Revalidation within the Scottish Government and includes a range of stakeholders with an interest in appraisal and revalidation.

An annual review of appraisal and revalidation is commissioned by RDBS on behalf of the Scottish Government produced by NHS Education for Scotland (NES) -Medical Appraisal & Revalidation Quality Assurance (MARQA) Review. The Chief Medical Officer (CMO) requires Medical Directors of NHS Boards to submit an Annual Report outlining the key performance indicators relating to the delivery of appraisal to their NHS Board. Submission of the MARQA report would normally suffice for this purpose.

Medical Appraisal and Revalidation processes in NHS Fife are overseen by the Medical Appraisal and Revalidation Group (MARG). The purpose of the group is to provide NHS Fife's Clinical Governance Committee (CGC) and Staff Governance Committee (SGC) with the assurance that systems/processes are in place, as per NHS Scotland's Guide to Enhanced Appraisal for Medical Revalidation to support annual appraisal of all doctors with a prescribed connection to NHS Fife to take place, thus enabling NHS Fife's Responsible Officer to make revalidation recommendations to the General Medical Council. The Medical Appraisal and Revalidation Annual Report is sent to both the CGC and SGC.



8. Roles and Responsibilities

8.1 Responsible Officer

The Responsible Officer (RO) is the Executive Medical Director for NHS Fife. The RO is tasked with making recommendations for revalidation to the GMC with regard to their Health Board's doctors based on their satisfactory completion of annual appraisals. The RO is also responsible for ensuring that a robust appraisal system is in place within the organisation and that the appraisers who conduct appraisals for revalidation purposes have been appropriately trained.

To avoid conflict of interest and protect the integrity of the system, ROs do not undertake appraisals for doctors for whom they will be required to make a revalidation recommendation.

Similarly, ROs in Scotland are appraised by a trained appraiser who is independently allocated to them by NHS National Services Scotland (NSS).

8.2 NHS Education Scotland (NES)

The Scottish Online Appraisal Resource (SOAR) is a secure online application developed by NES to facilitate the appraisal and revalidation processes. Funded by Scottish Government, SOAR is provided for all doctors connected to a designated body in Scotland. It facilitates safe collection and storage of information for appraisal. It also allows the organisation and tracking of appraisals and the storage of appraisal forms.

To ensure that appraisals are delivered to a uniform high standard across the country, all appraisers must undertake training. In Scotland, this is organised and delivered by NES. Appraisers are also expected to undertake refresher training, approximately every 5 years.

8.3 Appraisal Leads

The RO appoints an Appraisal lead for Secondary Care and Primary Care who oversee the process in their respective areas. They support both doctors and appraisers and are involved in the Appraiser recruitment and training processes for their respective areas.

8.4 Medical Appraisal & Revalidation Coordinator and Primary Care Appraisal Administrator

The Medical Appraisal and Revalidation Coordinator manages the appraisal process on behalf of the RO and Secondary Care Appraisal Lead. They are responsible for overseeing the day-to-day management of the process, making sure all secondary care doctors have access to an appraiser to enable them to complete annual appraisals. They also support both doctors and medical appraisers through the appraisal process, providing information, advice and training as necessary. The Primary Care Appraisal Administrator operates a similar process for appraisal within Primary Care on behalf of the RO and the Primary Care Appraisal Lead (Local Appraisal Advisor for Primary Care).

The Medical Appraisal and Revalidation Coordinator manages the revalidation process for both Primary and Secondary Care providing support to doctors and appraisers as well as ensuring the RO has all relevant information available when making revalidation recommendations.

8.5 Medical Appraisers

In Secondary Care the appraiser is expected to undertake around 10 appraisals and in Primary Care around 18 appraisals per year. The appraiser is responsible for reviewing the doctor's supporting documents, conducting the appraisal interview and completing the appraisal summary.

8.6 Doctors

All doctors are asked to reflect and review the entirety of their practice which should focus in the main on information gathered during the preceding year and provide relevant supporting information to demonstrate that they are continuing to meet the principles and values set out in Good Medical Practice. This will shape discussions with their appraiser.

9. Medical Appraisal

The appraisal is based on the GMCs Good Medical Practice Framework for Appraisal and Revalidation (March 2013) which describes the principles of good medical practice and standards of competence, care and conduct expected of doctors in all aspects of their professional work.

9.1 Appraiser

- To ensure that appraisals are delivered to a high standard all appraisers in Scotland must be approved by the Appraisal Lead and undertake the NES Appraiser Training. The central appraisal team at NES (Medical Appraisal Scotland) has responsibility for training appraisers and the development and maintenance of the Scottish Online Appraisal Resource (SOAR) used to record all appraisals in Scotland.
- The appraiser is responsible for reviewing the doctor's supporting documents, conducting the appraisal interview and completing the appraisal summary (Form 4). The Form 4 forms the evidence reviewed by the RO when making a recommendation.

9.2 Selecting an Appraiser

- Each doctor in NHS Fife is allocated an appraiser by the Medical Appraisal and Revalidation Coordinator or the Primary Care Appraisal Administrator. Should the doctor have reason not to accept the choice of appraiser, a new allocation will be arranged. There is no right of refusal of the second allocated appraiser.
- There is no requirement for an appraiser that is allocated to an appraisee to be from the same clinical discipline.

- Normally an appraiser will be in current practice or within 3 years of retirement.
- To ensure all doctors have an opportunity to experience different appraisals and to provide robust evidence for revalidation, a doctor should have at least 2 different appraisers within any 5-year period. An appraiser should not normally undertake more than 3 appraisals with the same doctor within this period.

9.3 The Appraisal

In preparation for their annual appraisals, doctors must provide supporting information to demonstrate that they are continuing to meet the principles and values set out in Good Medical Practice Framework 2013.

The appraisal:

- should focus on information gathered during the preceding year and the appraisal year is aligned to the financial year, running from 1st April to 31st March.
- uses the GMCs Good Medical Practice Framework (2013) as its focus and consists of 4 domains:
  - Knowledge, skills and performance
  - Safety and quality
  - Communication, partnership and teamwork
  - Maintaining trust
- is an opportunity for doctors to reflect on their clinical and non-clinical practice, the supporting information they have gathered, their health and wellbeing and identify areas they could make improvements, produce a Personal Development Plan (PDP) for the coming year and demonstrate that they are up to date.
- supports revalidation.
- provides assurance to the employing organisation and to the wider public that a doctor is up to date across their whole practice.

SOAR is a secure online application developed by NES to facilitate the appraisal and revalidation processes. Funded by Scottish Government, SOAR is provided for all doctors connected to a designated body in Scotland. It facilitates safe collection and storage of information for appraisal. It also allows the organisation and tracking of appraisals and the storage of Form 4s.

9.4 Supporting Information

Supporting information must include evidence of Continuing Professional Development, Quality Improvement Activity, Significant Events Analysis, review of complaints and compliments. Colleague multi source feedback (MSF) and patient feedback must be discussed at least once in every 5-year cycle as they are a GMC requirement for

Revalidation. Where a doctor does any work out with their designated body, they must include information about this in their appraisal.

- Continuing Professional Development (CPD)
  Doctors must show evidence of CPD for example: courses attended, online modules completed etc. to keep themselves up to date. They should also reflect on if/how the learning has changed their practice. This will often link into their personal development plan (PDP).
- Quality Improvement Activity
  All doctors must demonstrate and reflect upon participation in activities that review and evaluate their work, for example audit, review of performance against national benchmarks, case review etc.
- Significant Adverse Event Review (SAER)
  SAERs are used to analyse incidents where patients experience harm or could have been harmed during their care. The doctor should reflect either on any SAERs they have been involved in (what they have learned/how it has changed their practice), or if they do not have any, they should reflect on the local SAER process or what they have been doing to avoid the risk of an incident.
- Complaints and Compliments
  Doctors should reflect on any formal complaints they have been named in or if not demonstrate an understanding of how the complaints are managed. They can also reflect on any compliments they have received.
- Patient Feedback
  All doctors with patient contact are required to gather patient feedback. Any exemptions must be agreed by the RO. Forms and analysis are provided by the Medical Appraisal and Revalidation Team.
- Colleague Multi-Source Feedback (MSF)
  To support revalidation all doctors are required to gather MSF. This should be used as a learning and development tool to identify strengths and areas for improvement in a doctor's practice, to inform continuing professional development. NES provide a platform through SOAR to obtain MSF.

10. Revalidation

As outlined earlier, revalidation is the process by which doctors demonstrate to the General Medical Council (GMC) and reassure patients and employers that they are up to date and fit to practise.

- Revalidation has been a legal requirement in UK since 2012
- It provides assurance that a doctor is up to date and fit to practise.
- Doctors are required to revalidate every 5 years.
- The doctor is notified directly of their revalidation due date by the GMC.

- The RO must make a recommendation to the GMC based on a doctor's appraisals over a 5-year period.

10.1 Making a Recommendation

Below is the process undertaken to allow the RO to make a recommendation:

- The RO is advised by the Medical Appraisal and Revalidation Coordinator a month in advance which doctors are due to revalidate.
- The coordinator checks that the doctors have the relevant evidence included in their appraisals that is required for revalidation and advises of any potential issues.
- The RO reviews the Form 4s.
- The RO makes his recommendation to the GMC.
- The RO can make one of 3 recommendations:
    - Recommendation to revalidate.
    - Recommendation to defer (up to 1 year, usually due to insufficient evidence)
    - Recommendation of non-engagement (if a doctor has not been fully participating in the process).
- On the basis of the ROs recommendation, the GMC will decide whether the doctor's licence to practise should continue to be revalidated for a further 5 years.

11. References

- The Good Medical Practice Framework for Appraisal and Revalidation GMC March 2013.
- Medical Appraisal Guidance Scotland (MAGS) December 2021.
- Preparing for Appraisal for Revalidation Purposes – produced by Short Life Working Group of the Revalidation Delivery Board for Scotland (RDBS), November 2022.
- Medical Profession (Responsible Officers) Regulations 2010(1).
- Medical Profession (Responsible Officers) (Amendment) Regulations 2013(2).
- NHS Fife Medical Appraisal and Revalidation Policy and Procedure 2018.

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**12 January 2024**
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 October, although there are some measures with a significant time lag.

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 have been devised for 2023/24.

The Clinical Governance aspects of the report cover Adverse Events, HSMR, Falls, Pressure Ulcers, HAI and Complaints. A summary of the status of these is shown in the table below.

Measure	Update	Local/National Target	Current Status
Adverse Events [1]	Monthly	50%	Not achieving
HSMR	Quarterly	1.00 (Scotland average)	Below Scottish average
Falls [2]	Monthly	6.95 per 1,000 TOBD	Not 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	Not achieving
C Diff (HAI/HCAI)	Monthly	6.5 per 100,000 TOBD	Achieving
Complaints (S1)	Monthly	80%	Not achieving
Complaints (S2) [3]	Monthly	33%	Not achieving

[1] Reporting on the closure rate of actions from Major & Extreme Adverse Events started in December 2022

[2] As part of ongoing improvement work, revised targets for Falls and Pressure Ulcers have been set for FY 2023/24. These are a 15% reduction on the FY 2021/22 target for Falls, and a 20% reduction on the actual achievement in FY 2022/23 for Pressure Ulcers.

[3] An improvement target of 50% by March 2023, rising to 65% by March 2024 was agreed by the Director of Nursing. However, performance has been very much lower than the 50% provisional target, generally due to closing long-term complaints. A further measure (Stage 2 Complaints Raised in Month and Closed Within 20 Working Days) has been added.

2.3.1 Quality/ Patient Care

IPQR contains quality measures.

2.3.2 Workforce

IPQR contains workforce measures.

2.3.3 Financial

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

2.3.4 Risk Assessment/Management

A mapping of key Corporate Risks to measures within the IPQR is provided via a Risk Summary Table and the Executive Summary narratives.

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

Not applicable.

2.3.6 Climate Emergency & Sustainability Impact

Not applicable.

2.3.7 Communication, involvement, engagement and consultation

The NHS Fife Board Members and existing Standing Committees are aware of the approach to the production of the IPQR and the performance framework in which it resides.

The Clinical Governance extract of the Position at November IPQR will be available for discussion at the meeting on 12 January.

2.3.8 Route to the Meeting

The IPQR was ratified by EDG on 4 January 2024 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 & Quality Performance Report

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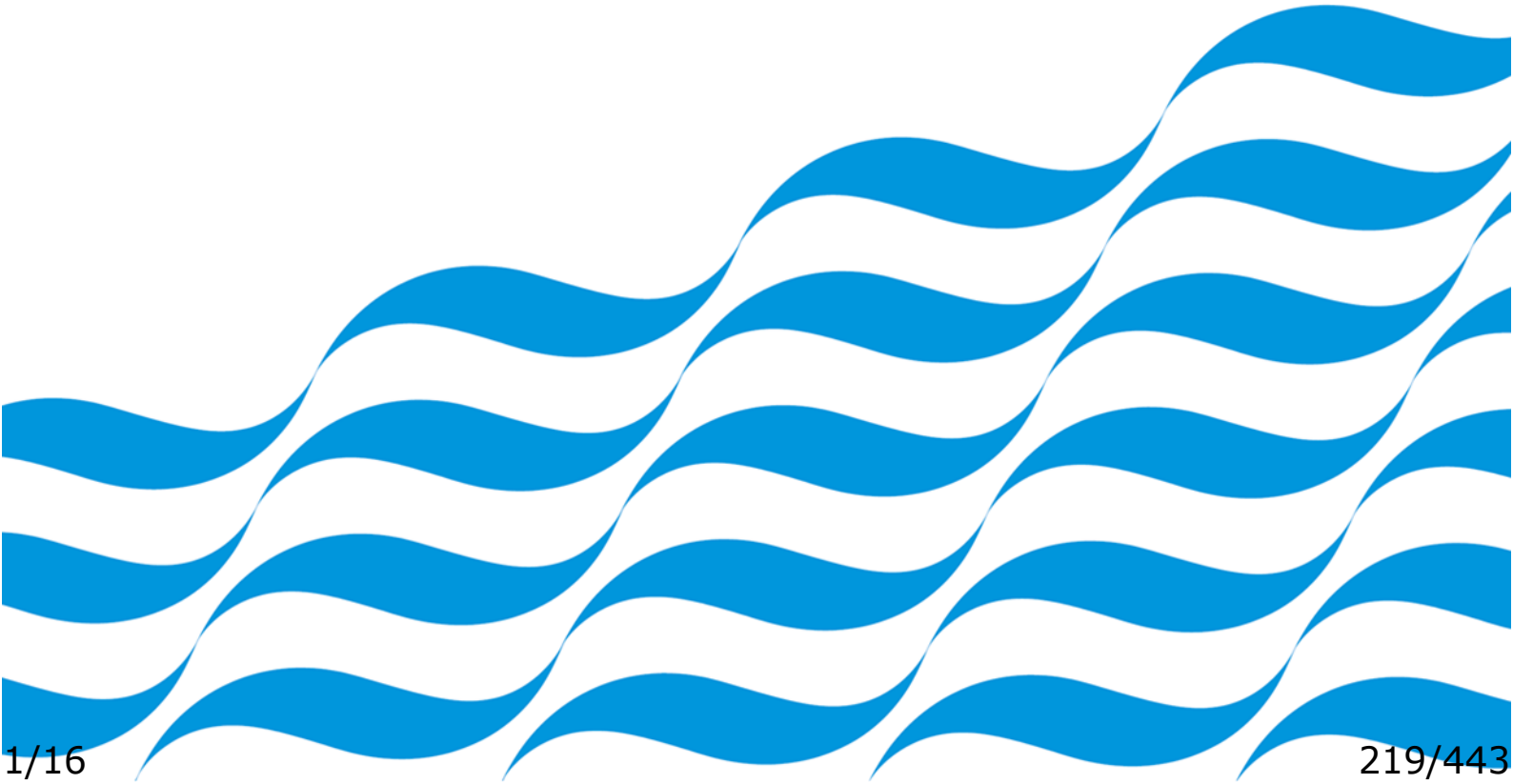
Fife Integrated Performance & Quality Report

CLINICAL GOVERNANCE

Position at November 2023
Produced in December 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
03 January 2024

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	6	5	1	-	-	◀ ▶	Moderate
To improve staff experience and wellbeing	2	2	-	-	-	◀ ▶	Moderate
To deliver value and sustainability	6	4	2	-	-	◀ ▶	Moderate
Total	19	13	6	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
On 28/11/23, the Board approved the addition to the Corporate Risk Register of the corporate risk associated with: **Preparation for the Implementation of the Health and Care (Staffing) (Scotland) Act 2019**
This risk is assessed as Moderate level.
It is mapped to Strategic Priority 'To improve the quality of health and care services' and will be reported for assurance purposes to the Staff Governance Committee.

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

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

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

b. Indicator Summary

Section	Indicator	Target 2023/24 2023/24 TBC		Reporting Period	Current Period	Current Performance	SPC Outlier	Vs Previous	Vs Year Previous	Benchmarking	
Clinical Governance	Major/Extreme Adverse Events - Number Reported	N/A	-	Month	Oct-23	63	○	▼	▼	●	
	Major/Extreme Adverse Events - % Actions Closed on Time	50%		Month	Oct-23	25.5%	●	▼	▼	●	
	HSMR	N/A	-	Year Ending	Jun-23	0.96	●	—	—	●	
	Inpatient Falls	6.95	(L)	Month	Oct-23	7.36	○	▼	▲	●	
	Inpatient Falls with Harm	1.44	(L)	Month	Oct-23	1.88	○	▼	▲	●	
	Pressure Ulcers	0.89	(L)	Month	Oct-23	1.44	○	▼	▼	●	
	SAB - HAI/HCAI	18.8	(N)	Month	Oct-23	12.8	○	▼	▼	●	QE Jun-23
	C Diff - HAI/HCAI	6.5	(N)	Month	Oct-23	3.2	○	▲	▲	●	QE Jun-23
	ECB - HAI/HCAI	33.0	(N)	Month	Oct-23	44.6	○	▼	▼	●	QE Jun-23
	S1 Complaints Closed in Month on Time	80%		Month	Oct-23	54.8%	●	◀▶	▼	●	2021/22
	S2 Complaints Closed in Month on Time	33%		Month	Oct-23	24.0%	○	▲	▲	●	2021/22
	S2 Complaints Due in Month and Closed On Time	N/A	-	Month	Oct-23	20.0%	●	▲	▲	●	
Operational Performance	IVF Treatment Waiting Times	90%		Month	Sep-23	100.0%	●	◀▶	◀▶	●	
	4-Hour Emergency Access (A&E)	95%	(N)	Month	Nov-23	74.1%	○	◀▶	▲	●	Oct-23
	4-Hour Emergency Access (ED)	82.5%	(L)	Month	Nov-23	66.6%	●	▼	▲	●	Oct-23
	Patient TTG % <= 12 Weeks	100%		Month	Oct-23	40.5%	●	▲	▼	●	Sep-23
	New Outpatients % <= 12 Weeks	95%		Month	Oct-23	42.7%	●	▼	▼	●	Sep-23
	Diagnostics % <= 6 Weeks	100%		Month	Oct-23	50.0%	●	▲	▼	●	Sep-23
	Cancer 31-Day DTT	95%		Month	Oct-23	91.8%	○	▼	▼	●	QE Jun-23
	Cancer 62-Day RTT	95%		Month	Oct-23	86.6%	○	▲	▲	●	QE Jun-23
	Detect Cancer Early	29%		Year Ending	Dec-22	27.6%	●	▼	▲	●	2020, 2021
	Freedom of Information Requests	85%		Month	Nov-23	97.1%	●	▲	▲	●	
	Delayed Discharge % Bed Days Lost (All)	N/A	-	Month	Nov-23	11.9%	●	▼	▲	●	Oct-23
	Delayed Discharge % Bed Days Lost (Standard)	5%		Month	Nov-23	7.5%	○	▼	▲	●	Oct-23
	Antenatal Access	80%		Quarter	Sep-23	92.1%	●	▼	▼	●	CY 2022
Finance	Revenue Resource Limit Performance	(£23m)	-	Month	Nov-23	(£19.414m)	●	—	—	●	
	Capital Resource Limit Performance	£12.077m	-	Month	Nov-23	£5.010m	●	—	—	●	
Staff Governance	Sickness Absence	4.00%		Month	Oct-23	7.39%	○	▼	▼	●	YE Jun-23
	Personal Development Plan & Review (PDPR)	80%	(L)	Month	Nov-23	42.6%	●	▲	▲	●	
	Vacancies - Medical & Dental	N/A		Quarter	Sep-23	9.4%	●	▲	▼	●	
	Vacancies - Nursing & Midwifery	N/A		Quarter	Sep-23	6.5%	●	▲	▼	●	
	Vacancies - AHPs	N/A		Quarter	Sep-23	8.0%	●	▲	▲	●	
Public Health & Wellbeing	Smoking Cessation (FY 2023/24)	473	(N)	YTD	Jul-23	61	●	—	—	●	YT Mar-23
	CAMHS Waiting Times	90%		Month	Oct-23	74.3%	○	▲	▼	●	QE Jun-23
	Psychological Therapies Waiting Times	90%		Month	Oct-23	66.8%	○	▼	▼	●	QE Jun-23
	Drugs & Alcohol Waiting Times	90%		Month	Sep-23	89.3%	●	▲	▼	●	QE Jun-23
	Flu Vaccination (Winter, Age 65+)	85%		Month	Nov-23	66.6%	●	▲	—	●	
	COVID Vaccination (Winter, Age 65+)	85%		Month	Nov-23	65.7%	●	▲	—	●	
	Immunisation: 6-in-1 at Age 12 Months	95%		Quarter	Jun-23	93.8%	○	▲	▼	●	QE Jun-23
	Immunisation: MMR2 at 5 Years	92%		Quarter	Jun-23	89.8%	○	▲	▼	●	QE Jun-23

Performance Key

- on schedule to meet Standard/Delivery trajectory
- behind (but within 5% of) the Standard/Delivery trajectory
- more than 5% behind the Standard/Delivery trajectory

SPC Key

- ○ Within control limits
- ○ Special cause variation, out with control limits
- ● No SPC applied

Change Key

- ▲ "Better" than comparator period
- ◀▶ No Change
- ▼ "Worse" than comparator period
- — Not Applicable

Benchmarking Key

- ● Upper Quartile
- ● Mid Range
- ● Lower Quartile
- ● Not Available

c. Projected & Actual Activity and Long Waits

Better than Projected | Worse than Projected
Better/Worse may be higher or lower, depending on context

		Month End			Quarter End	Month End			Quarter End	Quarter End
		Jul-23	Aug-23	Sep-23	Sep-23	Oct-23	Nov-23	Dec-23	Dec-23	Mar-24
ED 4-hour Performance (VHK only)	Projected	71.8%	73.1%	74.6%		75.8%	77.0%	78.5%		
	Actual	69.0%	72.2%	65.1%		66.8%	70.1%			
	Variance	-2.8%	-0.9%	-9.5%		-9.0%	-6.9%			
Elective Activity Diagnostics	Projected	5,121	5,121	5,121	15,363	5,121	5,121	5,121	15,363	15,363
	Actual	5,048	5,422	5,118	15,588	5,412				
	Variance	-73	301	-3	225	291				
Elective Activity New Outpatients	Projected	7,565	7,340	7,432	22,337	7,421	7,432	7,421	22,274	22,308
	Actual	6,414	7,942	7,224	21,580	7,090				
	Variance	-1,151	602	-208	-757	-331				
Elective Activity TTG	Projected	1,144	1,144	1,145	3,433	1,162	1,162	1,163	3,487	3,492
	Actual	918	1,294	1,077	3,289	1,109				
	Variance	-226	150	-68	-144	-53				
Long Waits Diagnostics > 26 weeks	Projected	94	79	63	63	42	26	10	10	0
	Actual	152	165	165	165	160				
	Variance	58	86	102	102	118				
Long Waits New Outpatients > 104 weeks	Projected	0	0	74	74	120	166	212	212	352
	Actual	1	2	2	2	2				
	Variance	1	2	-72	-72	-118				
Long Waits New Outpatients > 78 weeks	Projected	213	276	339	339	509	679	849	849	1358
	Actual	117	186	255	255	301				
	Variance	-96	-90	-84	-84	-208				
Long Waits TTG > 104 weeks	Projected	21	43	67	67	102	136	173	173	351
	Actual	20	20	17	17	25				
	Variance	-1	-23	-50	-50	-77				
Long Waits TTG > 78 weeks	Projected	203	258	305	305	388	465	547	547	893
	Actual	99	127	133	133	154				
	Variance	-104	-131	-172	-172	-234				
Arthroplasty 4 joint sessions	Projected				25.0%				25.0%	25.0%
	Actual	17.0%	14.0%							
	Variance									
Same Day Procedures Knee Arthroplasty	Projected				1.9%				1.9%	1.9%
	Actual									
	Variance									
Same Day Procedures Hip Arthroplasty	Projected				4.3%				4.3%	4.3%
	Actual									
	Variance									
Cancer Waiting Times 31-Day	Projected				94.1%				94.3%	94.5%
	Actual	94.7%	90.6%							
	Variance									
Cancer Waiting Times 62-Day	Projected				82.8%				85.0%	85.4%
	Actual	77.9%	77.1%							
	Variance									
CAMHS 18 Weeks RTT	Projected	85.0%	85.0%	70.0%		70.0%	70.0%	60.0%		
	Actual	71.0%	66.5%	68.4%		67.9%				
	Variance	-14.0%	-18.5%	-1.6%		-2.1%				
CAMHS Waiting List <= 18 weeks	Projected	230	218	228	228	232	257	235	235	200
	Actual	201	179	197	197	184				
	Variance	-29	-39	-31	-31	-48				
CAMHS Waiting List > 18 weeks	Projected	113	133	98	98	77	86	42	42	0
	Actual	82	90	91	91	87				
	Variance	-31	-43	-7	-7	10				
Psychological Therapies 18 Weeks RTT	Projected	65.2%	65.1%	73.5%		69.3%	68.2%	71.0%		
	Actual	53.4%	54.3%	54.8%		54.3%				
	Variance	-11.8%	-10.8%	-18.7%		-15.0%				
Psychological Therapies Waiting List <= 18 weeks	Projected	888	888	888	888	888	888	888	888	888
	Actual	1408	1497	1480	1480	1404				
	Variance	520	609	592	592	516				
Psychological Therapies Waiting List > 18 weeks	Projected	1625	1591	1569	1569	1609	1596	1680	1680	1604
	Actual	1227	1260	1219	1219	1184				
	Variance	-398	-331	-350	-350	-425				
Psychological Therapies Waiting List > 52 weeks	Projected	201	183	165	165	147	129	111	111	57
	Actual	262	262	251	251	278				
	Variance	61	79	86	86	131				

d. Assessment

CLINICAL GOVERNANCE

To improve the quality of health and care services

6

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Moderate

		Target	Current
Major & Extreme Adverse Events	*50% of Action from Major and Extreme Adverse Events to be closed within time*	**50%**	**25.5%**

There were 12 actions relating to LAER/SAER closed on time in October 2023, from a total of 47, which equates to a performance of 25.5%: a decrease on the 29.5% seen in September, a continuation of the downward trend seen since July and the lowest since January 2023.

There were 62 Major/Extreme adverse events reported in October out of a total of 1,475 incidents.

64.7% of all incidents were reported as 'no harm'. Over the past 12 months, Pressure Ulcer developing on ward has been the most reported Major/Extreme incident followed by Cardiac Arrest.

On average, 48.6 actions have been closed per month in 2023 compared to 37.7 over the same period in 2022.

There was a total of 376 actions open at the end of October, with 104 (27.7%) being within time.

Service Narrative

Focus improvement work continues on closure of actions on time to meet target of 50% by March 2024. To address some of the barriers to closure of actions on time (action owners having left NHS Fife or moved role) a new security group within Datix has been created which allows senior leaders across the directorates to have oversight of all open actions assigned within their services. A bi-monthly report of all open actions will be shared with this senior leadership group with the first being circulated in October 2023. Staff Support following an adverse event pathway launched in 3 pilot areas (ED, Labour areas and AU1) on 1st November 2023. Three education sessions were provided and were well attended for the 3 areas to support implementation of the pathway. The pilot will run for 3 months and, following a period of evaluation, will be rolled out across the organisation in spring 2024.

HSMR		**1.00**	**0.96**

Data for 2022 and 2023 demonstrates a return to a typical ratio for NHS Fife, with the data for year ending June 2023 showing a ratio below the Scottish average

Inpatient Falls	*Reduce **All Falls** (inpatient) rate by 15% in FY 2023/24 compared to baseline (YE Sep-21)*	**6.95**	**7.36**
	*Reduce **Falls with Harm** (inpatient) rate by 10% in FY 2023/24 compared to baseline (YE Sep-21)*	**1.44**	**1.88**

The number of inpatient falls in total was 219 in October 2023, up from 200 the month prior. This equates to a rate of 7.36 falls per 1,000 Occupied Bed Days (OBD). Performance is therefore outwith the target range of < 6.95 though remains within control limits and is on par with the 24-month average.

The number of falls within Acute Services was 113 in October. Though similar in numbers to September, this actually equates to a lower rate of 7.88 per 1,000 OBD (compared to 8.57 in September).

The number of falls within HSCP increased by 20% to 106 in October, though the rate only increased by 13% to 6.87 per 1,000 OBD (compared to 6.08 in September).

The majority of falls in the last 3 months (76.6%) were classified as 'No Harm' whilst 18.3% were classified as 'Minor Harm' and <3% were classified as 'Moderate Harm'. Falls classified as 'Major/Extreme Harm' accounted for 2.5% of the totals falls (compared to 1.4% in the preceding 3 months).

Service Narrative

As the data shows, there has been an increase in Falls and Falls with Harm during September and October particularly. This was identified at the recent Acute Services Division Clinical Governance Committee by Emergency Care Directorate, who reported a significant increase in all Falls over the last two months. Four incidents were categorised as major harm and will be subject to review for learning & improvement.

		Target	Current
Pressure Ulcers	*Reduce pressure ulcer rate by 20% in FY 2023/24 compared to the rate in FY 2022/23*	**0.89**	**1.48**

The total number of pressure ulcers in October 2023 was 44, the highest number recorded since Apr 2019. This equates to a rate of 1.48 per 1,000 Occupied Bed Days (OBD) which is the highest rate since Nov 2022. Performance is therefore outwith the target range of < 0.89 though it remains within control limits.

The number of pressure ulcers in Acute Services was 35 in October, an increase of 15 on the previous month (24-month average is 24 and rate is 2.44).

The number of pressure ulcers in HSCP was 9 in October, an increase of 6 on the previous month (24-month average is 7 and rate is 0.58).

Most pressure ulcers continue to be in Acute Services with 74 recorded between Aug-Oct 2023 compared with 15 in HSCP.

Service Narrative

The increase in October in PU's in both ASD and HSCP settings is disappointing. A review of monthly audit of SSKIN bundle compliance in HSCP inpatient areas continues and targeted work is ongoing in the areas identified with increased incidence. ASD and Fife HSCP Tissue Viability Services hosted a Link Practitioners Networking Day on the 17th November, National Stop the Pressure Day. This is the first of a series of planned events to raise awareness and educate staff on prevention of pressure damage. Early data from the Quality Improvement project work in the Community Nursing service indicates improvement in PU incidence in the local area the ToC is targeting and planning is in place to scale up in other areas. The ASD TV team continue to display pressure ulcer data within clinical areas, highlighting areas of concern and supporting mitigations to reduce incidence. The joint Acute/HSCP Tissue Viability steering group, chaired by Director of Nursing, a forum to review all current QI work and implementation of shared learning will also support the improvement of PU incidence. Challenges: The HoN vacancies in both ASD and HSCP delayed the target completion date of Aug 23 for Key deliverable 'Review of services and options for new service design'. A new HoN is in post in ASD and a date has been agreed for the new HSCP HoN to take up post. A new target completion date will be imminently agreed and included in the next return.

SAB (MRSA/MSSA)	*We will reduce the rate of HAI/HCAI by 10% between March 2019 and March 2024*	**18.8**	**12.8**

The SAB infection rate increased from 3.5 in September 2023 to 12.8 in October, this is +3.2 on the same month in 2022.

Of the 48 HAI/HCAI reported in the last 12 months, 9 have been categorised as ‘VAD’; 11 have been categorised as ‘Other’ or ‘Not Known’ and 9 have been categorised as 'Device Other Than VAD'.

Service Narrative

Q2 2023 Quarterly Report showed Fife (14.6 per 100,000) was below the national rate (18.3 per 100,000 bed days) for healthcare associated cases. Considering Q3 2023; there was a reduction in the number of HCAI cases (8 cases in total), compared to during Q2 2023 (13 cases). We are currently awaiting the Q3 2023 National Report for comparison.

The cumulative number of HCAI SAB cases, Jan-Oct 23 (n=41) is lower than during the same time period the previous year (Jan-Oct 22, n=43). There have been 8 dialysis line related SABs during Jan-Oct 23. Renal services carried out a CCR of each case (Jan-Apr) and the findings were discussed at a `Super SAER` meeting on 26th June 2023. The most recent case (August 2023) has been Datix`d by the Consultant Microbiologist.

C Diff	*We will reduce the rate of HAI/HCAI by 10% between March 2019 and March 2024*	**6.5**	**3.2**

The C Diff infection rate decreased to 3.2 in October. There was 1 infection reported in October 2023, 1 HAI/HCAI/Unknown.

This is the lowest figure since October 2022.

The most recent quarterly HAI report from Health Protection Scotland, covering the quarter ending June 2023, showed that NHS Fife was above the Scottish average of 16.1 at 18.0 putting it in in the lower-range of all Mainland Health Boards.

Service Narrative

Q2 2023 quarterly report showed Fife (18.0 per 100, 000 TOBDs) was slightly above the national rate (16.1per 100, 000 TOBDs) for healthcare associated cases. However, looking at Q3 CDI cases, there was a significantly lower number of HCAI cases (4 cases in total), compared to during Q2 2023 (16 cases in total). Currently awaiting National Report for board comparison.

For noting, the cumulative total of HCAI CDIs (Jan-Oct 2023) is higher than during the same time period in 2022 and 2021.

		Target	Current
ECB	*We will reduce the rate of HAI/HCAI by 25% between March 2019 and March 2024*	**33.0**	**44.6**

The number of HCAI infections increased from 5 in Septembe2 2023 to 14 in October and the rate of infection increased from 17.4 to 44.6 HAI/HCAI per 100,000 Occupied Bed Days (OBD).

Urinary Catheter related infections have been responsible for 27 of the 107 infections in the last year (25.2%) and remains a key focus for improvement work although the 'Not Known' category accounts for 25 infections (23.4%).

The most recent quarterly HAI report from Health Protection Scotland, covering the quarter ending June 2023, showed that NHS Fife (with a quarterly infection rate of 29.3)

Service Narrative

Q2 2023 quarterly report showed Fife (29.3 per 100,000 TOBDs) was lower than the national rate (37.6 per 100,000 TOBDs) for healthcare associated cases. However, looking at Q3 ECB cases, there was a slightly higher number of HCAI cases (n=28), compared to during Q2 2023 (n=26). We are currently awaiting the National Report for comparison.

For noting, the cumulative total of HCAI cases, Jan-Oct 23, was lower than during the same time period the previous 2 years. The majority of ECB infections occur in the community, and hepatobiliary and renal are the most common sources of infection. The number of CAUTI related ECBs have reduced over the past couple of years and, so far, for 2023, the trend is continuing.

Complaints – Stage 2	*At least 33% of Stage 2 complaints will be completed within 20 working days by March 2024*	**33%**	**24.0%**

There were 26 stage 2 complaints received in October, with 92.3% acknowledged within timescales, with 25 closed. Of those closed 24.0% were within timescales, the highest figure since April 2023.

With 12 greater than 40 days after due date, 7 of which were closed greater than 80 days after due date.

30 complaints were due to be closed in the month, 6 (20.0%) of which were closed on time.

64.2% of live complaints have been open for more than 40 days with 38.5% open for more than 80 days.

27.5% of live complaints are awaiting statements with 24.8% awaiting approval of final response.

Service Narrative

The Patient Experience Team (PET) is working with a Senior Project Manager (SPM) to assist with quality improvements and develop a project plan. 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. The Senior Project Manager is also assisting with analysing this data, and a further MSForm questionnaire will be sent to the PET to understand their challenges.

The new complexity scoring categorisation has been applied to every Stage 2 complaint, providing insight into the volume of complex complaints that NHS Fife receives and handles. The complexity categorisation has changed from complex and non-complex to negligible, minor, moderate, major and extreme. At the end of October 2023, 1 negligible, 15 minor, 57 moderate, 33 major, and 3 extreme stage 2 complaints were open.

Digital and information have created a PET Dashboard, which will be launched in November 2023. This dashboard will provide up-to-date data regarding open enquiries, concerns, and Stage 1 and 2 complaints.

A standard operating procedure (SOP) for " complaints escalation " is being drafted but has yet to progress further due to challenges within the PET team. This SOP will highlight and support processing complaints within the agreed national timescales, in line with the model complaint handling procedure.

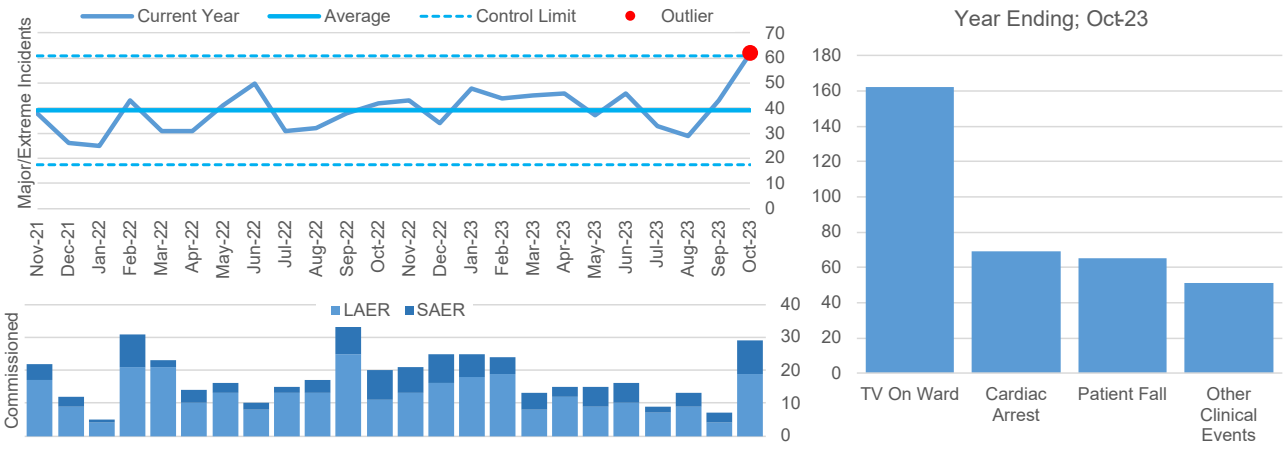
A new Patient Experience Team intranet page was launched on Blink. It provides information and guidance about the complaint-handling process, including links to education, training, and support.

The Navigator's post has been extended six months from within the existing funded establishment. The post supports data collection, chasing and tracking complaints, and providing administration and organisational support to the PET Officers. The 0.29 WTE Administration post and 1.0 WTE Band 6 PET Officer posts have been recruited.

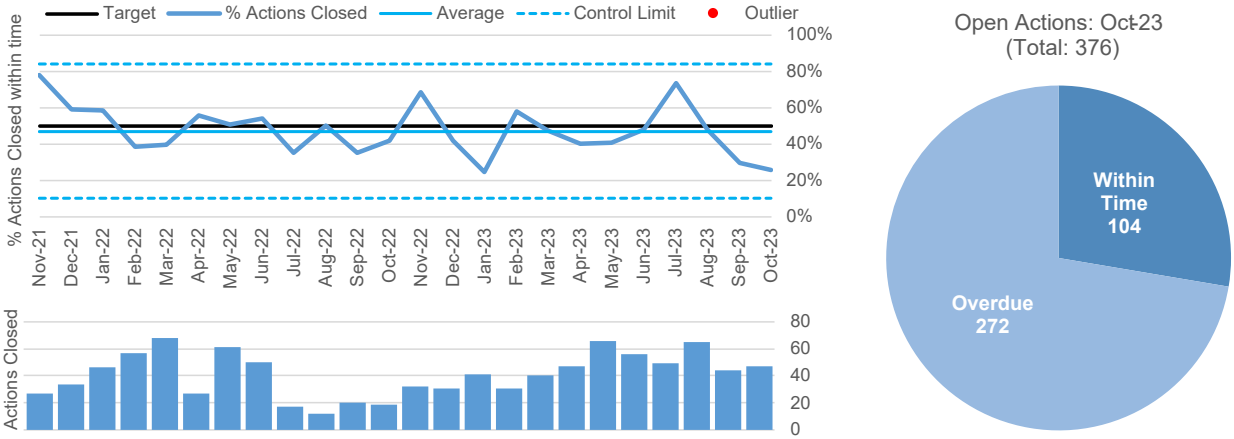
The number of live Stage 2 complaints increased slightly from 107 in August 2023 to 111 at the end of October 2023. This demonstrates that challenges continue to be faced in clearing the backlog of complaints. There were 8 stage 2's over 200 days and 1 over 300 days in August 2023; at the end of October, there was 1 complaint at 330 days and 8 over 200 days. Of the 9, 8 were out for final comment/approval with the services, and 1 required action from the Patient Experience Team. Delays remain with obtaining statements and approval of final responses. At the end of October 2023, 65.76% of all live complaints were awaiting statements or final approval by the Divisions, an improvement from 85% in August 2023. The Patient Experience Team have had significant absences, and there is a backlog of stage 2 complaints to be drafted 26 (23%).

e. Performance Exception Reports

Adverse Events	Number 62



Actions from Significant and Local Adverse Event Reviews	Closure Rate 25.5%



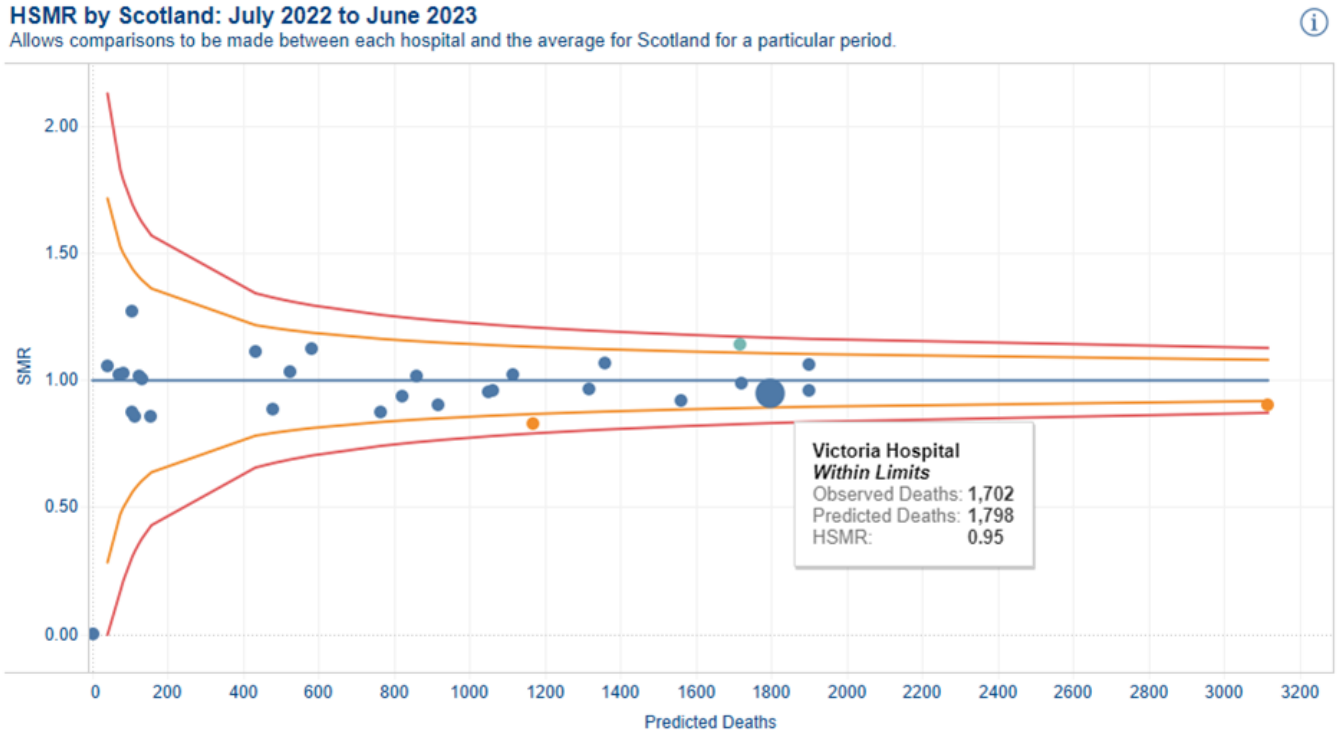
Key Deliverable	End Date
Off track / At risk / On track / Complete / Suspended	Proposed
Delivery of Clinical Governance Strategic Framework - Adverse Events	Mar-24
Key Milestones: Publication of updated Adverse Events Policy	Apr-23
Key Milestones: Adverse Events Management Resource Pack uploaded to Blink	Dec-23
Key Milestones: Deliver bespoke training session, where requested, to complement the e-learning package for review teams	Aug-23
Key Milestones: Facilitate short life working group to identify changes required to Datix action module	Mar-24
Key Milestones: 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
Key Milestones: 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: July 2022 to June 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 2022 and 2023 demonstrates a return to a typical ratio for NHS Fife, with the data for year ending June 2023 showing a ratio below the Scottish average

Inpatient Falls

All Falls

Reduce All Falls rate across Acute & HSCP by 15% Target Rate (by end March 2024) = 6.95 per 1,000 Occupied Bed Days (OBD)

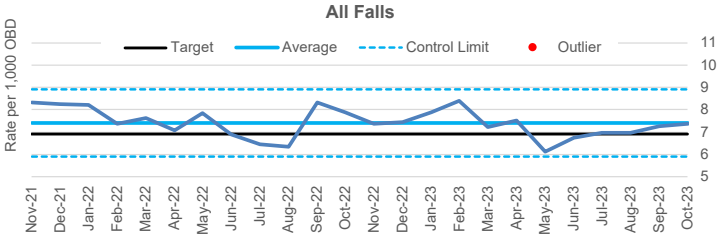
Performance 7.36

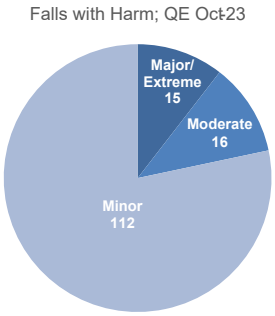
Falls with Harm

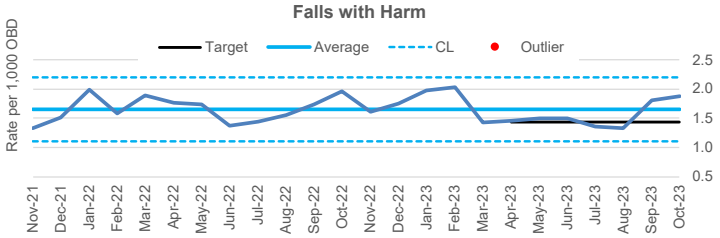
Reduce Falls with Harm rate across Acute & HSCP by 10% Target Rate (by end March 2024) = 1.44 per 1,000 Occupied Bed Days (OBD)

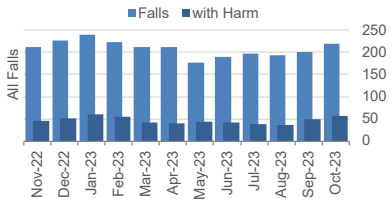
Performance 1.88

Local Performance









All Falls Performance by Service Area

	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
NHS Fife	7.37	7.44	7.88	8.39	7.24	7.50	6.12	6.75	6.99	6.97	7.26	7.36
Acute	8.21	7.20	8.22	9.73	6.52	8.90	5.70	6.76	6.25	7.59	8.57	7.88
HSCP	6.64	7.65	7.58	7.28	7.82	6.33	6.48	6.89	7.68	6.62	6.08	6.87

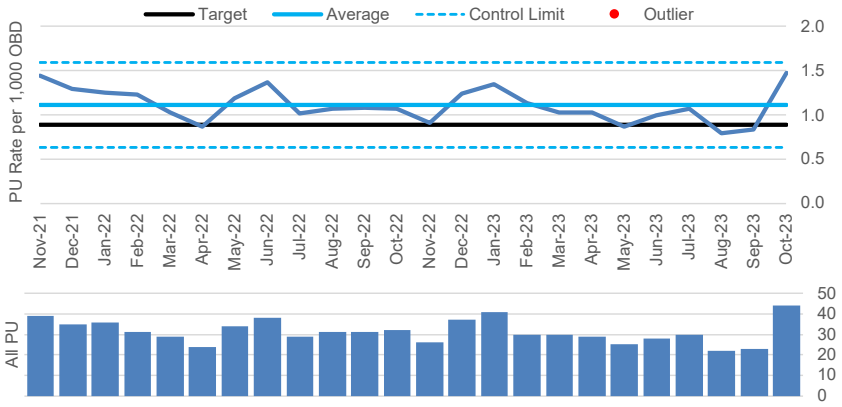
Key Deliverable		End Date
Off track / At risk / On track / Complete / Suspended		Proposed
Reduce Falls across all hospital inpatient setting		**Mar-24**
Key Milestones	Review and confirm falls link practitioners for each ward area on every hospital site.	Mar-24
	Ensure that falls related data is discussed and displayed in the ward to strengthen awareness across multi-disciplinary team.	Mar-24
	Rollout revised Falls toolkit including related policies e.g.: Boarding, Supervision, Bed rail.	Feb-24
	Support shared learning from incidents and share good practice	Dec-23
	Align all NHS work with the newly updated SPSP National Inpatient Falls driver diagrams	Feb-24
	Develop a national Falls education module within TURAS system	Mar-24
	Rollout new patient information leaflet and endeavour to audit the impact and benefit for patients	Feb-24
	Consider a Falls Co-ordinator Role to support the rollout of the revised toolkit and the Link Practitioners	Mar-24

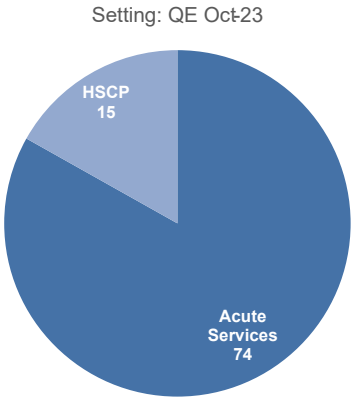
Pressure Ulcers

Reduce pressure ulcers (grades 2 to 4) developed in a healthcare setting
Target Rate (by end March 2024) = 0.89 per 1,000 OBD

Performance 1.48

Local Performance





Performance by Service Area

	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
NHS Fife	0.91	1.24	1.35	1.13	1.02	1.03	0.87	1.00	1.07	0.80	0.83	1.48
Acute	1.28	2.29	2.39	2.33	1.82	1.48	1.44	1.43	1.95	1.53	1.53	2.44
HSCP	0.59	0.32	0.44	0.14	0.37	0.65	0.38	0.66	0.39	0.20	0.21	0.58

Key Deliverable		End Date
Off track / At risk / On track / Complete / Suspended		Proposed
Reduce Pressure Ulcers (PU) developed on case load across all health care settings		**Mar-24**
Key Milestones	Acute TVNT - Provide training to over 1000 staff	Mar-24
	Acute TVNT - Re-launch the service (updating service spec, training resources, TVN link programme)	Jul-23
	Embed the use of the CAIR resource	Mar-24
	Embed the revised HIS Pressure Ulcer Standards (October 2020)	Mar-24
	Review of services and options for new service design	Mar-24

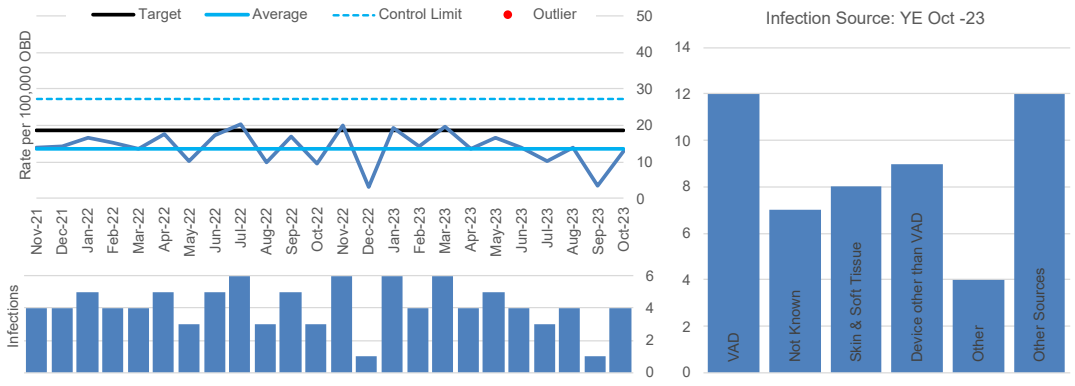
HAI/HCAI

SAB

Reduce Hospital Infection Rate by 10% (baseline 2018/19) by the end of 2022/23

Performance 12.8

Local Performance



National Benchmarking

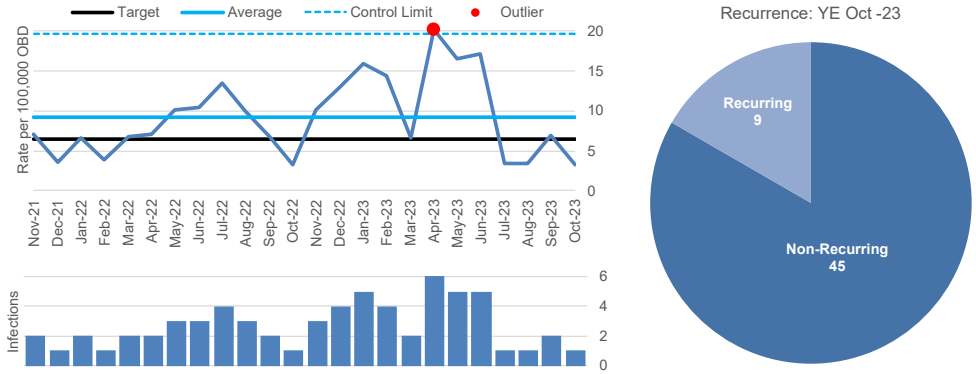
Quarter Ending	2020/21	2021/22				2022/23				2023/24
	Mar	Jun	Sep	Dec	Mar	Jun	Sep	Dec	Mar	Jun
NHS Fife	17.8	6.3	16.6	12.7	15.2	14.9	15.7	10.9	17.9	14.6
Scotland	18.4	18.6	18.3	17.3	16.3	17.3	17.1	19.2	19.1	18.3

C Diff

Reduce Hospital Infection Rate by 10% (baseline 2018/19) by the end of 2022/23

Performance 3.2

Local Performance



National Benchmarking

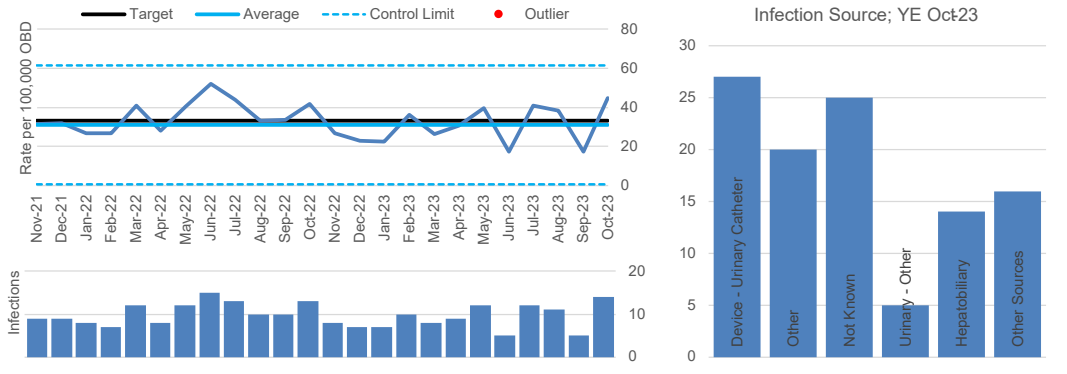
Quarter Ending	2020/21	2021/22				2022/23				
	Mar	Jun	Sep	Dec	Mar	Jun	Sep	Dec	Mar	Jun
NHS Fife	14.0	10.0	9.5	4.6	7.0	9.2	10.1	8.7	13.4	18
Scotland	15.8	14.6	16.8	13.3	12.6	14.3	13.1	13.6	13.4	16.1

ECB

Reduce Hospital Infection Rate by 25% (baseline 2018/19) by the end of 2022/23

Performance 44.6

Local Performance



National Benchmarking

Quarter Ending	2020/21	2021/22				2022/23				2023/24
	Mar	Jun	Sep	Dec	Mar	Jun	Sep	Dec	Mar	Jun
NHS Fife	21.6	37.6	60.3	33.6	31.6	40.2	36.9	30.4	27.9	29.3
Scotland	34.7	38.2	41.5	34.1	30.5	34.8	36.2	34.5	37.3	37.6

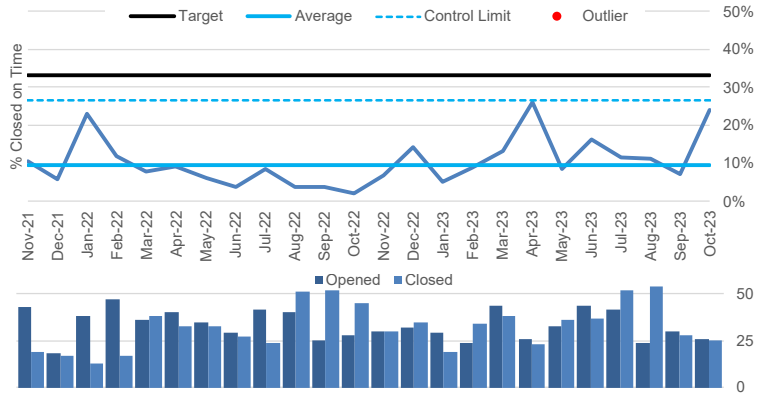
Key Deliverable		End Date
Off track / At risk / On track / Complete / Suspended		Proposed
Implement IPC Workforce Strategy 2022-24		**Sep-24**
Key Milestones	Complete a GAP analysis of the NHS Fife IPCT with regards to recommendations for local Boards	Apr-23
	Awaiting updates to national deliverables which are currently delayed. Recommendations 1, 9, 10,12, 14 and 15	Mar-24
	Engage with other key stakeholders outlined in the strategic plan (HPT and AMR) to begin discussions to determine roles and remits	Nov-23
	Oversight Board shall include an options appraisal of models of support for Primary Care and strategic plan developed. Including a subgroup, with collaboration with all key stakeholders (GP and Dental)	Dec-23
	Delivery date of September 2023 - SG to lead on discussions to improve quality and coverage of national - level workforce data for a functional IPC programme at the national and facility level	Mar-24
	Business case for additional resources and funding to be developed for consideration and Board approval	Mar-24
	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) in order to maintain individual safety within our healthcare settings.		Apr-24
Key Milestones	Aim for the pilot of the eCatheter insertion and maintenance bundle to have been completed and plan for role out to other areas in NHS Fife	Mar-24
	Complete QI project with D&I to improve data capture of ePVC	Dec-23
	Support roll-out of eCatheter insertion and maintenance bundles	Dec-23

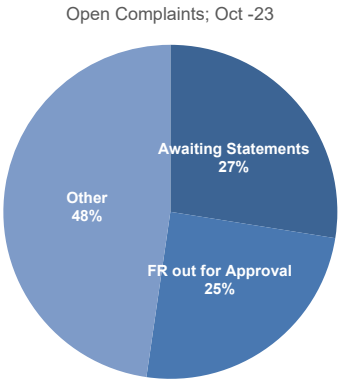
Complaints | Stage 2

At least 33% of Stage 2 complaints are completed within 20 working days by March 2024

Performance 24.0%

Local Performance





Performance by Service Area

		Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
NHS Fife	Opened in Month	30	32	29	24	44	26	33	44	42	24	30	26
	% Acknowledged on time	93.3%	96.9%	100.0%	95.8%	97.7%	96.2%	97.0%	93.2%	90.5%	100.0%	100.0%	92.3%
	Due in Month	30	27	32	30	28	38	29	35	43	46	19	30
	% Closed on time	3.3%	14.8%	6.3%	13.3%	14.3%	15.8%	6.9%	17.1%	16.3%	10.9%	15.8%	20.0%
	Closed in Month	30	35	19	34	38	23	36	37	52	54	28	25
	% Closed on time	6.7%	14.3%	5.3%	8.8%	13.2%	26.1%	8.3%	16.2%	11.5%	11.1%	7.1%	24.0%
Acute	Closed in Month	22	26	17	23	23	16	27	23	43	36	16	18
	% Closed on time	9.1%	19.2%	5.9%	13.0%	13.0%	31.3%	7.4%	21.7%	11.6%	16.7%	6.3%	27.8%
HSCP	Closed in Month	7	9	2	10	15	7	9	14	6	18	12	6
	% Closed on time	0.0%	0.0%	0.0%	0.0%	13.3%	14.3%	11.1%	7.1%	0.0%	0.0%	8.3%	0.0%

Key Deliverable		End Date
Off track / At risk / On track / Complete / Suspended		Proposed
Adherence to the NHS Scotland Model Complaints Handling Procedures (DH 2017) and compliance with National targets		Mar-24
Key Milestones	PET to meet regularly with Acute and H&SCP to discuss Model Complaint Handling process improvements to assist with meeting target	Dec-23
	Implement complexity scoring system to categorise complaints	Dec-23
	Supportive escalation process to be implemented to highlight delays within the Model Complaint Handling Process	Dec-23
	New weekly complaint report to be created and shared with services to provide data and highlight delays within the Model Complaint Handling Process	Dec-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 Milestone	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	Dec-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	Dec-23
	Discuss and agree data to be displayed within Patient Experience Team screen	Dec-23
	Identify test area prior to roll out	Dec-23
	Education and training	Dec-23
	Test implementation of dashboard	Nov-23
	Communication, promotion and raise awareness of dashboard	Jan-24
	Roll out Dashboard within NHS Fife	Jan-24

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**12 January 2024**
Title:	**Healthcare Associated Infection Report (HAIRT)**
Responsible Executive:	**Janette Keenan, Director of Nursing**
Report Author:	**Julia Cook, Infection Control Manager**

1 Purpose

Update for Infection Prevention and Control for December 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 December 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 December 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 Q2 2023 (April- June), NHS Fife was below the national rate for healthcare associated infection (HCAI).
- Q3 2023 (July- Sep, n=17), has seen a reduction in the number of SAB cases, from Q2 2023 (Apr-Jun, n=26). Awaiting national comparison.
- There have been no further dialysis line related SABs since the last report.
- NHS Fife had achieved over a full year without a PVC related SAB and over 464 days for CVC related SABs.

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 Q2 2023 (April- June), NHS Fife was above the national rate for HCAI and below for CAI.
- The cumulative total of CDIs for the period Nov 22-Oct 23 (n=55) is higher than the number of cases during the same time-period the previous year (n=35).
- However there was a reduction in the total number of CDI cases in Q3 (Jul-Sep 23, n=12), compared to Q2 (Apr-Jun, n=18).

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 Q2 2023 (April- June), NHS Fife was below the national rate for HCAI & CAI.
- Considering the time-period November 2022 to October 2023, the number of ECBs (n=232) has reduced, when compared to the same time-period the previous year (Nov 21-Oct 22, n=274). This reduction is also reflected in the number of HCAI cases.

Current ECB Initiatives

- The Infection Prevention and Control team continue to work with the Urinary Catheter Improvement Group (UCIG).
- Infection control surveillance alert the patients care team Manager by Datix when an ECB is associated with a traumatic catheter insertion, removal or maintenance.
- Monthly ECB reports and graphs are distributed within HSCP and Acute services
- Catheter insertion/Maintenance bundles now in MORSE for District nurse documentation
- CAUTI bundles have now been installed onto Patientrack and have been trailed on V54 ward. Amendments to the tool are awaited by Patientrack, prior to this being rolled out across the board.

Surgical Site Infection (SSI) Surveillance Programme

National surveillance programme for SSI has been paused due to the COVID-19 pandemic. DL (2023) 06 published February 2023 advises surgical site infection (SSI) and enhanced surveillance reporting remains paused for the time being.

Caesarean Section SSI

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

Large Bowel Surgery SSI and Orthopaedic Surgery SSI

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

Outbreaks (September - October 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

- 19 new ARHAI Scotland reportable outbreaks/incidents of COVID-19 which are detailed in the HAIRT

Hospital Inspection Team
There have been no new inspections during this reporting period (September – end of October 2023)

Healthcare Improvement Scotland (HIS): Safe Delivery of Care Inspection - Unannounced inspection to Victoria Hospital, NHS Fife, 31st of July- 2nd of August.

- Full publication: Thursday 26th October.
- 2 Recommendations
- 9 Requirements
- 4 areas of Good Practice

Hand Hygiene

- There is currently no robust electronic recording system for reporting HH compliance from clinical areas across Fife. eHealth have recommended that LanQIP can be utilised 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 2 (July- Sept 2023) was **95.6%**.

National Cleaning Services Specification

The National Cleaning Services Specification – quarterly compliance report result for Quarter 2 (July- Sept 2023) shows NHS Fife achieving **Green** status.

Estates Monitoring

The National Cleaning Services Specification – quarterly compliance report result for shows Quarter 2 (July- Sept 2023) NHS Fife achieving **Green** status.

2.3.1 Quality/ Patient and Value-Based Health & Care

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

2.3.2 Workforce

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

2.3.3 Financial

A potential cost pressure to implement a new HH audit platform for governance and assurance.

2.3.4 Risk Assessment/Management

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

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

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

2.3.6 Climate Emergency & Sustainability Impact

N/A

2.3.7 Communication, involvement, engagement and consultation

This paper has been considered by the Infection Control Manager

2.3.8 Route to the Meeting

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

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

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

Infection Prevention
and Control Team

Fife Health & Social Care Partnership

NHS Fife

HAIRT Report

HAIRT Report for Infection Control Committee on 6th December 2023

(Validated Data up to October 2023)

October 2023

Contents

Board Wide Issues

Key Healthcare Associated Infection Headlines

1.1 Achievements:

***Staphylococcus aureus* Bacteraemia Prevention (SAB)**

During Q2 2023 (April- June), NHS Fife was below the national rate for healthcare associated infection (HCAI).

Q3 2023 (July- Sep, n=17), has seen a reduction in the number of SAB cases, from Q2 2023 (Apr-Jun, n=26). Awaiting national comparison.

There have been no further dialysis line related SABs since the last report.

NHS Fife had achieved over a full year without a PVC related SAB and over 464 days for CVC related SABs.

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

During Q2 2023 (July- Sep), NHS Fife was below national rate for CAI.

There was a reduction in the total number of CDI cases in Q3 (Jul-Sep 23, n=12), compared to Q2 (Apr-Jun, n=18). There was also a significant improvement seen in the number of HCAI cases during Q3 (n=4), compared to Q2 (n=16). Awaiting national comparison.

***Escherichia coli* bacteraemia (ECB)**

During Q2 2023 (July- Sep), NHS Fife was below the national rate for HCAI & CAI.

Considering the time-period November 2022 to October 2023, the number of ECBs (n=232) has reduced, when compared to the same time-period the previous year (Nov 21-Oct 22, n=274). This reduction is also reflected in the number of HCAI cases (Nov 22-Oct 23, n=108, versus Nov 21-Oct 22, n=126) and CAUTI related ECBs (Nov 22-Oct 23, n=27, versus Nov 21-Oct 22, n=31).

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 October 23), there have been 10 PWID related SAB cases.

CDI

During Q2 2023 (July- Sep), NHS Fife was above national rate for HCAI.

The cumulative total of CDIs for the period Nov 22-Oct 23 (n=55) is higher than the number of cases during the same time-period the previous year (n=35). There is also an increase in the number of HCAI (HAI+HCAI+Unknown) cases (Nov 22-Oct 23, n=39, Nov 21-Oct 22, n=26). IPCT will continue to monitor cases to assess if there is a sustained rise.

Caesarean Section SSI/ Large Bowel Surgery SSI/ Orthopedics Surgery SSI

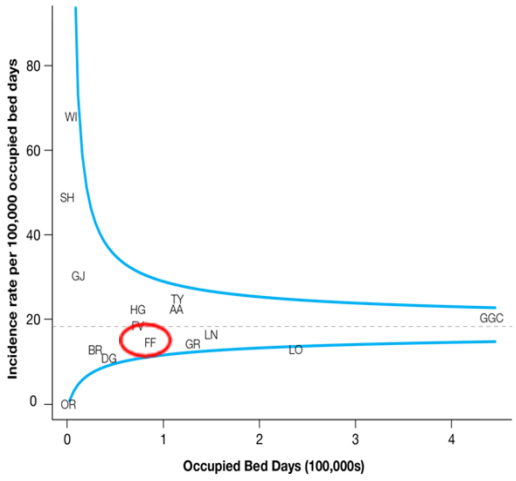
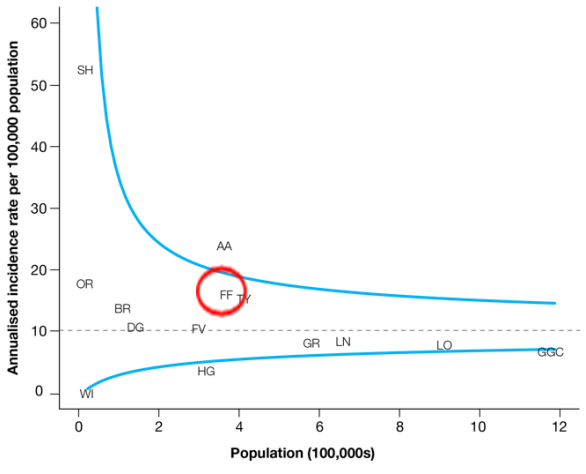
National surveillance programme for SSI has been paused due to the COVID-19 pandemic. DL (2023) 06 published February 2023 advises surgical site infection (SSI) and enhanced surveillance reporting remains paused for the time being.

Surveillance

2. Staphylococcus aureus incorporating MRSA/CPE screening compliance

2.1 Trends – Quarterly

Staphylococcus aureus Bacteraemias (SABs)				
Local Data: Q3 2023 (Jul-Sep) **(Q3 2023 National comparison awaited)**				
In Q3 2023 NHS Fife had:	17 SABs	8 HCAI/HAI 9 CAI	This is **DOWN** from:	26 Cases in Q2 2023

Q2 2023 (Apr-Jun) - ARHAI Validated data with commentary			
Healthcare associated SABs		**Community associated SABs infection**	
HCAI SAB rate: **14.6**	Per 100,000 bed days	CAI SABs rate: **16.1**	Per 100,000 Pop
No of HCAI SABs: 13		No of CAI SABs: 15	
This is **BELOW** National rate of 18.3		This is **ABOVE** National rate of 10.2	
			
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 June 2023 (HPS)		
SAB by rate 100,000 Total bed days	**14.7** per 100,000 TBDs	
SAB by Number of HCAI cases	**53**	

Local Device related SAB surveillance

- Localised enhanced surveillance focuses on high-risk clinical areas and vascular line SABs.
- Weekly reports issued to Senior Charge Nurses if their ward has failed to achieve **90%** of all PVC being removed prior to the 72hr breach.
- PVC & CVC related SABs will continue to be Datix'd by Dr Morris and undergo a SAER.
- There have been 8 dialysis line related SABs during Jan-Oct 2023. Renal services carried out a CCR of each case (Jan-Apr 2023 cases) and the findings were discussed at a `Super SAER` meeting on 26th June 2023. The most recent case (August 2023) has been Datix`d by the Consultant Microbiologist.

As of **01/11/2023** the number of days since the last confirmed SAB is as follows:	
CVC SABs	464 Days
PWID (IVDU)	1 Day
Renal Services Dialysis Line SABs	72 Days
Acute services PVC (Peripheral venous cannula) SABs	14 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 **93%** compliance with the **MRSA** CRA in Q3 2023 (Jul-Sep)

This was **BELOW** Q2 2023 (98%), but **ABOVE** the compliance target of 90%.

This was **ABOVE** the national rate for Q3 2023

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

Quarter	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	Q3 2023 Jul-Sep
Fife	98%	88%	93%	98%	98%	98%	100%	100%	98%	93%

Scotland	84%	81%	82%	81%	80%	78%	74%	78%	81%	80%

CPE (Carbapenemase Producing Enterobacteriaceae)
From April 2018, CRA has also included screening for CPE.
NHS Fife achieved **100%** compliance with the **CPE** CRA for Q3 2023 (Jul-Sep)
This was **EQUAL** to the compliance rate in Q2 2023
This was **ABOVE** the national rate for Q3 2023.
CPE Critical risk assessment (CRA) screening KPI compliance summary:

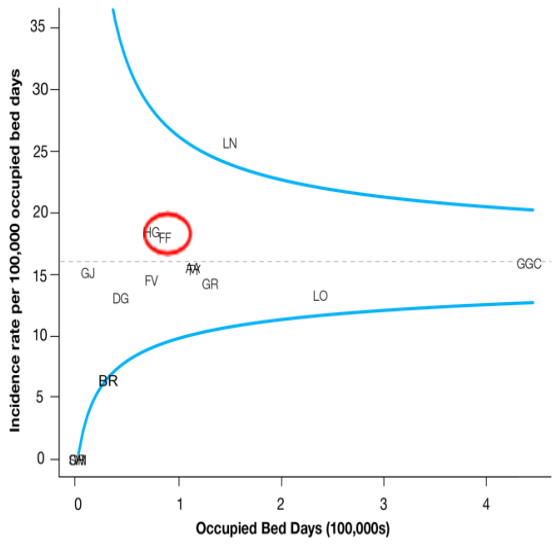
Quarter	Q2 2021 Apr-Jun	Q3 2021 Jul-Sep	Q4 2021 Oct-Dec	Q1 2022 Jan-Mar	Q2 2022 Apr- Jun	Q3 2022 Jul-Sep	Q4 2022 Oct-Dec	Q1 2023 Jan-Mar	Q2 2023 Apr-Jun	Q3 2023 Jul-Sep
Fife	90%	100%	98%	100%	98%	100%	100%	100%	100%	100%
Scotland	83%	82%	80%	80%	79%	78%	76%	77%	80%	81%

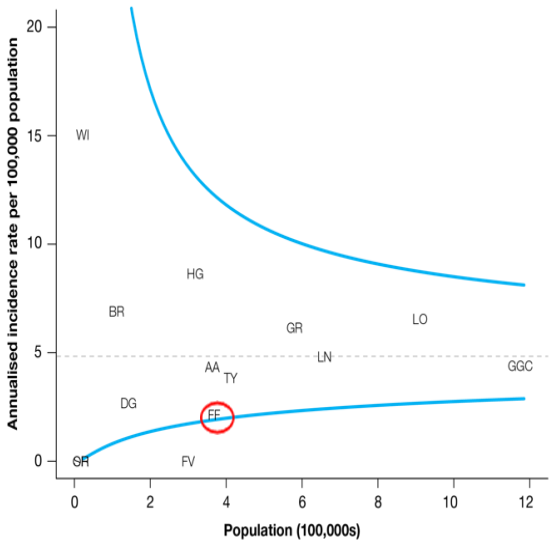
3 Clostridioides difficile Infection (CDI)

3.1 Trends

Clostridioides difficile Infection (CDI)				
Local Data: Q3 Jul-Sep 2023 **(Q3 2023 HPS National comparison awaited)**				
In Q3 2023 NHS Fife had:	12 CDIs	4 HCAI/HAI/Unknown 8 CAI	This is **DOWN** from	18 Cases in Q2 2023

Q2 (Apr-Jun) 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: **18.0**	Per 100,000 bed days	CAI CDIs rate: **2.1**	Per 100,000 Pop
No of HCAI CDIs: 16		No of CAI CDIs: 2	
This is **ABOVE** National rate of 16.1		This is **BELOW** National rate of 4.8	





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 June 2023 (HPS)		
CDI by rate 100,000 Total bed days	**12.2** per 100,000 TBDs	
CDI by Number of HCAI cases	**44**	

3.2 Current Risk Register Rating

Corporate Directorate – Nursing Directorate Infection Control Team Risk Register		
ID: 646 CDI Local Delivery Standard Target		
Initial Risk Level	**Current Risk Level**	Target Risk Level
Moderate 8	**Moderate Risk 9**	Low Risk 6

3.3 Current CDI initiatives

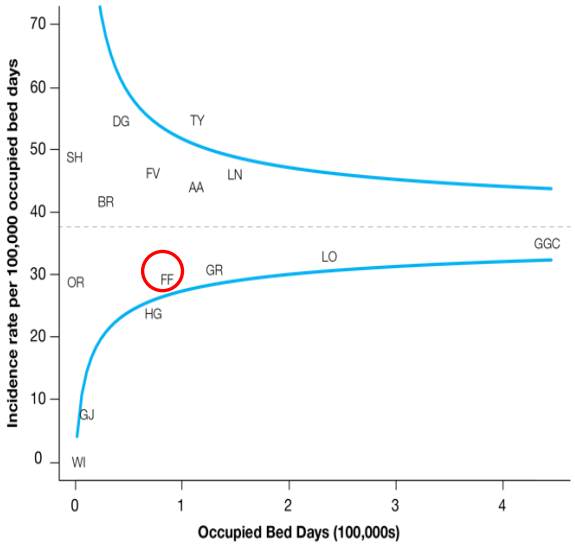
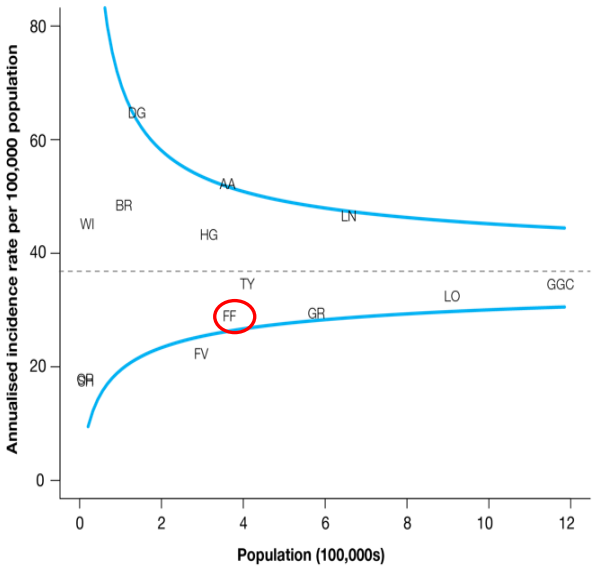
Follow up of all hospital and community cases continues to establish risk factors for CDI

- Monthly CDI reporting to Acute Services & HSCP with summary of all CDI cases
- Enhanced surveillance & HPS trigger tool completion for any triggers/ areas of concerns.
- Dr Venkatesh establishing optimum antimicrobial therapy for multiple recurrence CDI case.
- From October 2019 each CDI case is assessed for suitability of extended pulsed Fidaxomicin (EPFX) regime aiming to prevent recurrent disease in high risk patients.
- Commercial faecal transplant (FMT) is now available and NHS Fife will use this for recurrences that have failed first and second line treatments
- Bezlotoxumab is available, only when FMT is contra-indicated, or if the patient is unable to tolerate the procedure.

4.0 Escherichia coli Bacteraemias (ECB)

4.1 Trends:

Escherichia coli Bacteraemias (ECB)				
Local Data: Q3 (Jul-Sep) 2023 **(Q3 2023 HPS National comparison awaited)**				
In Q3 2023 NHS Fife had:	68 ECBs	28 HAI/HCAIs 40 CAIs	This is **UP** from	49 Cases in Q2 2023
Q3 2023 There were **9** Urinary catheter associated (1 of which was from a Suprapubic catheter) ECBs, which was higher than during Q2 2023, when there were 5 CAUTIs.				

Q2 (Apr-Jun) 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: **29.3**	Per 100,000 bed days	CAI ECBs rate: **28.9**	Per 100,000 Pop
No of HCAI ECBs: 26		No of CAI ECBs: 27	
This is **BELOW** National rate of 37.6		This is **BELOW** National rate of 36.7	
			
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 June 2023 (HPS)		
ECB by rate 100,000 Total bed days	**31.1** per 100,000 TBDs	
ECB by Number of HCAI cases	**112**	

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 Q3	TBC	*** 27.3%**	
2023 Q2	18.1%	**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 Q3 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 Q3	TBC	***35.3%**	
2023 Q2	22.6%	**22.2%**	
2023 Q1	26.5%	**12.5%**	
2022 TOTAL	22.7%	**30.9 %**	* Locally calculated data- TBC by HPS when Q3 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 9**	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 10th November 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 October 2023, there have been 22 CAUTI ECBs (19 from urinary & 3 from a supra-pubic catheter). 5 of these have been associated with trauma.

Infection control surveillance alert the patients care team Manager by Datix when an ECB is a urinary catheter associated infection, to then undergo a CCR, to provide further learning from all ECB CAUTIs.

CAUTI insertion & maintenance bundles have now been installed onto Patientrack in February 2022 and were trailed on V54 ward. Amendments to the tool are now awaited by Patientrack before this can then be rolled out across the board.

5. Hand Hygiene

- Good hand hygiene by staff, patients and visitors is a key way to prevent the spread of infections and to minimize risk.
- NHS Boards should monitor hand hygiene (HH) and ensure a zero tolerance approach to non-compliance, to provide assurance of optimum practice.
- A minimum of 20 observations are required to be audited, per month, per ward/unit.
- Reporting of Hand Hygiene performance was based on data submitted by each ward via LanQIP, which displayed the results on it's dashboard.
- There is currently no robust electronic recording system for reporting HH compliance from clinical areas across Fife. eHealth have 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 2 (Jul-Sep 2023) was **95.6%**.
- The cleaning compliance score for NHS Fife & each acute hospital can be found in Section 11

6.1 Trends

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

- **National Cleaning Services Specification**

Domestic Location	Q2 Jul-Sep 23	Q1 Apr-Jun 23
Fife	95.6%	95.9%
Scotland	95.2%	95.3%

- The National Cleaning Services Specification – quarterly compliance report result for Quarter 2 (Jul-Sep) 23 shows NHS Fife achieving **GREEN** status.

- **Estates Monitoring**

Estates Location	Q2 Jul-Sep 23	Q1 Apr-Jun 23
Fife	96.0%	96.3%
Scotland	96.0%	96.2%

- The Estates Monitoring – quarterly compliance report result for Quarter 2 (Jul-Sep) 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).

September – end of October 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 September – October 2023, there has been 19 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
QMH	WARD 7	31/10/2023	0	10	1
QMH	WARD 6	31/10/2023	1	8	4
QMH	WARD 5	10/10/2023	1	7	2
QMH	WARD 6	13/09/2023	0	4	0
QMH	WARD 5	08/09/2023	0	4	2
SACH	WARD 2	19/10/2023	1	7	2
SACH	WARD 1	10/10/2023	3	11	6
GLENROTHES	WARD 3	13/09/2023	0	2	0
LYNEBANK	Levendale	01/09/2023	0	2	0
CAMERON	SGSU	01/09/2023	0	3	4
VHK	WARD 32	19/10/2023	0	6	1
VHK	WARD 53	06/10/2023	0	2	0
VHK	WARD 44	06/10/2023	0	5	0
VHK	WARD 41	06/10/2023	0	2	0
VHK	WARD 41	11/09/2023	0	2	1
VHK	WARD 9	01/09/2023	0	5	4

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 new inspections during this reporting period (September – end of October 2023)

Healthcare Improvement Scotland (HIS): Safe Delivery of Care Inspection - Unannounced inspection to Victoria Hospital, NHS Fife, 31st of July- 2nd of August.

- Full publication: Thursday 26th October.
- 2 Recommendations
- 9 Requirements
- 4 areas of Good Practice

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	4	6	10	5	1	6	5	9	14
Jul-23	3	4	7	1	2	3	12	15	27
Aug-23	4	1	5	1	1	2	11	18	29
Sep-23	1	4	5	2	5	7	5	7	12
Oct-23	4	4	8	1	0	1	14	13	27

Cleaning Compliance (%) TOTAL FIFE												
	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23
Overall	96.2	96.2	96.0	96.4	95.9	95.9	95.9	95.9	95.6	95.6	95.7	96.0

Estates Monitoring Compliance (%) TOTAL FIFE												
	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23
Overall	96.6	96.6	96.6	96.3	96.3	96.5	96.5	96.0	96.1	95.7	96.2	95.7

Victoria Hospital

	VHK		
	SAB >48hrs admx	CDI >48hrs admx	ECB >48hrs admx
Month	HAI	HAI	HAI
Apr-23	4	4	2
May-23	2	3	3
Jun-23	1	3	1
Jul-23	1	0	2
Aug-23	3	0	6
Sep-23	1	0	3
Oct-23	3	1	7

Cleaning Compliance (%) Victoria Hospital												
	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23
Overall	95.6	96.3	95.9	96.6	95.8	96.1	95.6	96.1	95.4	95.4	95.8	96.4

Estates Monitoring Compliance (%) Victoria Hospital												
	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23
Overall	97.6	97.2	97.1	96.5	97.5	97.5	97.3	97.0	97.3	96.2	97.6	97.1

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
Jul-23	0	0	0
Aug-23	1	0	0
Sep-23	0	0	0
Oct-23	0	0	1

		Cleaning Compliance (%) Queen Margaret's hospital										
	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23
Overall	96.4	96.3	96.9	96.5	95.9	96.5	96.7	96.6	95.8	96.6	96.4	96.8

Estates Monitoring Compliance (%)Queen Margaret's hospital											
	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23
Overall	95.9	96.6	96.1	95.5	94.8	94.9	95.5	94.1	94.6	95.0	94.4	95.5

Community Hospitals

	COMMUNITY HOSPITALS		
	SAB >48hrs admx	CDI >48hrs admx	ECB >48hrs admx
Month	HAI	HAI	HAI
Apr-23	0	1	1
May-23	0	0	0
Jun-23	0	0	0
Jul-23	0	0	0
Aug-23	0	0	0
Sep-23	0	0	0
Oct-23	0	0	0

Out of Hospital

	OUT OF HOSPITAL					
	SAB <48hrs admx		CDI <48hrs admx		ECB <48hrs admx	
Month	HCAI	Community / Not Known	HCAI / UnKnown	Community	HCAI	Community / Not Known
Apr-23	0	3	0	1	5	5
May-23	2	4	1	0	9	9
Jun-23	3	6	2	1	4	9
Jul-23	2	4	1	2	10	15
Aug-23	0	1	1	1	5	18
Sep-23	0	4	2	5	2	7
Oct-23	1	4	0	0	6	13

Appendix 1 References and Links

References & Links
Understanding the Report Cards – Infection Case Numbers *Clostridioides difficile infections (CDI)* and *Staphylococcus aureus* bacteraemia *(SAB)* cases are presented for each hospital, broken down by month by Healthcare Associated (HCAI & HAI) & Community (Community/Unknown) onset. More information on these organisms can be found on the NHS24 website: *Clostridioides difficile*: https://www.hps.scot.nhs.uk/a-to-z-of-topics/clostridioides-difficile-infection/ *Staphylococcus aureus* : https://www.hps.scot.nhs.uk/a-to-z-of-topics/staphylococcus-aureus-bacteraemia-surveillance/ For each hospital, the total number of cases for each month are those, which have been reported as positive from a laboratory report on samples taken more than 48 hours after admission. For the purposes of these reports, positive samples taken from patients within 48 hours of admission will be considered confirmation that the infection was contracted prior to hospital admission and will be shown in the "out of hospital" report card. **Targets** There are national targets associated with reductions in C.diff and SABs and from 2019 for e.coli bacteraemias (ECBs). More information on these can be found on the Scotland Performs website: http://www.scotland.gov.uk/About/Performance/scotPerforms/partnerstories/NHSScotlandperformance **Understanding the Report Cards – Hand Hygiene Compliance** Hospitals carry out regular audits of how well their staff are complying with hand hygiene. Each hospital report card presents the combined percentage of hand hygiene compliance with both opportunity taken and technique used. **Understanding the Report Cards – Cleaning Compliance** Hospitals strive to keep the care environment as clean as possible. This is monitored through cleaning and estates compliance audits. More information on how hospitals carry out these audits can be found on the Health Facilities Scotland website: http://www.hfs.scot.nhs.uk/online-services/publications/hai/ **Understanding the Report Cards – *'Out of Hospital Infections'*** *Clostridium difficile infections* and *Staphylococcus aureus bacteraemia* cases can be associated with being treated in hospitals. However, this is not the only place a patient may contract an infection. This total will also include infections from community sources. The final Report Card report in this section covers '*Out of Hospital Infections*' and reports on SAB and CDI cases reported to NHS Fife which are not attributable to a hospital.
For HPS categories for Healthcare Associated Infections: **https://www.hps.scot.nhs.uk/web-resources-container/quarterly-epidemiological-commentary-for-the-surveillance-of-healthcare-associated-infections-in-scotland-methods-caveats/**

Appendix 2 Categories of Healthcare & Community Infections

Categories of Healthcare & community Infections

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

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

Hospital Acquired Infection (HAI):
Positive Blood culture obtained from patient who has been
-Hospitalised for >48 hours
If the patient was transferred from another hospital the duration of the in-patient stay is calculated from the date of the first hospital admission
OR
-The patient was discharged from hospital in the 48 hours prior to the positive blood culture being obtained
OR
-A patient receives regular haemodialysis as an outpatient

Community Infection
-Positive Blood culture obtained from a patient with 48 hours of admission to hospital who does not fulfil any of the criteria for the healthcare associated blood stream infections

Not known:
-Only to be used if the ECB is not a HAI and unable to determine if community or HCAI

Healthcare Associated Infection (HCAI):-
Positive blood culture obtained within 48 hours of admission to hospital and fulfils one or more of the following criteria:
-Was hospitalised overnight in the 30 days prior to the +ve blood culture being obtained.
OR
-Resides in a Nursing home, long term facility or residential home
OR
-IV,IM, Intra-articular or sub cut medication in the 30 days prior to the positive blood culture,
but EXCLUDING IV illicit drug use.
OR
-Underwent venepuncture in the 30 days before +ve BC
OR
-Underwent medical procedure which broke mucous or skin barrier i.e. biopsies or dental extraction in the 30 days before +ve BC
OR
-Underwent any care for chronic medical condition or manipulation of medical device by a healthcare worker in the community in the 30 days prior to the +ve BC being obtained i.e. podiatry or dressing of chronic ulcers, catheter change or insertion
OR
-Has a long term indwelling device (i.e. catheter, central line, drain (excluding a haemodialysis line)

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

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

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

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

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

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NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**12 January 2024**
Title:	**Patient Experience and Feedback Report**
Responsible Executive:	**Janette Keenan, Director of Nursing**
Report Author:	**Siobhan McIlroy, Head of Patient Experience (HoPE)**

1 Purpose

The purpose of this paper is to provide an update on patient experience and feedback, and to describe work being taken forward to present a more rounded picture of patient experience, ensuring improvements are made and are featured in future reports.

This report is presented for:

- Assurance

This report relates to:

- Emerging issue
- Government policy / directive
- Local policy

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

- Person Centred

2 Report summary

2.1 Situation

Patient complaints are reported monthly through the Fife Integrated Performance and Quality Report (IPQR). The indicators are identified as:

- Stage 1 Closure rate (target 80%)
- Stage 2 Closure rate (target 33% by 31st March 2024)

Whilst concern has been raised about the level of performance, these indicators do not adequately capture patient experience and a review is underway to ensure that the quality of patient experience is described, and to improve the complaint handling performance in line with national timeframe standards.

2.2 Background

Person centred care is about ensuring the people who use our services are at the centre of everything we do. It is delivered when health and social care professionals work together with people, to tailor services to support what matters to them. It is about:

- respect for patients' values, expressed needs and preferences
- coordination and integration of care
- communication, information, education,
- physical comfort
- emotional support
- involvement of family and friends

How do we know we are getting it right?

DEFINING THE PATIENT EXPERIENCE

Patient experience is based partly on the patients' and family's *expectations* of what is about to happen and the *cumulative evaluation* of their journey through our system.

- We have opportunities to delight or disappoint based on their clinical and emotional interactions with us, and their interactions with our staff, our processes, and the environment

MEASURING THE EXPERIENCE

Currently, 'patient experience and feedback' is captured through:

- Care Opinion
- Compliments and comments
- Complaints
- Initiatives, such as the Care Experience Improvement Model
- MS Forms Questionnaires / Surveys

Moving forward, we will also make use of:

- Surveys e.g. Your Care Experience
- Focus groups
- Post discharge / appointment phone calls
- Warm welcome / fond farewell
- Care Assurance processes, for example:
    - Shadowing / observation
    - Walkarounds
    - 15 step challenge

IMPROVING THE EXPERIENCE

It is important to analyse the data, identifying themes and any issues:

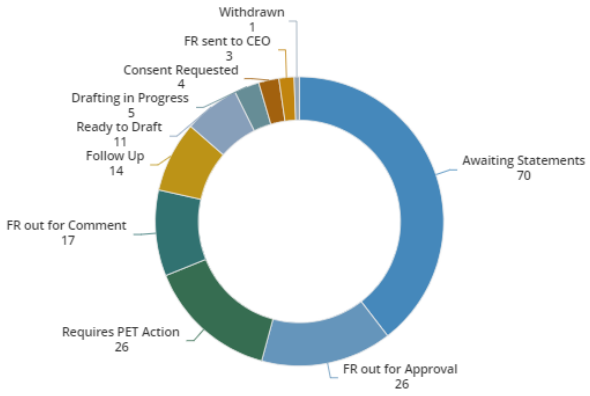
- Develop and share goals and targets based on data
- Assess processes
- Create an enabling infrastructure:
    - Framework
    - Leadership
    - Education and training
- Engage staff, patients, families, and carers in improvement work

2.3 Assessment

The complaint "complexity scoring" tool to triage complaints and categorise them as low, moderate, or high complexity continues to be tested, and all open stage 2 complaints have been re-categorised. The complexity categorisation score will provide insight into the volume of complex complaints that NHS Fife receives and handles. This will also ensure that all major or extreme complaints are appropriately escalated within the organisation and linked to adverse events or incidents.

With stage 2 complaints, there is now a level of detail that clarifies where each complaint is in the process. Data taken from the first week in January 2024 shows delays in the process remain:

- Awaiting statements – 21% (previous 28% at the end of October 2023)
- Final response with Service for comment or approval – 57% (previously 41%, at the end of October 2023)
- Ready to draft, drafting or requires PET action – 18% (previously 30% at the end of October 2023)



In the last week of September 2023 (Q2), there were 113 stage 2 complaints in the system, and there are now 72 stage 2 complaints, which is a 36% reduction.

NB As of 4 January 2024, there are 72 stage 2 complaints;

Twelve are within the 20-day target, with two at the drafting stage, 2 requiring further PET action, and 1 with the final draft out for approval. Seven of these complaints are "awaiting statements". PET is prioritising its workload and focusing on drafting the complaints within 20 days. An additional staff member (bank, retired PET officer) has been supporting PET with drafting the backlog of stage 2 complaints, which was 26 at the end of September 2023 (Q2) and now 9, a 65% decrease.

Of the 12 stage 2 complaints within the 20-day target, there are zero minor, 10 moderate, and 2 major. The 12 moderate and major stage 2 complaints will likely be answered after the 20-day standard timeframe target. Therefore, figures over the next quarter for compliance with responding to a complaint within the national 20-day standard timeframe target are predicted to remain low.

Clinical pressures continue to impact performance by obtaining statements and final response approval. The Patient Experience Team also faced significant absences due to sickness absences, annual leave, and vacancies, which contributed to the rise in complaints awaiting PET action or drafting. All vacancies are in the recruitment process.

Despite these challenges, the Patient Experience Team continue to offer support in gathering statements, however this is yet to be requested by the Services.

The additional 0.26WTE Bank Patient Experience Support Officer that joined the Patient Experience Team to gather patient feedback in the form of Care Opinion, Lived Experiences, and Participation and Engagement has temporarily stopped due to absence, but hopefully, this will restart soon. This has impacted on the number of Care Opinion stories that have been gathered.

Work with services continues to review new ways of working and understand challenges. The weekly complaint meetings with Acute have been reinstated. New meetings have been established with HSCP (Community Care and Primary and Preventative Care). The Patient Experience Team Lead has been in communication with Complex and Critical Care to set up similar meetings.

Initial work has begun with a Senior Project Manager within the Corporate Project Management Office to assist with streamlining and implementing changes in complaint handling-processes. Results from an MS Forms questionnaire sent to Senior Medical staff have been collated, and results have provided valuable data highlighting potential improvements regarding further education & training, support, and changes to the complaints handling process. The Patient Experience Team has completed an MS Forms questionnaire to understand their challenges and what works well. The Head of Patient Experience and the Senior Project Manager will work together to create an improvement action plan based on the findings of both these questionnaires. Further work is planned to engage with the services.

A "complaints escalation" standard operating procedure (SOP) is being drafted. This will highlight and support processing complaints within the agreed national timescales, in line with the model handling complaint procedure.

The first version of the Complaint Dashboard has been created and is available on MicroStrategy. This was launched in November 2023. The Complaint Dashboard provides live complaint data across NHS Fife, highlighting delays and stages of complaints within the complaint handling process. The Dashboard has received good feedback from Services, helping to raise awareness and focus on all open complaints. The next step is to create a further dashboard specifically for the Patient Experience Team to monitor departmental performance and workload.

A Recovery and Improvement Plan has been developed to guide the redesign of the Patient Experience service, focusing on patient experience and feedback.

A quarterly report has been developed for the Clinical Governance Committee, which captures information on ‘Measuring the Experience’ and ‘Improving the Experience’. The report provides information on different methods of gathering feedback and, as we emerge from the pandemic, will report on work being taken forward to understand and improve the patient experience.

The report also captures performance data, which is required as part of the Model Complaints Handling Procedure.

Importantly, in line with the Organisational Learning Group, emerging themes, lessons learned, and quality improvement initiatives will be highlighted in future reports.

2.3.1 Quality, Patient and Value-Based Health & Care

Analysing data will lay the foundation for quality improvement work. The Organisational Learning Group will review themes, trends and lessons learned from complaints and adverse events, which can be triangulated with activity and staffing resources.

2.3.2 Workforce

Workforce planning

The Patient Experience Team establishment continues to be reviewed, examining workload and workforce planning. Understanding the complexity of complaints and the time required to draft a response, for example, will support workforce planning and the model of complaints management.

The team establishment consists of 1.0 WTE Band 7 team leader, 3.6 WTE Band 6 Patient Experience Officers, 1.8 WTE Band 4 Patient Experience Support Officers, and 2.07 WTE Band 3 Patient Experience Administrators.

The new Band 4 Support Officer (0.69 WTE) started in December 2023, and the Band 6 Patient Experience Officers (1.0 WTE) started in January 2024.

The 1.0 WTE Band 4 Administrator (Navigator) post to support administrative, coordination, and data aspects of the complaints handling process has been extended for six months. This role will help to release more time for Officers and help streamline systems and processes.

A retired Band 6 Patient Experience Officer has joined the bank and agreed to support with drafting. The additional 0.26WTE Bank Patient Experience Support Officer that joined the Patient Experience Team to gather patient feedback in the form of Care Opinion, Lived Experiences, and Participation and Engagement has temporarily stopped due to absence, but hopefully, this will restart soon.

2.3.3 Financial

n/a

2.3.4 Risk Assessment / Management

Complaints handling and learning from complaints are vitally important in reducing reputational risk.

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

People can expect to experience integrated care and support services that are underpinned by a Human Rights Based Approach, in which:

- People‘s rights are respected, protected and fulfilled.

- Providers of care clearly inform people of their rights and entitlements.
- People are supported to be fully involved in decisions that affect them.
- Providers of care and support respect, protect and fulfil people's rights and are accountable for doing this.
- People do not experience discrimination in any form.
- People are clear about how they can seek redress if they believe their rights are being infringed or denied.

2.3.6 Climate Emergency & Sustainability Impact

n/a

2.3.7 Communication, involvement, engagement and consultation

NMAHP leadership group has been involved in discussions and improvement action planning.

2.3.8 Route to the Meeting

Update from Patient Experience Team.

2.4 Recommendation

CGC is asked to take **assurance** from the report that work continues to improve complaints management.

3 List of appendices

The following appendices are included with this report:

- Appendix No. 1, Flashcard
- Appendix No. 2, Recovery & Improvement Plan

Report Contact

Siobhan McIlroy
Head of Patient Experience
Email: Siobhan.mcilroy@nhs.scot

Patient Experience Flashcard

December 2023

Concerns, Stage 1 and Stage2 complaints:

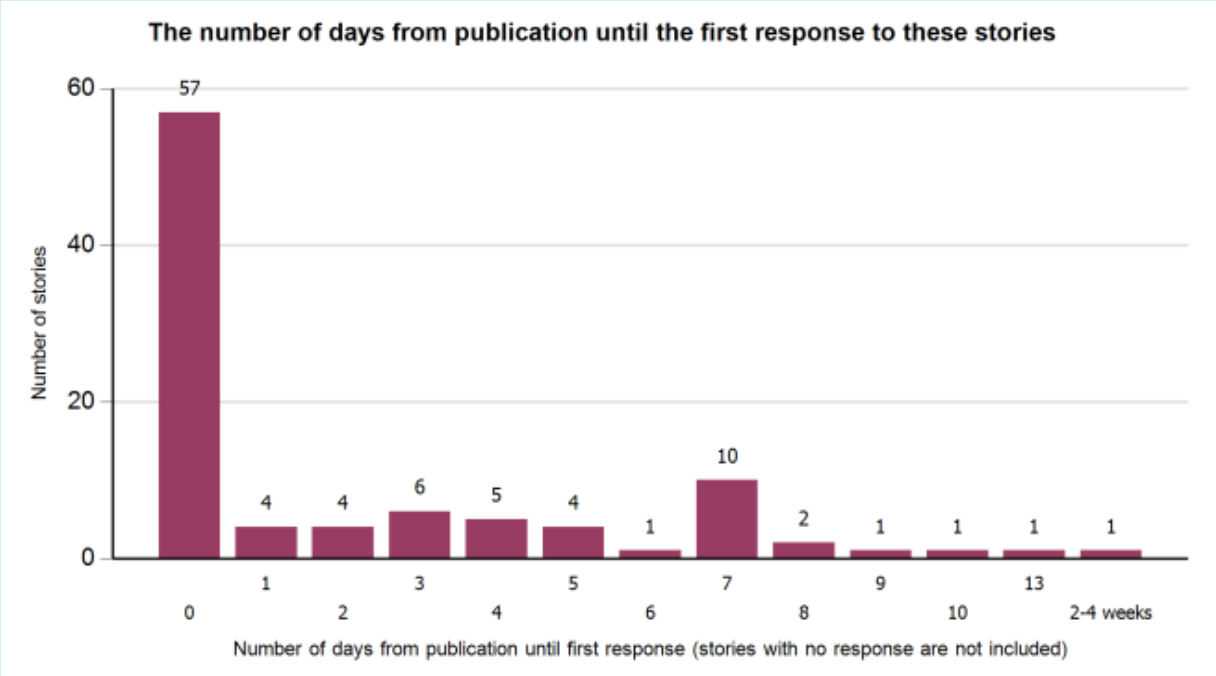
Records logged in Datix Complaints module – 01/07/2022-30/06/2023--Admin	22/23 Q3	22/23 Q4	23/24 Q1	23/24 Q2	Total
Stage 1 Complaint	122	133	151	139	**545**
Stage 2 Complaint	85	92	102	87	**366**
Concern	139	92	124	131	**486**
Enquiry	143	151	189	210	**693**
Total	**489**	**468**	**566**	**567**	**2090**

	22/23 Q3	22/23 Q4	23/24 Q1	23/24 Q2
1	Disagreement with treatment / care plan (11)	Disagreement with treatment / care plan (49)	Disagreement with treatment / care plan (26)	Co-ordination of clinical treatment (39)
2	Co-ordination of clinical treatment (8)	Staff attitude (22)	Co-ordination of clinical treatment (11)	Disagreement with treatment / care plan (23)
3	Staff attitude (5)	Co-ordination of clinical treatment (18)	Face to face (5)	Staff attitude (18)
4	Poor nursing care (5)	Unacceptable time to wait for the appointment / admission (15)	Poor nursing care (5)	Unacceptable time to wait for the appointment / admission (12)
5	Face to face (4)	Face to face (13)	Staff attitude (4)	Poor nursing care (11)

		Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
NHS Fife	Opened in Month	30	32	29	24	44	26	33	44	42	24	30	26
	% Acknowledged on time	93.3%	96.9%	100.0%	95.8%	97.7%	96.2%	97.0%	93.2%	90.5%	100.0%	100.0%	92.3%
	Due in Month	30	27	32	30	28	38	29	35	43	46	19	30
	% Closed on time	3.3%	14.8%	6.3%	13.3%	14.3%	15.8%	6.9%	17.1%	16.3%	10.9%	15.8%	20.0%
	Closed in Month	30	35	19	34	38	23	36	37	52	54	28	25
	% Closed on time	6.7%	14.3%	5.3%	8.8%	13.2%	26.1%	8.3%	16.2%	11.5%	11.1%	7.1%	24.0%
Acute	Closed in Month	22	26	17	23	23	16	27	23	43	36	16	18
	% Closed on time	9.1%	19.2%	5.9%	13.0%	13.0%	31.3%	7.4%	21.7%	11.6%	16.7%	6.3%	27.8%
HSCP	Closed in Month	7	9	2	10	15	7	9	14	6	18	12	6
	% Closed on time	0.0%	0.0%	0.0%	0.0%	13.3%	14.3%	11.1%	7.1%	0.0%	0.0%	8.3%	0.0%

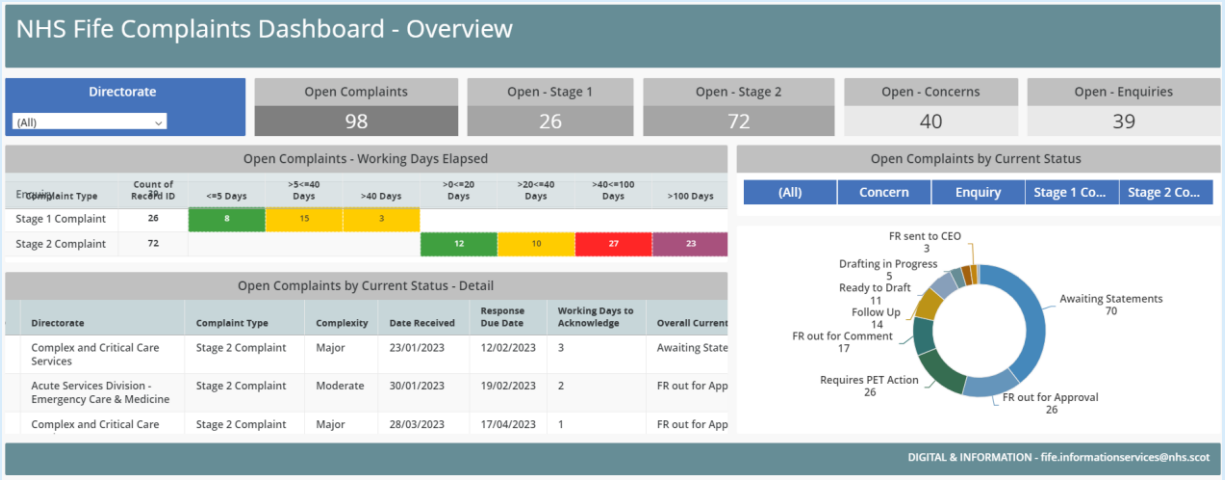
Patient Feedback

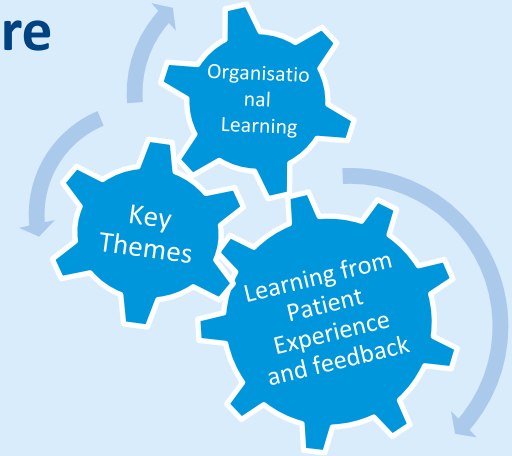
April – 82 (17 – HSCP) Read 5,200 times
May – 105 (19 – HSCP) Read 5,253 times
June – 171 (5 – HSCP) Read 6,944 times
July – 123 (11 - HSCP) Read 5,253 times
August – 107 (27 - HSCP) Read 6,055 times
September – 109 (30 - HSCP) Read 4,951 times
October – 104 (27 – HSCP) Read 6,409 times

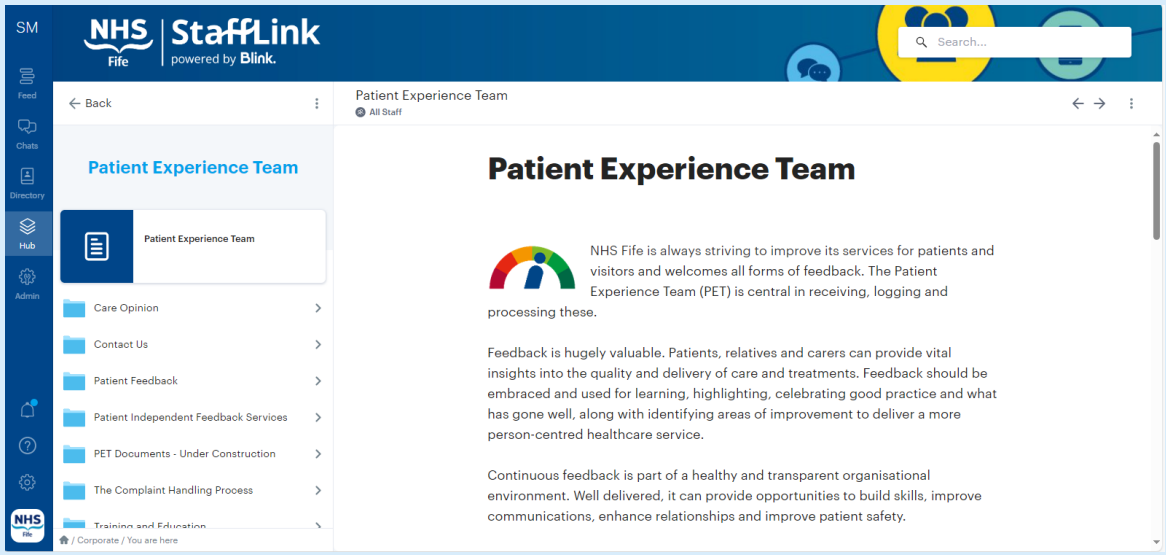


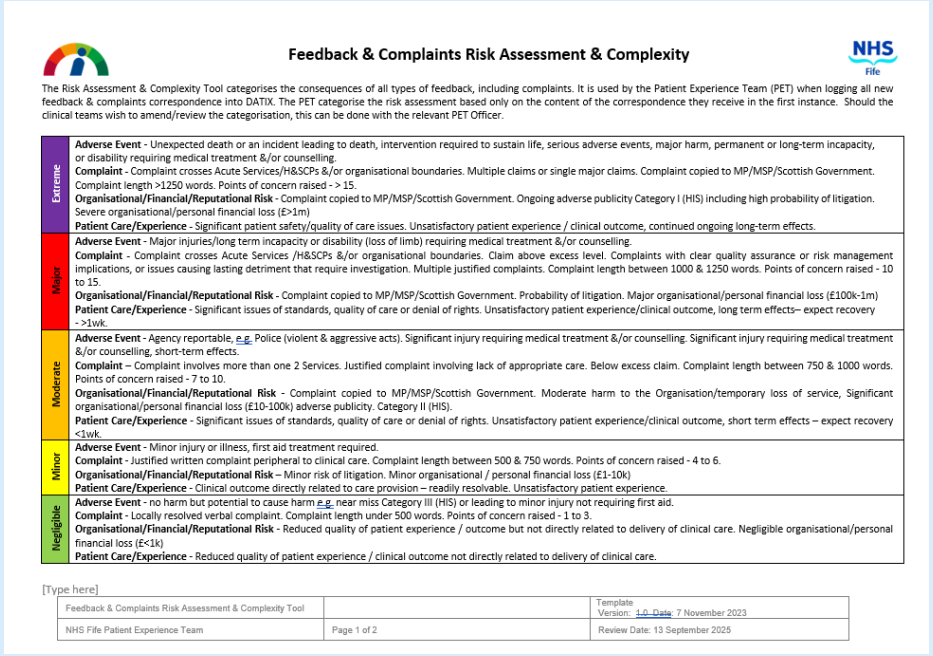
Compliments	22/23 Q3	22/23 Q4	23/24 Q1	23/24 Q2	Total
Acute Services Division - Planned Care & Surgery	216	91	126	138	571
Acute Services Division - Emergency Care & Medicine	9	22	30	36	97
Acute Services Division - Women, Children and Clinical Services	6	11	23	5	45
Community Care Services	65	41	70	43	219
Primary and Preventative Care Services	25	27	22	29	103
Complex and Critical Care Services	15	6	9	13	43
Corporate Directorates	1	4	1	0	6
No value - Miscellaneous	27	25	15	56	123
Total	364	227	296	320	1207

PET updates – Dashboard, New Blink Pages and Complexity Score









Feedback & Complaints Risk Assessment & Complexity

The Risk Assessment & Complexity Tool categorises the consequences of all types of feedback, including complaints. It is used by the Patient Experience Team (PET) when logging all new feedback & complaints correspondence into DATIX. The PET categorise the risk assessment based only on the content of the correspondence they receive in the first instance. Should the clinical teams wish to amend/review the categorisation, this can be done with the relevant PET Officer.

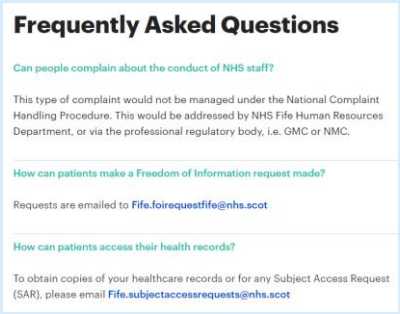
Extreme	**Adverse Event** - Unexpected death or an incident leading to death, intervention required to sustain life, serious adverse events, major harm, permanent or long-term incapacity, or disability requiring medical treatment &/or counselling. **Complaint** - Complaint crosses Acute Services/H&SCPs &/or organisational boundaries. Multiple claims or single major claims. Complaint copied to MP/MSP/Scottish Government. Complaint length >1250 words. Points of concern raised - > 15. **Organisational/Financial/Reputational Risk** - Complaint copied to MP/MSP/Scottish Government. Ongoing adverse publicity Category I (HIS) including high probability of litigation. Severe organisational/personal financial loss (£>1m) **Patient Care/Experience** - Significant patient safety/quality of care issues. Unsatisfactory patient experience / clinical outcome, continued ongoing long-term effects.
Major	**Adverse Event** - Major injuries/long term incapacity or disability (loss of limb) requiring medical treatment &/or counselling. **Complaint** - Complaint crosses Acute Services /H&SCPs &/or organisational boundaries. Claim above excess level. Complaints with clear quality assurance or risk management implications, or issues causing lasting detriment that require investigation. Multiple justified complaints. Complaint length between 1000 & 1250 words. Points of concern raised - 10 to 15. **Organisational/Financial/Reputational Risk** - Complaint copied to MP/MSP/Scottish Government. Probability of litigation. Major organisational/personal financial loss (£100k-1m) **Patient Care/Experience** - Significant issues of standards, quality of care or denial of rights. Unsatisfactory patient experience/clinical outcome, long term effects– expect recovery - >1wk.
Moderate	**Adverse Event** - Agency reportable, e.g. Police (violent & aggressive acts). Significant injury requiring medical treatment &/or counselling. Significant injury requiring medical treatment &/or counselling, short-term effects. **Complaint** – Complaint involves more than one 2 Services. Justified complaint involving lack of appropriate care. Below excess claim. Complaint length between 750 & 1000 words. Points of concern raised - 7 to 10. **Organisational/Financial/Reputational Risk** - Complaint copied to MP/MSP/Scottish Government. Moderate harm to the Organisation/temporary loss of service, Significant organisational/personal financial loss (£10-100k) adverse publicity. Category II (HIS). **Patient Care/Experience** - Significant issues of standards, quality of care or denial of rights. Unsatisfactory patient experience/clinical outcome, short term effects – expect recovery <1wk.
Minor	**Adverse Event** - Minor injury or illness, first aid treatment required. **Complaint** - Justified written complaint peripheral to clinical care. Complaint length between 500 & 750 words. Points of concern raised - 4 to 6. **Organisational/Financial/Reputational Risk** – Minor risk of litigation. Minor organisational / personal financial loss (£1-10k) **Patient Care/Experience** - Clinical outcome directly related to care provision – readily resolvable. Unsatisfactory patient experience.
Negligible	**Adverse Event** - no harm but potential to cause harm e.g. near miss Category III (HIS) or leading to minor injury not requiring first aid. **Complaint** - Locally resolved verbal complaint. Complaint length under 500 words. Points of concern raised - 1 to 3. **Organisational/Financial/Reputational Risk** - Reduced quality of patient experience / outcome but not directly related to delivery of clinical care. Negligible organisational/personal financial loss (£<1k) **Patient Care/Experience** - Reduced quality of patient experience / clinical outcome not directly related to delivery of clinical care.

[Type here]

Feedback & Complaints Risk Assessment & Complexity Tool		Template Version: 1.0 Date: 7 November 2023
NHS Fife Patient Experience Team	Page 1 of 2	Review Date: 13 September 2025

What Makes a Good Statement and Response?

A good statement should be written in plain English, using clear, concise language that is easy to understand. Ensure your response is free from jargon and technical/medical terms. Where it is appropriate to use these, please explain them in a simple form. Avoid advising 'on review of the patient notes/healthcare records' within your response. As part of the complaint investigation, healthcare records will always be reviewed. If it is in the notes, it happened.



Frequently Asked Questions

Can people complain about the conduct of NHS staff?

This type of complaint would not be managed under the National Complaint Handling Procedure. This would be addressed by NHS Fife Human Resources Department, or via the professional regulatory body, i.e. GMC or NMC.

How can patients make a Freedom of Information request made?

Requests are emailed to Fife.foirequestfife@nhs.scot

How can patients access their health records?

To obtain copies of your healthcare records or for any Subject Access Request (SAR), please email Fife.subjectaccessrequests@nhs.scot

PET updates

SENIOR PROJECT TEAM
- Supporting PET with Quality Improvements for Complaints
- Priority to improve the Complaint Handling Process
- Action Plan created
- MS Forms Questionnaires
- 3 Project Actions added to PET Risk Register

WEEKLY PET MEETINGS WITH SERVICES
- Primary & Preventative Care
- Community Care Services
- Need to arranged Complex and Critical Care
- Excellent Model within Community Care Services

PLANNING MONTHLY PET MEETINGS WITH SERVICES
- Collaborative Working
- Improvement work
- Delays

LEARNING FROM COMPLAINTS
- Varying processes for recording evidence of learning

EARLY RESOLUTION
- Stage 1 – Services to resolve
- Reduce number of Stage 1 written response
- Stage 2 – offering an initial meeting to support response letter

SINGLE POINT OF CONTACT
- Trialling Single point of contact within Primary and Preventative Care for all complaints

SAER and Complaint Process
- Looking at the process for Complaints and SAER's
- Flow Chart to follow

WORKFORCE TOOL
- Review PET Establishment

CHALLENGES
- Delayed drafting
- Delays within Services in PET receiving statements, and final responses
- Quality of Statements
- Absence within the PET

Patient Experience and Feedback

Recovery and Improvement Plan

December 2023

Published Month Year

www.nhsfife.org

CONTENTS

ISSUE: 1	IMPROVE COMPLIANCE				
OBJECTIVE	Adherence to the NHS Scotland Complaints Handling Procedures (DH 2017) and compliance with National targets. At least 33% of Stage 2 complaints will be completed within 20 working days by March 2024				
No	**ACTIONS**	**LEAD**	**DATE**	**PROGRESS**	**STATUS**
1.1	Revamp and commence PET weekly meeting with Services and review membership to include, clinical and managerial teams	HoPE	Feb 24	Meetings to be organised with HSCP to review complaint handling process. Regularly meeting with Acute. Regular meetings established with Primary and Preventative Care and Community Care within HSCP. However, PET have been liaising with Complex and Critical Care to establish set meeting dates and times.	Ongoing
1.2	Implement complexity scoring system to categorise complaints	HoPE	Mar 24	All open Stage 2 complaints have been recategorized with new complexity scoring. Complexity guidelines to be finalized. A draft copy was sent December 2023 to Senior Management for review and comment.	Ongoing
1.3	Supportive escalation process to be implemented to highlight delays within the Model Complaint Handling Process	PET Lead	April 24	Escalation standard operating procedure to be finalised. Staffing shortages within PET have delayed this project.	Ongoing
1.4	New weekly complaint report to be created and shared with services to provide data and highlight delays within the Model Complaint Handling Process	PET Lead	Nov 23	A new weekly PET report has been created and first issued at the end of November 2023. Data is taken from the Datix Complaint Dashboard.	Complete
1.5	Testing of focused Multidisciplinary Team Meeting (MDT) within Acute to respond to complex complaints in a view to negate the requirement for statements and reduce service response time	PET Lead	Mar 24	Further discussions to take place with Acute to test this.	Ongoing

ISSUE: 2	'MEASURING THE EXPERIENCE': ANALYSIS AND REPORTING				
OBJECTIVE	Digital Solutions for report Live Patient Experience (Complaint) data				
No	**ACTIONS**	**LEAD**	**DATE**	**PROGRESS**	**STATUS**
2.1	Meet with Information Services to discuss and develop Dashboard	HoPE	Apr 23	Met with Digital and Information. Several meetings to discuss proposed Dashboard.	Complete
2.2	Liaise with other Health boards regarding their Dashboards	HoPE	May 23	Met with Lothian and Tayside to review and discuss Dashboards. Sharing of information.	Complete
2.3	Discuss and agree data to be displayed with Acute, Corporate and H&SCP	HoPE	Dec 23	Discussions to take place with Acute and H&SCP once first version of the Dashboard has been shared.	Complete
2.4	Discuss and agree data to be displayed within Patient Experience Team screen	HoPE PET Lead	Mar 24	Once first version of the Dashboard has been shared to display data, further discussions will take place Digital and Information to design PET Dashboard. Initial discussions have taken place.	Not Started
2.5	Identify test area prior to roll out dashboard	HoPE	Nov 24	Once initial version is finalised, this will be rolled out. This was rolled out November 2023.	Complete
2.6	Education and training for dashboard	HoPE	Jan 24	This is being provided ad hoc and a session was delivered to H&SCP.	Ongoing
2.7	Test implementation of dashboard	HoPE	Jan 24	Have requested feedback from users.	Ongoing
2.8	Communication, promotion and raise awareness of dashboard	HoPE	Jan 24	Email sent to all users regarding new Dashboard.	Ongoing
2.9	Roll out Dashboard within NHS Fife	HoPE	Jan 24		Complete
2.10	Scope potential software to utilise as an automated database for complaint handling	HoPE	Jan 24	Met with AXLR8 team 27/10/23 for demonstration of the system.	Ongoing

ISSUE: 3	AWARENESS, EDUCATION AND TRAINING				
OBJECTIVE	Raise awareness and education of the National Complaint Handling Process				
No	**ACTIONS**	**LEAD**	**DATE**	**PROGRESS**	**STATUS**
3.1	Design and publish intranet "Blink" Patient Experience Team page for NHS Staff	HoPE	Dec 23	New PET staff page has been created and launched on Blink.	Complete

3.2	Devise and implement training and education delivery plan	PET Lead	Mar 24	Provisional education and delivery plan to be created. Received template form PPDU.	Ongoing
3.3	Review training and education materials	PET Lead	Mar 24		Not started
3.4	Re-commence regular training and education to staff	PET Lead	Mar 24	Ad hoc training has been provided as requested. Regular training dates will be implemented once a training plan is in place.	Not started

ISSUE: 4	'IMPROVING THE EXPERIENCE': QUALITY IMPROVEMENT				
OBJECTIVE	Ensure that lessons learned from all forms of patient feedback are used to inform quality improvement and promote patient safety				
No	**ACTIONS**	**LEAD**	**DATE**	**PROGRESS**	**STATUS**
4.1	Deliver Patient Experience focused work across NHS Fife, gathering patient feedback and lived experiences	HoPE PET Lead	Mar 24	Bank Patient Support Officer focusing on gathering patient experience from patients who otherwise are unable to provide this.	Ongoing

ISSUE: 5	WORKFORCE				
OBJECTIVE	Ensure that PRT is supported and developed. Ensure that workload and workforce planning is considered in design of team				
No	**ACTIONS**	**LEAD**	**DATE**	**PROGRESS**	**STATUS**
2.1	Complete Workforce analysis tool	HoPE	Mar 24	Gathered data to help with analysis of workload and compare with other National Patient Experience Teams. Comparison between Health boards in relation to number of staff and complaints.	Ongoing
2.2	New Patient Experience Navigators Role within the team	HoPE	Apr 24	Ongoing review of role and responsibilities. Fixed term post appointed to and ongoing review.	Ongoing

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**12 January 2024**
Title:	**Medical Appraisal and Revalidation Annual Report 2022/23**
Responsible Executive:	**Dr Chris McKenna, Medical Director**
Report Author:	**Dr Shirley-Anne Savage, Associate Director of Quality & Clinical Governance**

1 Purpose

This is presented for:

- Assurance

This report relates to a:

- Annual Operational Plan

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The Medical Staff Revalidation and Appraisal report for 2022-2023 (Appendix 1) is being brought to the Staff Governance Committee for their awareness and to provide the committee with assurance that doctors in NHS Fife are up-to-date and are practising to the appropriate professional standards.

2.2 Background

Any doctor wishing to practise medicine in the UK must be registered with the General Medical Council (GMC) and hold a licence to practise which needs to be revalidated every 5 years. This is to assure patients, employers and other healthcare professionals that licensed doctors are up-to-date and are practising to the appropriate professional standards.

2.3 Assessment

NHS Fife continue to meet the requirements of the GMC in terms of Medical Revalidation and Appraisal. Although primary care has no issues around recruitment of appraisers, secondary care has found this a challenge and struggle to recruit and retain sufficient NES trained appraisers. However, this is covered by their current appraisers enhanced with bank appraisers. The role continues to be advertised.

2.3.1 Quality/ Patient and Value-Based Health &Care

Medical appraisal ensures that licensed doctors are up-to-date and are practising to the appropriate professional standards.

2.3.2 Workforce

The impact of the Covid 19 pandemic continues to affect appraisal and revalidation. Many doctors experienced significant delays to their appraisals during the pandemic resulting in some of them only being able to complete 4 appraisals rather than the required 5 during their current revalidation cycle.

2.3.3 Financial

- Not applicable

2.3.4 Risk Assessment/Management

There may be a risk of being unable to meet the GMC requirements for Medical Revalidation and Appraisal if unable to recruit and retain sufficient numbers of NES Trained Appraisers.

2.3.5 Equality and Diversity, including health inequalities

- Not applicable

2.3.6 Climate Emergency & Sustainability Impact

- Not applicable

2.3.7 Communication, involvement, engagement and consultation

NHS Fife has a Medical and Appraisal Revalidation Group, who assess and implement any changes which need to be made to current system to adhere to the national enhanced appraisal process.

NHS Fife meets with representatives of the GMC twice yearly. These meetings cover feedback on actions from the last meeting; GMC and local updates, current GMC cases, closed GMC cases, GMC related press enquiries for NHS Fife doctors and the opportunity for the RO to discuss any other issues such as revalidation.

2.3.8 Route to the Meeting

- Not applicable.

2.4 Recommendation

- Assurance

3 List of appendices

The following appendices are included with this report:

- Appendix 1: Medical Appraisal and Revalidation Annual Report 2022/2023

Report Contact

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NHS Fife

Medical Appraisal and Revalidation Annual Report

Consultants, Career Grade Doctors and General Practitioners

2022/2023

Contents

Medical Appraisal and Revalidation 2022/2023

Consultants, Career Grade Doctors and General Practitioners

Background

Any doctor wishing to practise medicine in the UK must be registered with the General Medical Council (GMC) and hold a licence to practise which needs to be revalidated every 5 years. This is to assure patients, employers and other healthcare professionals that licensed doctors are up-to-date and are practising to the appropriate professional standards.

Revalidation requires annual appraisal, including feedback from colleagues and patients at least once during the five year period. Evidence of the doctor's range and volume of practice, such as the number of operations carried out or prescribing patterns is also reviewed.

Governance Structure

Every doctor wishing to practise medicine in the UK must be linked to a Designated Body and its' Responsible Officer (RO) referred to as a "prescribed connection". Recommendations for the revalidation of all doctors is achieved through each Health Board's RO.

NHS Fife meets with representatives of the GMC twice yearly. These meetings cover feedback on actions from the last meeting; GMC and local updates, current GMC cases, closed GMC cases, GMC related press enquiries for NHS Fife doctors and the opportunity for the RO to discuss any other issues such as revalidation.

In line with national policy Dr Chris McKenna is NHS Fife's Responsible Officer, Dr Iain MacLeod and Dr Helen Hellewell are NHS Fife's Deputy Responsible Officers. This responsibility covers all Consultants, Career Grade Doctors and General Practitioners employed by NHS Fife.

Medical Revalidation in NHS Fife is overseen by the Medical Appraisal and Revalidation Group chaired by Dr Chris McKenna, Medical Director/Responsible Officer – NHS Fife. This group reports to NHS Fife's Clinical and Staff Governance Committees.

Annual Appraisal

Revalidation for doctors in Scotland is achieved by using a standardised bespoke "Enhanced Appraisal" system designed by the National Appraisal Leads Group for Scotland (NALG).

All doctors in both Primary Care and Secondary Care are required to participate in an annual appraisal.

Appraisals are documented using the NHS Education Scotland (NES) provided web based system SOAR (Scottish Online Appraisal Resource). A signed Form 4 (appraisal summary) is proof that an individual has successfully engaged in the Appraisal process for that year.

Appraisers

All appraisers in Scotland must be NES trained. In Primary Care there are 14 NHS Fife appointed NES trained Appraisers. This allows every General Practitioner (GP) to have an annual appraisal. GP Appraiser recruitment is undertaken locally. GP appraisers are expected to undertake around 18 appraisals per annum for 1 session.

In Secondary Care there were 42 NES trained appraisers as of 31 March 2023, having lost one of the bank appraisers and gaining 2 part time appraisers toward the end of the period.

The recruitment and retention of appraisers in Secondary Care can be challenging hence NHS Fife has enlisted the help of a small bank of retired appraisers and are working on developing a strategy to attract eligible doctors to undertake appraiser training and encourage the recruitment of trained appraisers within Secondary Care.

Appraisers in Secondary Care are expected to cover 10 appraisals per year within 0.5 of a Supporting Professional Activity (SPA), although there are a number who do half of this

NES offer the new appraiser training course with 2 courses available most months; however with the pressures on services, it has still been difficult to recruit. The course is 2 half days delivered virtually in combination with e-learning modules.

Continuing Impact of Covid 19 Pandemic on Appraisal/Revalidation

Although the appraisal and revalidation process is essentially back to normal, the impact of the pandemic continues to affect appraisal and revalidation. Many experienced significant delays to their appraisals during the pandemic meaning they have only been able to complete 4 appraisals rather than 5 during their current revalidation cycle.

While a light year for revalidation with only 69 doctors due for revalidation during 2022-2023, a number of doctors have required a deferral of their revalidation date due to the delays and lack of evidence. There were a total of 74 recommendations made as 5 who were deferred were later revalidated during the same appraisal period, 2 in Primary Care and 3 in Secondary Care. See Chart 1 for figures.

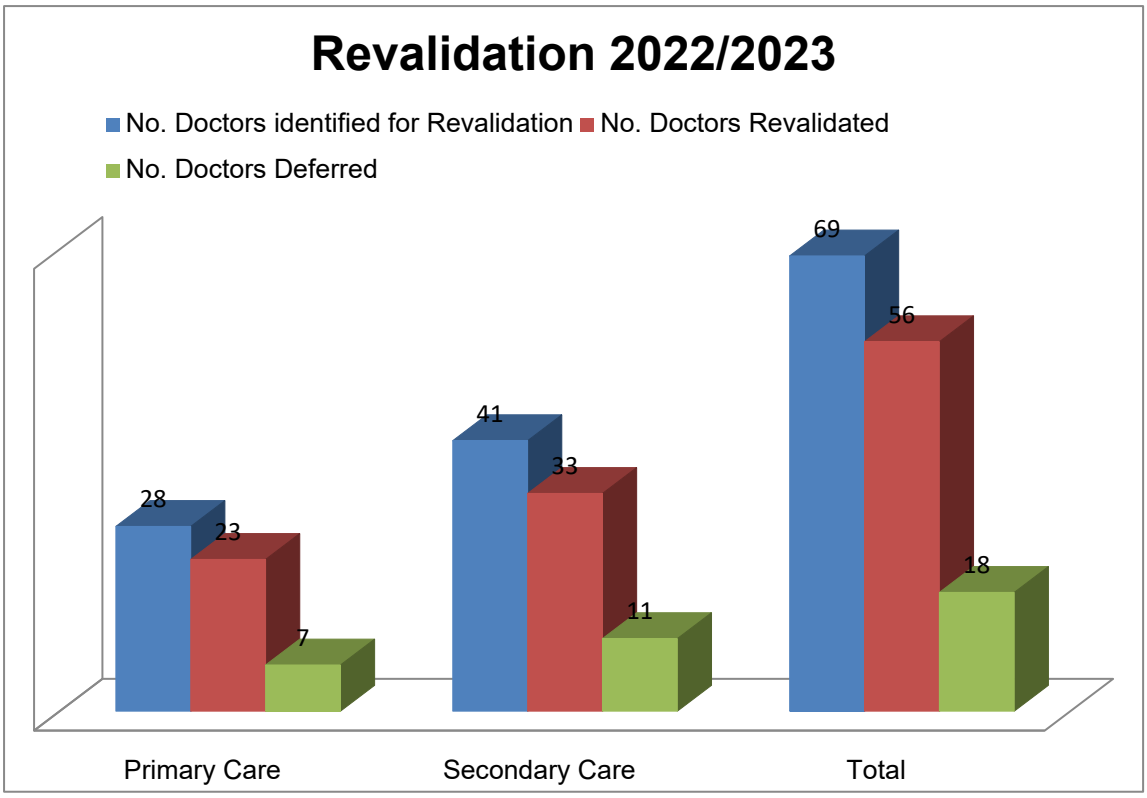


Chart 1: Revalidation 2022/2023
* A total of 5 doctors (2 PC and 3 SC) were deferred later revalidated in the same period.

Appraisal within NHS Fife for Period 1 April 2022– 31 March 2023

As at 31 March 2023 there were 722 doctors with a prescribed connection to NHS Fife. This includes Primary Care (GP's), Secondary Care (Consultants, SAS Doctors, Clinical Fellows and Honorary Consultants), and University staff without an honorary contract.

Appraisals, in the most part, have returned to pre pandemic levels of evidence. Although some are still struggling to obtain patient feedback due to virtual or telephone appointments, the majority are now managing to obtain this without too much difficulty. Despite the delays, most are getting back on track to meet their future revalidation requirements. The focus of appraisal remains on wellbeing.

The figures in Chart 2 show that the majority of those eligible managed to have an appraisal this year. A proportion were not eligible because they were either new to their role and not yet due an appraisal during the period or were issued a Form 5A, giving them exemption for the period. Table 1 shows appraisal numbers for those eligible. Chart 3 shows the reasons for a Form 5A having been issued.

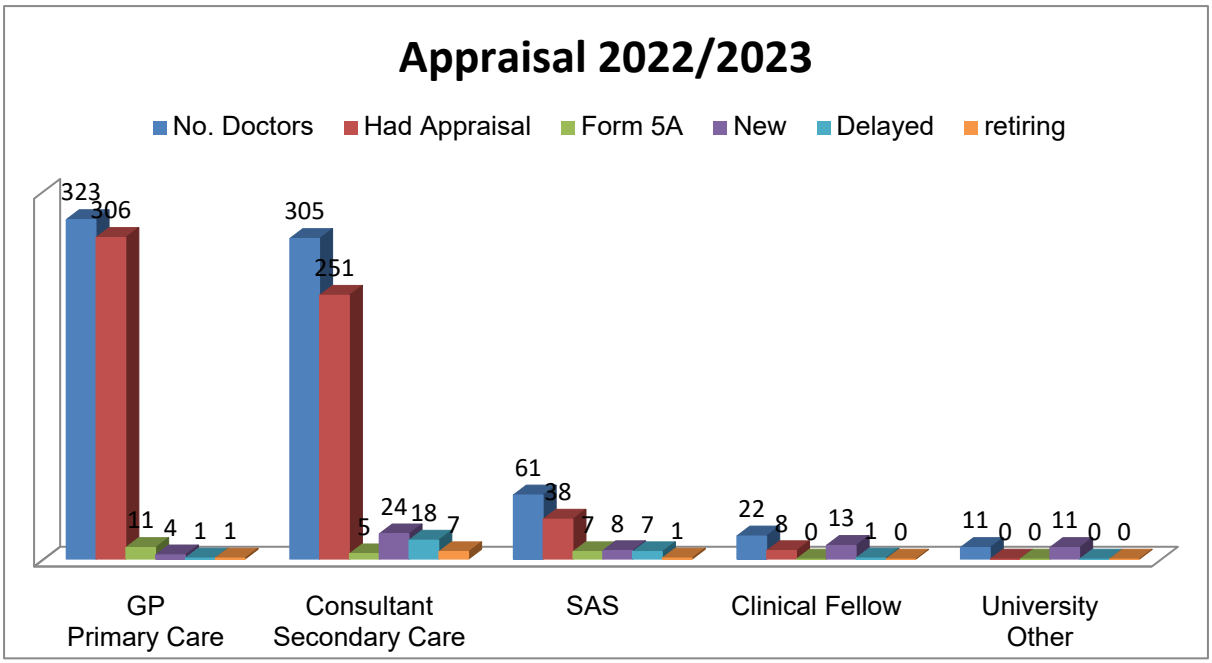


Chart 2: Appraisal 2022/2023

		No. Doctors	No. Not eligible (exempt or new)	**No. Eligible**	No. Had appraisal	**% had appraisal**
Primary Care	GP	323	15	**308**	306	**99.35%**
Secondary Care	Consultant	304	29	**275**	251	**91.27%**
	SAS	83	15	**68**	38	**55.88%**

Table 1: Appraisal Numbers - Those Eligible 2022/2023

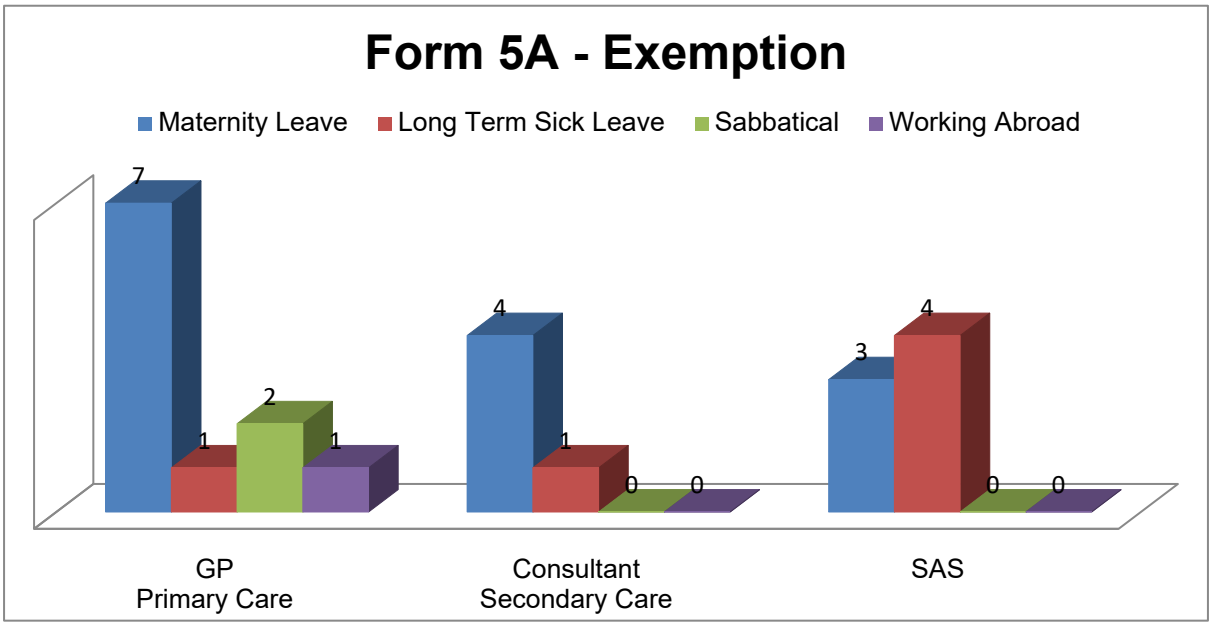


Chart 3: Form 5A's Issued 2022/2023

Summary

The key issues for 2022/2023

1. NHS Fife continues to respond well to the challenges of Medical Appraisal and Revalidation and is getting back on track following the Covid 19 pandemic delays.
2. The GP Appraisal scheme in Fife continues to run well with little or no problems identified therefore no further action is required at this time.
3. The Appraisal process in Secondary Care continues to run well with few problems identified other than recruitment and retention of Appraisers.
4. MARG continues to be instrumental in overseeing the appraisal and revalidation processes and ensuring any issues/challenges that arise are resolved.

The key actions for 2023/2024

1. Continue to maintain an up-to-date record of all Consultants, Career Grade Doctors and General Practitioners with whom NHS Fife has a “prescribed connection”.
2. Continue to develop and implement a strategy to encourage the recruitment of trained appraisers within secondary care in NHS Fife. Create a supportive ‘myth busting’ approach towards appraisal and revalidation in Fife.
3. Continue to support doctors with the appraisal/revalidation process.
4. Develop Medical Appraisal and Revalidation Strategic Framework.

Alison Gracey
Medical Appraisal and Revalidation Coordinator
NHS Fife
6 October 2023

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**12 January 2024**
Title:	**Participation and Engagement Report**
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:

- Annual Delivery Plan
- Government policy / directive
- Legal requirement
- 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 report has been prepared to provide assurance to the Committee on public engagement and consultation work undertaken in the last year.

2.2 Background

"*Community engagement is a purposeful process which develops a working relationship between communities, community organisations and public and private bodies to help them to identify and act on community needs and ambitions. It involves respectful dialogue between everyone involved, aimed at improving understanding between them and taking joint action to achieve positive change*" (The National Standards for Community Engagement, Scottish Community Development Centre).

"**Planning with People**, Community Engagement and Participation Guidance for NHS Boards, Integration Joint Boards and Local Authorities that are planning and commissioning care services in Scotland" was published in March 2021, replacing CEL4 2010. This guidance supports organisations to deliver their existing statutory duties for engagement and public involvement. "Planning with People" sets out how members of the public can expect to be engaged by NHS Boards, Integration Joint Boards and Local Authorities. It encourages close working between bodies to minimise duplication and share learning.

This guidance applies to all health and care services and promotes working with people as equal partners whilst embedding consistency, culture change and collaboration. Although not legally binding, the guidance supports organisations to deliver their existing statutory duties for engagement and public involvement.

The Quality Framework for Community Engagement and Participation, which was published in April 2023, supports NHS boards and Health and Social Care Partnerships (HSCP) to carry out effective community engagement and demonstrate how they are meeting their statutory duties for public involvement and community engagement. It provides a framework to organisations and those assuring them, on what good quality engagement looks like and helps to develop practice and share learning.

It is suggested that the self-evaluation is completed on a 12-month rolling cycle by NHS boards and HSCPs. However, organisations can decide when to use the framework and which domains to include. This self-evaluation will form the basis for organisations demonstrating how their engagement activity is in line with statutory duties, as set out in national guidance. Regular self-evaluation will form part of good internal governance and is a key driver for local improvement work.

Importantly, NHS Fife is developing a **Public Participation and Community Engagement Strategy 2024 – 2028**, led by the Associate Director of Communications. Self-evaluation will be completed as part of this work. It will be closely aligned to the Integration Joint Board Participation and Engagement Strategy for Fife 2022-25.

2.3 Assessment

There has been extensive engagement with staff and the public in relation to the development of the **Population Health and Wellbeing Strategy.**

In March 2023, the NHS Fife Board approved its new Population Health and Wellbeing Strategy for the next five years, with a commitment to providing high-quality health and care services for all Fife citizens.

There was wide-ranging engagement undertaken with members of the public in Fife, community groups and the NHS Fife workforce. An external company, Progressive, was commissioned to support this work. A survey was undertaken which received 1300 responses. Further work was commissioned with Progressive to follow up with a range of focus groups and interviews to explore the findings of the questionnaire in more detail.

Public participation and community engagement will play a crucial role in the implementation and delivery of the strategy, with a focus on a comprehensive engagement programme. The organisation will regularly update staff and the public on progress while seeking feedback and ideas and suggestions from service users and communities across Fife to help shape current and future service delivery in line with the ambitions outline in NHS Fife's strategy and to ensure they address the needs of our diverse range of stakeholders.

Collaborating with other partner organisations involved in planning and providing services will be essential to achieving the strategy's objectives and our community engagement ambitions.

The new NHS Fife Public Participation and Community Engagement Strategy will outline the best practice methods for achieving this engagement.

This includes collaborating with the Fife Health and Social Care Partnerships Engagement team to deliver their participation and engagement strategy ensuring we work in partnership to build services around people's needs and aspirations and work with individuals and communities to build their resilience so that people in Fife are supported to live healthy, independent lives.

The model for participation and engagement includes a **Participation & Engagement Advisory Group (PEAG).**

PEAG is made up of professional staff who act as a single point of contact for services seeking public participation across Acute Services, HSCP Services, Corporate Services and Localities.

Over the last year there has been 21 requests to the PEAG for support. Activity is described in Appendix 1.

Another example of public participation and engagement is with Women and Childrens Services. Service users as part of our midwife led unit development research in conjunction with the City of London University (MUSA). Service users are engaged in the development of pathways of care, for example, Induction of Labour, parent education.

2.3.1 Quality / Patient Care and Value-Based Health & Care

As highlighted in the Feeley Report, "*Service design and delivery can only improve if people with lived experience are involved in the process. It is impossible to address inequality if the people who experience it are not in the room*". Meaningful and sustained engagement practice will ensure that a person-centred approach is undertaken in the planning and delivery of services. Work is being taken forward to ensure people with 'lived experience' are explicitly involved deign and redesign.

The NHS Fife Public Participation and Community Engagement Strategy 2024-2028 will be a significant enabler for delivery of the Population Health and Wellbeing Strategy together with other local strategies. Therefore, it will contribute towards improving Quality / Patient Care.

2.3.2 Workforce

Public participation and engagement supports our workforce to consider how to continually improve the ways in which people and communities can become involved in developing services that meet their needs.

2.3.3 Financial

n/a

2.3.4 Risk Assessment / Management

The duty to involve people and communities in planning how their public services are provided is enshrined in law in Scotland.

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

People can expect to experience integrated care and support services that are underpinned by a Human Rights Based Approach, in which:

- People's rights are respected, protected and fulfilled
- Providers of care clearly inform people of their rights and entitlements
- People are supported to be fully involved in decisions that affect them
- Providers of care and support respect, protect and fulfil people's rights and are accountable for doing this
- People do not experience discrimination in any form
- People are clear about how they can seek redress if they believe their rights are being infringed or denied

2.3.6 Climate Emergency & Sustainability Impact

n/a

2.3.7 Communication, involvement, engagement and consultation

HIS CE recommends that the self-evaluation and improvement plans are shared and published on NHS Fife website to demonstrate how the organisation is planning to improve its approach to community engagement. A group will be established to take this work forward.

2.3.8 Route to the Meeting

This paper has been previously considered by the Patient Experience Team

2.4 Recommendation

- The Committee is asked to take **assurance** from this report and note future steps.

3 List of appendices

The following appendices are included with this report:

- Participation and Engagement Activity, 1 April 2022 – 31 March 2023

Report Contact
Janette Keenan
Executive Director of Nursing
Email janette.keenan@nhs.scot

PEAG: PARTICIPATION AND ENGAGEMENT ACTIVITY 1 APRIL 2022 – 31 MARCH 2023

	Project Title	Request	Distribution	Outcome / Notes
1	Consultation Kincardine Pharmacy	Share with PPD / PP for information	N/A	N/A
2	ENT Leaflets	Readability & Format	N/A	Comments collated and shared with service
3	CYPOT - leaflets	Readability & Format	N/A	Add note
4	RGR - QA Oversight Group	RGR - QA Oversight Group (mental health)	RGR	On hold
5	Psychology Leaflet BLIGSH	Readability & Format	N/A	Comments collated and shared with service
6	Psychology Leaflet Mindfulness & Relaxation	Readability & Format	N/A	Comments collated and shared with service
7	Pharmaceutical Consultation	Consultation	P&ED / P&E External networks	Comments collated and shared with service
8	Consent	Readability & Format	N/A	Comments collated and shared with service
9	Patient Relations Re-branding concept	To ascertain notes of interest	P&ED / P&E External networks	Comments collated and shared with service
10	Stakeholder Event - Fife Rehabilitation Service	To ascertain notes of interest	P&ED / P&E External networks	Comments collated and shared with service
11	Digital Information	Request Public Reps	P&ED / P&E External networks	Comments collated and shared with service
12	SMART East Region	Range participation activities	P&ED	Comments collated and shared with service
13	PE rebranding concepts	Readability & Format	N/A	Comments collated and shared with service
14	Ophthalmology Leaflets	Readability & Format	N/A	Comments collated and shared with service
15	Patient Experience Questionnaire	Readability & Format	N/A	Comments collated and shared with service

16	Patient Hub Project Group	To ascertain notes of interest	PED / PP / Dist lists	Notes of interest collated and shared with service. 18/01/2023
17	Review Map page website Communications	Readability and Format	P&ED Review Group	Comments collated and shared with Service.
18	Cancer Services Groups	Representation	P&ED / P&E External networks	Notes of interest collated and shared with service 27/03/2023
19	Pulmonary Rehabilitation	Readability and Format	P&ED Review Group	Comments collated and shared with Service.
20	Oral & Maxillofacial	Readability and Format	P&ED Review Group	Comments collated and shared with Service.
21	CIRCuiTS - Psychology	Readability and Format	P&ED Review Group	Comments collated and shared with Service.

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**Friday 12 January 2024**
Title:	**Research & Development Progress Report & Strategy Review 2023-25**
Responsible Executive:	**Dr Christopher McKenna, Medical Director and Executive Lead RIK**
Report Author:	**Professor Frances Quirk, Assistant Director Research, Innovation and Knowledge**

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Annual Delivery Plan

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The Research and Development Review of Strategic Priorities 2022-2023 and the refreshed Research, Innovation and Knowledge (RIK) Strategy 2022-2025 are being brought to the Clinical Governance Committee for their Awareness to provide an update on activities against 2021-2022.

2.2 Background

This Review details the activities aligned to the 2022-2023 Strategic Priorities within RIK across NHS Fife from April 2022 to March 2023. The RIK Strategy documents the refreshed strategies to address direction and priorities for 2022-2025. The RIK strategy will support NHS Fife's overall strategic aim to 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. The RIK Strategy will support this by:

- promoting a culture that supports and encourages research and innovation 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 and innovation;

- promoting research and innovation within an appropriate governance framework;

- developing research and innovation knowledge and skills of staff and appropriate independent contractors;

- working in partnership with the citizens of Fife to ensure that research and innovation is patient-centered;

- aligning activity and priorities with the Population Health and Wellbeing Strategy and the Boards ambition to transition to Teaching/University Hospital status.

  Effective completion of activities supporting these priorities will better position NHS Fife to: seriously address the research and innovation agenda; compete successfully in the national research and innovation arena; attract new and retain existing staff; whilst improving healthcare for the citizens of Fife.

2.3 Assessment

Notwithstanding significant achievements it is recognised that there is still scope to increase the research and innovation capacity and capability within NHS Fife. The outcomes of the Research Capacity and Culture Survey identified the main barriers to research are; a lack of protected time and/or dedicated funds for research, a lack of peer group support, lack of training in research skills and a perceived lack of the relevance / importance of research.

Every NHS organisation requires an appropriate balance of service delivery, research and learning in order to deliver the healthcare needs of the population. NHS Fife is predominately involved with service delivery supported by lifelong learning. Taking account of future demographic, social and technological change NHS Fife must increase the emphasis placed on research and innovation activity in order to support the delivery of the local health plan, the Annual Delivery Plan, the Population Health and Wellbeing Strategy and the national research and innovation agenda into the future.

2.3.1 Quality, Patient and Value-Based Health & Care

Clinical research and innovation inform the development of better outcomes in healthcare. New knowledge gained through clinical research and innovation results in improved methods of disease detection, prevention, diagnosis and treatment.

The benefits of clinical research and innovation are not only limited to patients who receive better health journeys as a result of their participation in clinical studies and innovation projects. Studies show that research and innovation active hospitals have improved

outcomes for all patients, not just study participants, research and innovation engagement also improves staff recruitment and retention through improved job satisfaction.

2.3.2 Workforce

The ongoing recovery from a focus on COVID studies alongside restarting suspended studies placed strain on staff's ability to adequately service restarted non-COVID studies and has had implications for capacity to participate in eligibly funded studies. This may have implications for future budget allocations. Reaching capacity will impact on meeting priorities related to increasing the number of studies, recruitment numbers and CSO budget allocations.

2.3.3 Financial

NHS Fife's annual research budget allocation of Support Funding from CSO (Chief Scientist's Office) was £830,000 in 2022-23, this was increased to £845,000 with an additional £15,000 uplift to cover the 7.5% pay award. These monies are provided for research considered eligible for funding, in recognition of the costs incurred by the NHS of undertaking and participating in such projects. This is currently the main source of funding available to support research in NHS Fife. Additional funding can be secured by increasing the number of eligibly funded projects undertaken by an NHS organisation, increasing the number of NHS Fife Chief Investigators and the recruitment into such studies. Additionally, commercial research and a small number of specific grant funded projects undertaken across NHS Fife also provide funding to support key staff to be employed to enable the research to be undertaken. Commercial research does not attract support funding from CSO since all costs to the NHS of participating in such activities must be met in full by the participating companies. Income from commercial recruitment activity during 2021-22 was £107,000 (compared with £77,000 in 2021-2022 and £135,603 in 2020-2021).

2.3.4 Risk Assessment / Management

Research, Innovation and Knowledge Oversight Group has noted the changes in the number of staff involved in research and commercial and non-commercial income generated over the reporting period. These KPI's will be a focus of monitoring and the development of strategies to address them in 2023-2024. A strategy to support and develop growth in Chief and Principal Investigators has been developed and is being implemented.

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

-

2.3.6 Climate Emergency & Sustainability Impact

-

2.3.7 Communication, involvement, engagement and consultation

Communication is the lynchpin of creating a research and innovation focused culture. During 2022-2023 regular NHS Fife Research and Innovation Newsletters and Bulletins were delivered, a monthly Publications Bulletin was circulated. Relevant updates, funding opportunities and education and training was circulated on StaffLink. The Publications

Bulletin and R&D weekly updates have been made available as outward facing to facilitate knowledge sharing and foster opportunities for collaboration. The NHS Fife Research Annual Report 2022-2023 has been produced and will be disseminated with stakeholders and research education and training was provided for NHS Fife staff and others.

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.

- Research, Innovation and Knowledge Operational Group – papers reviewed by circulation, feedback requested and responded to, where relevant (1st November 2023)
- Fife Community Advisory Council – papers reviewed and feedback requested (December 2023)
- Research, Innovation and Knowledge Oversight Group – papers reviewed, feedback requested and responded to (11th December 2023)
- Executive Directors Group- for Awareness (4th January 2024)

2.4 Recommendation

This paper is provided to members for:

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

3 List of appendices

The following appendices are included with this report:

- Appendix No 1 Research Strategy Priorities 2022-2023
- Appendix No 2 Research, Innovation and Knowledge Strategy 2022-2025

Report Contact
Professor Frances Quirk
Assistant Director Research, Innovation and Knowledge
Email frances.quirk@nhs.scot

OUTCOME OF ACTIVITIES AGAINST RIK STRATEGIC PRIORITIES 2022-2023

The following plan of activities has been developed from the 2022-2025 NHS Fife Research Strategy. To ensure delivery, activities have been prioritised and resource requirements determined. Completion of this plan will better position NHS Fife to: seriously address the research and innovation agenda; successfully compete in the national research and innovation arena; attract new and retain existing staff; whilst improving healthcare for the citizens of Fife.

(A) PROMOTING A CULTURE THAT SUPPORTS AND ENCOURAGES RESEARCH AND INNOVATION.

Investment in new clinical posts (medical, pharmacy, psychology, allied health professional, nursing and supporting staff) in order to establish meaningful clinical academic positions and/or active researchers with identified and protected research time.

	OUTCOME
A1. To continue to encourage discussion of research as part of normal Personal Development Plans and appraisals of health care staff.	**ONGOING**
A2. To continue RIK participation in the development of the medical, pharmacy, allied health professions and nursing clinical academic career development in Fife.	**ONGOING**
A3. To continue to support and participate in NHS Research Scotland (NRS) East of Scotland research node with St Andrews and Dundee Universities, and NHS Tayside by establishing for example joint standard operating procedures, co-sponsorship agreements.	**ONGOING**

(B) WORKING WITH PARTNERS.

Establish a mutually meaningful and productive link with academic institutions

In order to establish this NHS Fife will continue to:

	OUTCOME
B1. Identify and understand corporate arrangements with institutions such as St Andrews, Edinburgh, Dundee, Napier, Queen Margaret and Abertay Universities to facilitate collaboration.	**ONGOING**
B2. Continue investment (financial or other) with academic institutions (especially St Andrews University Medical School) that will result in a critical mass of research active individuals, employed/seconded by NHS Fife and/or universities to build research capacity and governance structures.	**ONGOING**

(C) PROMOTING RESEARCH AND INNOVATION WITHIN AN APPROPRIATE GOVERNANCE FRAMEWORK AND SECURING APPROPRIATE SUPPORT TO ENSURE FINANCIAL PROBITY

	OUTCOME
In consolidating the research and innovation governance structures the current areas that need to be considered include:	
C1. Continuing to identify commonalities / engagement between the clinical, research, innovation, quality improvement, information and educational governance structures within NHS Fife.	**ACHIEVED**
C2. Preparing for a potential inspection from Medicines and Healthcare products Regulatory Agency.	**ONGOING**
Increasing the income generated from increased research activity, creating opportunities to further enhance and invest in research programmes in Fife by:	
C3. Maximising commercial and non-commercial research opportunities locally and in collaboration on with external partners.	**ONGOING**

(D) WORKING IN PARTNERSHIP WITH STAFF AND COMMUNICATING RESEARCH AND INNOVATION INFORMATION ACROSS NHS FIFE.

Consolidate a research and innovation communication strategy with all NHS Fife communities.

Communication is the linchpin of creating a research and innovation focused culture. During 2022-23 we will:

	OUTCOME
D1. Deliver a regular NHS Fife Research Newsletter.	**ACHIEVED**
D2. Produce and disseminate an NHS Fife Research Annual Report.	**ACHIEVED**
D3. Provide research workshops for patients, carers and other citizens of Fife	**ACHIEVED**

(E) PATIENT AND PUBLIC INVOLVEMENT

	OUTCOME
E1. Develop meaningful engagement of the public in research and innovation	**ACHIEVED**

Professor Frances Quirk
Assistant RIK Director, NHS Fife

December 2023

Progress against these priorities has been discussed and agreed by the NHS Fife RIK Operational Group and the NHS Fife Research, Innovation and Knowledge Oversight Group.

RESEARCH, INNOVATION & KNOWLEDGE STRATEGY 2022-25

Greater knowledge
Better services …

Last review date: **November 2023**

Next Formal Review: **August 2024**

Implementation Date: **December 2023**

Authors: **Prof Frances Quirk, Assistant Research, Innovation and Knowledge Director, NHS Fife Research, Innovation and Knowledge Leadership Team**

Submission Plan	Date
NHS Fife Research Innovation and Knowledge Operational Group	1st November 2023 (by circulation)
NHS Fife Research Innovation and Knowledge Oversight Group	11th December 2023
NHS Fife Clinical Governance Committee	12th January 2024
Executive Directors Group	18th January 2024

1. INTRODUCTION

1.1 NHS Research Scotland (NRS) via the Chief Scientist Office (CSO) has highlighted the need for the NHS to be an innovative and research-active environment, to ensure that good ideas are translated into wider practice and that ideas with commercial potential are identified and promoted.

1.2 The Scottish Government Health Department (SGHD) is committed to increasing the level of high quality research conducted in Scotland for the health and financial benefits of our population, so we are recognised globally as a leader in health science (Delivering Innovation through Research – Scottish Government Health and Social Care Research Strategy, 2015, UK Vision for Clinical Research Delivery and Implementation Plan). Both the SGHD and the UK Vision for Clinical Research strategies highlight what needs to be done, detailing the areas where we can and should make a difference and the need to increase the scope, relevance and quality of research to meet the health and healthcare needs of the people of Scotland.

1.3 The 4 national Research Governance Frameworks (RGF) for Health and Community Care (2006), updated to create an overarching UK Policy Framework for Health and Social Care Research (2017), promotes improvements in research quality and sets the standards for good practice.

1.4 At a local level NHS Fife, as part of Fife Partnerships is working towards greater integration of research and innovation activities in order to:

'Develop and make best use of knowledge from research, innovation and information resources to help achieve Fife's Population Health and Wellbeing Strategic priorities'.

1.5 For the purposes of this strategy 'Research' is defined as:

- All forms of clinical and population research involving patients or members of the public in Fife. This includes work that entails new data collection as well as the analysis of routinely collected data. It also includes research into care pathways that cross boundaries with other agencies.

'Development' is defined as:

- any systematic evaluation of the application of the results of research into practice.

'Innovation' is defined as;

- 'the act or process of introducing new ideas, devices, or methods'. Within healthcare, the World Health Organization (WHO) explains that 'health innovation' improves the efficiency, effectiveness, quality, sustainability, safety, and/or affordability of healthcare.

And 'Partners' are defined as:

- academic institutions, regional and national research networks and other agencies involved in, for example, Fife's Health and Social Care Partnership.

2. CURRENT RESEARCH, INNOVATION and KNOWLEDGE ACTIVITY

2.1 NHS Fife's annual research budget allocation of Support Funding from CSO (Chief Scientist's Office) was £830,000 in 2022-2023. These monies are provided for research considered eligible for funding, in recognition of the costs incurred by the NHS of undertaking and participating in such projects. This is currently the main source of funding available to support research in NHS Fife. Additional funding can be secured by increasing the number of eligibly funded projects[1] undertaken by an NHS organisation, increasing the number of NHS Fife Chief Investigators and the recruitment into such studies. Additionally, commercial research and a small number of specific grant funded projects undertaken across NHS Fife also provide funding to support key staff to be employed to enable the research to be undertaken. Commercial research does not attract support funding from CSO since all costs to the NHS of participating in such activities must be met in full by the participating companies. Income from commercial recruitment activity during 2022-23 was £107,000 (compared with £77,000 in 21-22, £135,603 in 20-21 and £99,850 in 19-20).

2.2 Funding is used to support research and development activities in NHS Fife. It provides the responsive and collaborative infrastructure (Appendix 1) necessary to ensure the required management and governance of the research undertaken. Appendix 2 illustrates the NHS Fife committee structure in relation to RIK.

2.3 There are 87 currently recruiting research projects registered across NHS Fife (compared with 103 in 21-22, 259 in 19-20 and 237 in 18-19). The top 6 Scottish Specialties in 2022-2023 in terms of recruited participants for Eligibly funded studies were: Reproductive Health & Childbirth (473), Trauma & Emergencies (393), Cardiovascular (131), Infectious Diseases & Microbiology (130), Stroke (59) and Respiratory Disorders (56).
There are currently 56 NHS Fife staff who are active as CI's and/or PI's, with 4 of these staff acting as PI for 4 or more clinical research studies.

2.4 Despite ongoing achievements it is recognised that there is still scope to increase the research and innovation capacity within NHS Fife. The recently completed Research Capacity and Culture Survey identified a lack of protected time, and a perceived lack of the relevance / importance and visibility of research as relevant. The Survey responses also identified that links with Universities, particularly the University of St Andrews were key to research and innovation growth.

[1] projects funded by any of the non-commercial charitable or government organisations detailed in the list of qualifying funders on the CSO website.

2.5 Every NHS organisation requires an appropriate balance of service delivery, research, innovation and learning in order to deliver the healthcare needs of the population. NHS Fife is predominately involved with service delivery supported by lifelong learning. Taking account of future demographic, social and technological change NHS Fife must increase the emphasis placed on research activity in order to support the delivery of the local health plan and Clinical Strategy into the future.

3. NHS FIFE'S VISION FOR RESEARCH, INNOVATION AND KNOWLEDGE

3.1 Strategy Aim

The RIK strategy will support NHS Fife's overall strategic aim to 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. The RIK strategy aligns with the NHS Fife Population Health and Wellbeing Strategy and will support the four priorities and ambitions within.
https://www.nhsfife.org/news-updates/campaigns-and-projects/population-health-and-wellbeing-strategy/

The RIK Strategy will support this by:

- promoting a culture that supports and encourages research and innovation 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 and innovation;
- promoting research and innovation within an appropriate governance framework;
- developing research and innovation knowledge and skills of staff and appropriate independent contractors;
- working in partnership with the citizens of Fife and Fife Community Advisory Council to ensure that all activity is patient-centered and is informed by patient and public input;

4. PROMOTING A CULTURE THAT SUPPORTS AND ENCOURAGES RESEARCH AND INNOVATION

4.1 As a result of receiving R&D support funding from NRS and Innovation support through the Health Innovation Hub South East Scotland (HISES) considerable progress has been made in NHS Fife, supporting and encouraging research

and innovation activities. Work will continue to be taken forward within existing resources to make research and innovation meaningful and increasingly accessible and to ensure its integration into everyday practice and policy development.

4.2 We (NHS Fife) will continue to achieve this by:

- supporting the NHS Fife Executive Lead and Assistant Director Research, Innovation and Knowledge (RIK) to deliver against corporate and strategic objectives

- supporting the NHS Fife Research, Innovation and Knowledge Oversight Group

- advocating to include RIK information in recruitment and induction materials, personal development plans, knowledge and skills frameworks, contracts and terms of employment

- enabling access to the evidence base to support research and innovation by providing access to a full range of library services

- promoting research and innovation' achievements in Fife as part of clinical governance activities

- producing an annual report on research, innovation and knowledge activity for submission to Fife NHS Board and Clinical Governance Committee

- ensuring RIK is a high profile item for discussion on the agenda of appropriate NHS Fife meetings e.g. Clinical Governance Committee

- including measurable objectives for research and innovation within NHS Fife's RIK Strategy

5 WORKING WITH PARTNERS

5.1 NHS Fife currently works with a number of partners to take forward research and innovation. By improving the co-ordination and links at a senior level we aim to increase the volume and quality of research and innovation and the opportunities for Fife-based clinicians and other staff to become Principal / Chief Investigators.

5.2 In addition to supporting an NHS Fife Executive Lead/Assistant Director for Research Innovation and Knowledge we have achieved this by:

- enabling joint senior clinical appointments with our university partners

- identifying and supporting staff to nominate for honorary appointments with our university partners

- seeking opportunities to improve research and innovation collaboration with NHS Fife's Health and Social Care Partnership (HSCP)

- promoting multidisciplinary and multiagency research and innovation

- identifying local research and innovation education/training needs

- working with established regional and national networks (such as the Scottish Cancer Research Network (SCRN), Scottish Primary Care Research Network (SPCRN), Scottish Diabetes Research Network (SDRN), Scottish Stroke Research Network (SSRN), Scottish Mental Health Research Network (SMHRN), Scottish Neuroprogressive and Dementia Research Network (SDCRN), and Social Dimensions of Health Institute (SDHI), HISES, Scottish Health and Industry Partnership (SHIP) and InnoScot Health) to identify resources and mentors to provide support for staff undertaking research and Innovation.

- concentrating on developing and supporting developing researchers through targeted funding calls and support for applications for both research and Innovation Fellowships and following Fellowship completion.

<u>NRS Fellowships, Clinical Research and Innovation Champions and Clinical Innovation pre and post Fellowship support:</u>

  - Infectious Diseases
  - Orthopaedics
  - Palliative Care
  - Addiction Medicine
  - Women and Children's Health (Developmental Dysplasia of the Hip)

<u>Collaborative workshops:</u>

  - Digital Health Science Initiatives

  - Supporting the South East Regional Innovation Programme through our involvement with the South East Health Innovation Hub (HISES).

  - CSO Innovation Open Innovation Challenges and Consortium

Over the next 12 months we will:

- Continue to identify and prioritise joint clinical academic and honorary positions between NHS Fife and the University of St. Andrews
- Continue to improve the research and innovation culture within the clinical environment in Fife by supporting the nursing, allied health professional and supporting staff to establish their research and innovation priorities
- Support NHS Fife's vision in helping to shape /deliver the Clinical Strategy that meets the demands of future populations and COVID-19 recovery and resilience programmes

- Deliver the Joint Annual Collaborative Research and Innovation Symposium with the University of St Andrews

5.3 As a result of the above actions we will aim to:

- *increase the number of staff actively involved in Research and Innovation activity by 7.5% each year*

- *increase the number of ongoing projects, including eligibly funded /adopted projects as defined by the CSO, and commercial research within NHS Fife by 10% per year*

- *increase the number of publications by NHS Fife Staff in peer reviewed journals by 10% per year*

- *Increase the number of clinical academic positions by 10% over the next 3 years.*

6 PROMOTING RESEARCH AND INNOVATION WITHIN AN APPROPRIATE GOVERNANCE FRAMEWORK

6.1 Research and Innovation Governance is the framework through which NHS Fife Board can be assured that the quality of research and innovation is maintained and continuously improved and that high standards of patient care are maintained when research and innovation is carried out.

Research and Innovation Governance is used as an overarching term to describe the cohesive set of management and quality improvement systems to ensure NHS Fife meets its commitment to deliver high quality research and innovation, whilst protecting patients and researchers alike. The processes and procedures for Research Governance are much better developed and supported nationally and locally than Innovation Governance. The internal framework for Innovation Governance is being rolled out in 2022 and mirrors the process at HISES

The UK Policy Framework for Health and Social Care Research (2017) highlights 'the need for organisations to be aware of the activity involved in supporting research and of what it costs'. Further, as a minimum requirement, the CSO expects that as part of sound research governance arrangements NHS organisations should ensure that expert accounting input is available for the costing and monitoring of all research (both commercial and non-commercial). NHS Fife needs to be able to demonstrate to its auditors that it is covering the entire cost of undertaking research, including appropriate R&D Department costs and organisation overheads for commercial research. NHS Fife, therefore, needs to deliver rigorous and effective costing mechanisms and financial management in RIK.

This has been achieved in Fife through delivery of efficient research management and approval processes, developing research databases, providing support & training for researchers, ensuring financial probity, utilising

EDGE to monitor individual study costs and monitoring ongoing research and the publications arising from it.

Our approach to Research and Innovation Governance demonstrates to staff, users and carers that improving the quality of research and Innovation provided by NHS Fife is viewed as an important issue across the organisation.

6.2 In order to achieve this we will:

- ensure that all externally (out with NHS Fife) and internally (within NHS Fife) commissioned research undertaken in NHS Fife is registered and accurately costed
- Implement and refine the new Innovation Governance Framework
- ensure that policies are in place to support invention and innovation in NHS Fife while exploiting the potential these activities present for the organisation
- update, improve and develop NHS Fife policy, procedures and guidelines for commercial and non-commercial research and innovation
- ensure we undertake an annual monitoring exercise to identify all ongoing research and innovation
- ensure we undertake an annual audit of all research sponsored by NHS Fife
- ensure accurate data capture systems are in place to record RIK activity for analysis and dissemination
- maintain RIK tabs and links on the NHS Fife StaffLink Corporate hub and the RIK website
- hold regular awareness raising sessions around R&D, Innovation and Intellectual Property (IP)
- continue to employ a dedicated RIK Business Accountant from the NHS Fife Finance Directorate and have:
    - appropriate financial management, ensuring that the allocation of financial resources is effective & sustainable, bringing value to RIK as a service while providing guidance on the costs of research and recovery of such costs
    - costing mechanisms for commercial and non-commercial research
    - systems to identify patient recruitment to studies, raise invoices and track payments
    - systems that comply with financial probity to facilitate appropriate transfer of monies from one organisation to another
    - systems to accept, manage, monitor and disseminate funds.

- ensure that financial systems and audit trails are in place to capture and account for support funding expenditure and NHS Fife overheads from commercial research.

6.3 As a result of the above actions we will continue to:

- *provide R&D support for every research project registered in NHS Fife*
- *provide assurance to NHS Fife Board that all research activity meets the requirements of the UK Policy Framework for Health and Social Care Research*
- *increase the identification and protection of intellectual property by 5% each year thereby increasing commercialisation activity, increasing both financial and healthcare benefits for NHS Fife through opportunities arising from the HISES Innovation Programmes*
- *ensure that a minimum of 10% of all 'high risk' projects[2] sponsored by NHS Fife are audited annually.*
- *continue to provide accurate regular updates and annual reports on financial expenditure and research activity to the CSO*
- *continue to provide financial information for the NHS Fife Research Innovation and Knowledge Annual Report*
- *continue to identify the actual cost of research undertaken in NHS Fife and maximise our returns from commercial research.*
- *Maximise utilisation of the Clinical Research Facilities and explore opportunities for extension.*

7 WORKING IN PARTNERSHIP WITH STAFF

7.1 Research and Innovation is undertaken by and with staff for the benefit of patients and members of the public. It is essential that we work with staff and the Public Partnership Forum to promote the benefits of research and innovation activity for individual staff members as part of their commitment to personal development.

Research and Innovation activity depends on staff having appropriate skills. The Assistant RIK Director and RIK Team will, in collaboration with other NHS organisations, university partners and external agencies and within existing resources, provide the necessary information for staff to access regular research education and workshops both within and out with NHS Fife.

7.2 In order to achieve this we will continue to:

[2] projects where the potential for an adverse event is deemed to be higher, such as those involving investigational medicinal products, devices or investigations. NB NHS Fife does not currently sponsor Clinical Trials of Investigational Medicinal Products.

- Identify / determine research and innovation education needs within NHS Fife

- encourage staff to consider research and innovation training and education and the development of evidence-based practice as part of their CPD

- work jointly with other external organisations to promote access to high quality multidisciplinary/multiagency programmes which address identified research and innovation training requirements

- encourage and support NHS Fife staff to apply for NRS Research Fellowships, CSO Clinical Innovation Fellowships, Doctoral Training Programme Fellowships and other programmes, details of which will be circulated throughout NHS Fife.

- identify sources of funding and work towards securing funds in partnership with new and established researchers and innovators to undertake research and innovation within the identified priorities and needs areas.

7.3 As a result of the above actions we will, in addition to increasing the percentage of staff actively involved in research and innovation activity:

  - *review the demand and access to research and innovation training and education, plan and determine access to widely accessible programmes out with NHS Fife and with university partners aimed at increasing the capability of staff to undertake research and innovation*

  - *increase the number of staff participating in research and innovation training and education both within and out with NHS Fife*

  - *support staff aspirations in registering for higher degrees.*

8 PATIENT AND PUBLIC INVOLVEMENT IN RESEARCH AND INNOVATION

8.1 It is important that the organisation has systems in place to identify the involvement of consumers in research and to ensure their involvement in the development and execution of research projects.

8.2 In order to achieve this we will continue to:

- ensure that there is patient and public representation on relevant RIK groups
- encourage the involvement of patients and the public in the development of studies and patient information relating to research and innovation projects

9 COMMUNICATING RESEARCH AND INNOVATION INFORMATION ACROSS NHS FIFE

9.1 Two-way communication of Research and Innovation information across NHS Fife presents a significant challenge due to the dispersed nature of the

organisation. In light of this, established communication networks are used where possible.

9.2 Health & Social Care Partnerships, the Division and Corporate Directorates use current systems such as StaffLink, local newsletters, briefing sheets or web sites to disseminate information about local and National research initiatives.

9.3 RIK has presence on StaffLink along with a RIK website. Relevant information and updates will also continue to be provided via the monthly electronic bulletin, quarterly newsletter and on the website and the RIK Twitter account. Updates to this information will be supported by staff within RIK and co-ordinated by the Assistant RIK Director.

9.4 The NHS Fife Research, Innovation and Knowledge Oversight Group will continue to be actively involved in promoting research awareness, the RIK Strategy and communicating the benefits of Research and Innovation to staff, users, carers and other partner organisations in Fife, Scotland and the rest of the UK.

10 PLAN OF ACTIVITIES AND PRIORITIES FOR 2023-24

11.1 In order to ensure the continued implementation of this wide-ranging strategy, it has been agreed that a number of strategic 'priorities' will be selected annually, to be advanced throughout the year, and reported on at the year end. These priorities are included in Appendix 3.

12 REVIEW

This Strategy and Plan of Activities and Priorities will be reviewed in August 2024 leading to refinements to the first Research, Innovation and Knowledge Strategy and Annual Priorities from November 2024.

References

1. UK vision for clinical research delivery (launched March 2021)
2. The Future of UK Clinical Research Delivery: 2022 to 2025 implementation plan
3. Delivering Innovation through Research (2015)
4. Scottish Office Department of Health Research Strategy (2009)
5. UK Policy Framework for Health and Social Care Research (2017)
6. Scottish Office Department of Health Funding Manual (2004)
7. Policy Framework for the Management of Intellectual Property within the NHS Arising from Research & Development MEL (1998)23.
8. Management of Intellectual Property in the NHS. HDL (2004) 09
9. NHS Fife Population health and wellbeing strategy (2023–2028)

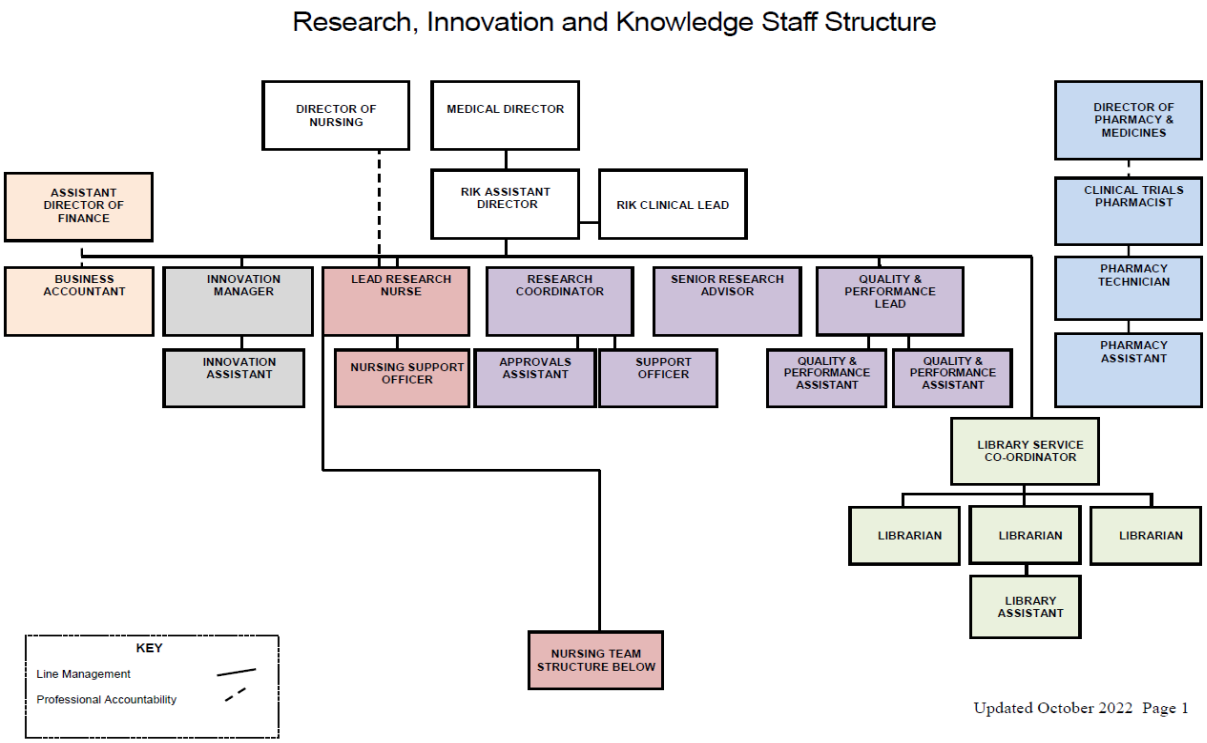
13 RECOMMENDATION

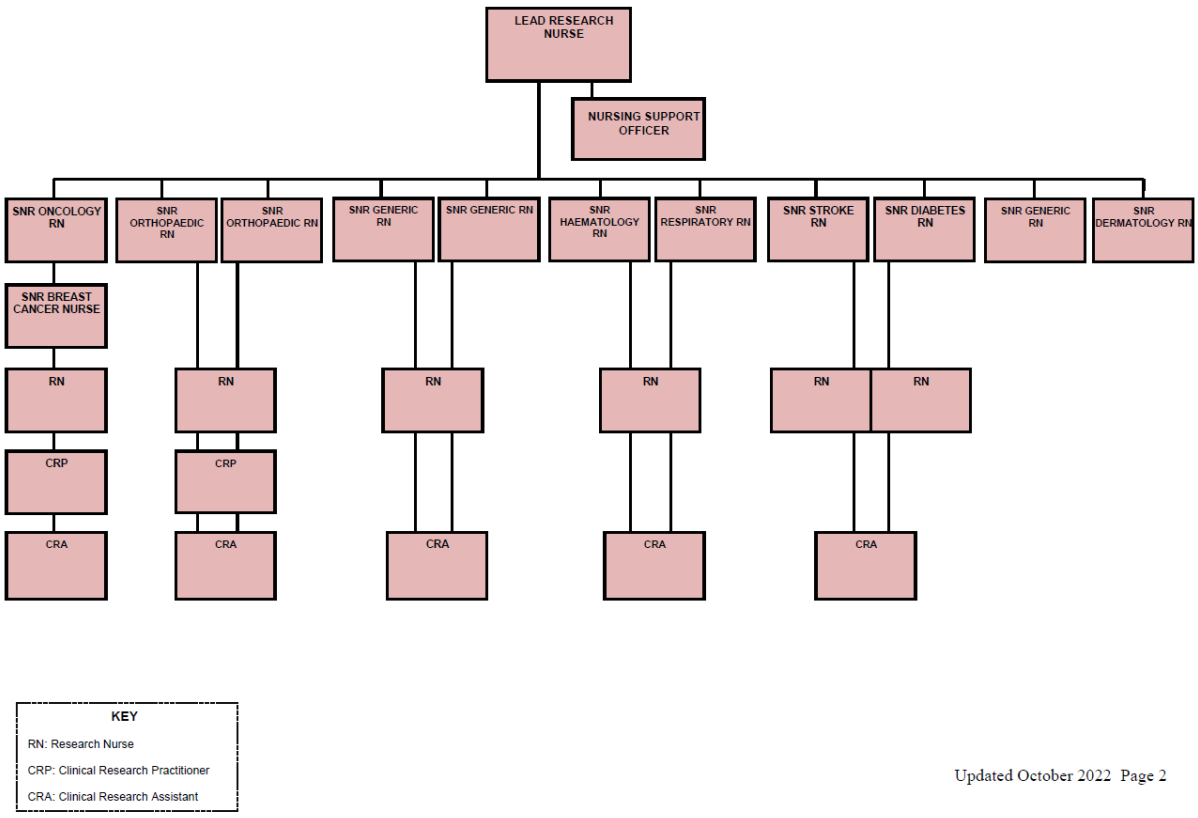
This paper is provided for:

- Assurance

Appendix 1

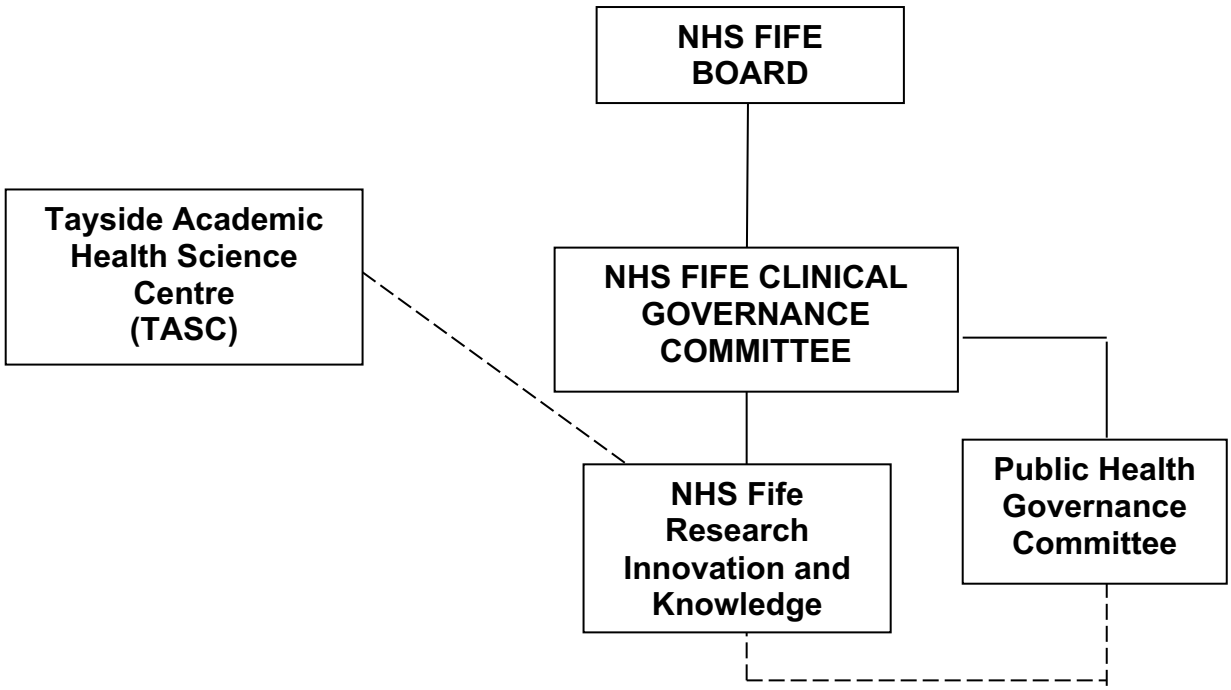
NHS Fife Research, Innovation and Knowledge Support Structure 2022-23





Appendix 2

COMMITTEE STRUCTURE / NHS FIFE IN RELATION TO RESEARCH, INNOVATION AND KNOWLEDGE



Accountability ————

Communication _ _ _ _ _ _ _ _ _

Appendix 3

PLAN OF ACTIVITIES AND PRIORITIES FOR 2023-24

The following plan of activities has been developed from the current NHS Fife RIK Strategy. To ensure delivery, activities have been prioritised and resource requirements determined. Completion of this plan will better position NHS Fife to: seriously address the research and innovation agenda; compete in the national research and innovation arena; attract new and retain existing staff; whilst improving healthcare for the citizens of Fife.

(A) PROMOTING A CULTURE THAT SUPPORTS AND ENCOURAGES RESEARCH AND INNOVATION.

Investment in new clinical posts (medical, psychology, allied health professional, nursing and supporting staff) in order to establish meaningful clinical academic positions and/or active researchers or innovators with identified and protected time.

A1. To continue to encourage discussion of research and innovation as part of normal Personal Development Plans and appraisals of health care staff.

A2. To continue RIK participation in the development of the medical, nursing and allied health professional clinical academic career development in Fife.

A3. To continue to support and participate in NHS Research Scotland (NRS) East of Scotland research node with St Andrews and Dundee Universities, and NHS Tayside by establishing for example joint standard operating procedures, co-sponsorship agreements.

(B) WORKING WITH PARTNERS.

Establish a mutually meaningful and productive link with academic institutions

In order to establish this NHS Fife will continue to:

B1. Identify and understand corporate arrangements with institutions such as St Andrews, Dundee, Edinburgh, Napier, Queen Margaret and Abertay Universities to facilitate collaboration.

B2. Continue investment (financial or other) with academic institutions (especially St Andrews University Medical School) that will result in a critical mass of research and innovation active individuals, employed/seconded by NHS Fife and/or universities to build research and innovation capacity and governance structures.

(C) PROMOTING RESEARCH WITHIN AN APPROPRIATE GOVERNANCE FRAMEWORK AND SECURING APPROPRIATE SUPPORT TO ENSURE FINANCIAL PROBITY

In consolidating the research and innovation governance structure the current areas that need to be considered include:

C1. Continuing to identify commonalities / engagement between the clinical, research, innovation, quality improvement, digital and e/health, information governance structures within NHS Fife.

C2. Consolidate preparations for future inspection(s) from Medicines and Healthcare products Regulatory Agency.

Increasing the income generated from increased research activity, creating opportunities to further enhance and invest in research programmes in Fife by:

C3. Maximising commercial research opportunities locally and in collaboration with external partners.

(D) WORKING IN PARTNERSHIP WITH STAFF AND COMMUNICATING RESEARCH INFORMATION ACROSS NHS FIFE.

Consolidate a research and innovation communication strategy with all NHS Fife communities.

Communication is the linchpin of creating a research and innovation focused culture. During 2023-24 we will:

D1. Deliver regular NHS Fife RIK news updates, bulletins and newsletters.

D2. Produce and disseminate an NHS Fife RIK Annual Report.

D3. Support research and innovation workshops for patients, carers and other citizens of Fife

(E) PATIENT AND PUBLIC INVOLVEMENT

E1. Develop ongoing, meaningful engagement of the public in research

Prof Frances Quirk
Assistant RIK Director
NHS Fife

December 2023
These priorities have been discussed and agreed by the NHS Fife RIK Operational Group and the NHS Fife Research, Innovation and Knowledge Oversight Group.

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**Friday 12 January 2024**
Title:	**Research, Innovation and Knowledge Annual Report 2022-2023**
Responsible Executive:	**Dr Chris McKenna, Medical Director and Executive Lead Research, Innovation and Knowledge**
Report Author:	**Professor Frances Quirk, Assistant Director Research, Innovation and Knowledge**

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Annual Delivery Plan

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The Research, Innovation and Knowledge Annual Report 2022-2023 is being brought to the Clinical Governance Committee for their Awareness to provide an update on activities in increasing culture to include research and innovation as part of roles and to build research and innovation capacity and delivery against 2022/2023 strategic priorities.

2.2 Background

This report details the activities within Research, Innovation and Knowledge across NHS Fife from April 2022 to March 2023. It details progress made over the last 12 months in relation to ongoing work, previously identified challenges and identifies the key challenges currently facing Research, Innovation and Knowledge (RIK).

Continued significant developments within RIK include our relationship with the Universities of St Andrews, Edinburgh and Dundee in relation to research and innovation

activities and education and training. The joint clinical academic appointments with the University of St Andrews have produced benefits in terms of collaboration, Doctoral Training Fellows and contribution to an expanding NHS Fife research culture. The successful Inaugural NHS Fife and University of St Andrews Research Symposium in October 2022 contributed significantly to a greater sense of partnership.

The format of the report has been revised to reflect feedback from the lay representative member of the Research, Innovation and Knowledge Oversight Group and input from the Fife Community Advisory Council.

2.3 Assessment

During 2022-23 the research and innovation culture within NHS Fife has maintained recent advances, delivering: consistent levels of research activity, growing innovation activity, increased numbers of clinical academics; compliance with the research governance framework, development of an innovation governance framework, monitoring 100% of Fife Sponsored studies; and the delivery of a RIK Education Programme albeit revised to accommodate ongoing Covid restrictions.

The following challenges have been amalgamated from unmet objectives from the 2022-23 RIK Strategy Key Performance Indicators (KPIs), and the NRS objectives & associated performance metrics to be delivered during 2022-23:

Unmet KPIs (R&D Strategy2022-23):

- Increase the number of staff actively involved in research
- Increase non-commercial income

.

R&D Strategy priorities (2022-23):

All activities detailed in the prioritised plan of the RIK Strategy for 2022-23 are ongoing or have been achieved.

2.3.1 Quality, Patient and Value-Based Health & Care

-

2.3.2 Workforce

The restarting of non-COVID studies and the commitment to commence new studies, along with the impact of changes to work patterns, have led to some resourcing implications and challenges for staff in RIK. The wellbeing of staff is considered a priority and this has been an ongoing focus with the appointment of a Wellbeing Champion.

2.3.3 Financial

Research is categorised as 'commercial' (funded by the pharmaceutical or medical device industry) or 'non-commercial'. Non-commercial research is further divided into "eligible" (funded by charitable organisations, research councils or Government bodies), or "non-eligible" (NEF - funded by a non-eligible organisation or is unfunded).

R&D funding is provided via NHS Research Scotland (NRS) by the Chief Scientist Office (CSO) in respect of research considered 'eligible' for funding, in recognition of the unfunded costs incurred by the NHS for undertaking and participating in such projects.

CSO funding remains the main source of income to support all non-commercial R&D activities across NHS Fife. It is used to provide and support the R&D infrastructure (Appendix 2), to maximise its activity and to ensure the required management, governance and support of research.

CSO Funding Allocation Income 2022-2023 -£830,000 (with an additional £15,000 uplift to accommodate the 7.5% pay award to a total of £845,000)

Commercial Income 2022-2023- £107,000

Cost Savings (Pharmacy and Medicines) 2022-2023 -£198,000

2.3.4 Risk Assessment / Management

Research, Innovation and Knowledge Oversight Group has noted changes in the number of staff involved in research, commercial income, non-commercial income and cost savings generated over the reporting period. These KPI's will be a focus of monitoring and the development and implementation of strategies to address them in 2023-2024.

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

-

2.3.6 Climate Emergency & Sustainability Impact

-

2.3.7 Communication, involvement, engagement and consultation

Two-way communication of Research and Innovation information across NHS Fife has improved despite the challenges of the dispersed nature of the organisation. The creation of Clinical Research and Innovation Champion roles (first appointed cohort 2022-2024: Dr Devesh Dhasmana, Dr Susanna Galea-Singer, Mr Phil Walmsley) will support professional engagement within NHS Fife and across our stakeholders (the University of St Andrews and the South East Health Innovation Hub). To further facilitate communication, key research information is available via a dedicated NHS Fife RIK webpage, weekly updates, and monthly or quarterly bulletins and newsletters. The format of these has been revised to take advantage of newly available platforms, such as SWAY.

Internal Communications

Updates on the research training programme, R&D support and details of research and innovation conferences are circulated regularly. A monthly Publications Bulletin circulated via email and shared with stakeholders provides visibility of the range of publications

including NHS Fife authors. Monthly electronic research 'bulletins' are sent to all research/innovation active staff (past and present), providing up to date information about advice clinics, seminars, workshops and recently issued commissioned bids / grants - within and out with NHS Fife.

Details of events and training opportunities have been regularly included in the electronic organisation-wide 'StaffLink'. To reach staff that do not have access to email, details of the RIK Department, its staff and the support offered have been placed on electronic notice boards and sites across the organisation.

External Communications

Work is ongoing on a fully refreshed RIK website www.nhsfife.org/research with dedicated Clinical Research Facility, Publications and News Updates pages. The website has been updated to reflect the transition from R&D to Research, Innovation and Knowledge (RIK).

Generic R&D email address have been created to maximise the efficiency of responses to queries to the department, fife.randd@nhs.scot and for R&D news fife.rdnews2@nhs.scot

Our Public Involvement representative with a special interest in research is a member of the joint University of St Andrews and Fife Community Advisory Committee (FCAC). They have been an active member of the NHS Fife Research, Innovation and Knowledge Oversight Group in their role as Lay Advisor.

The FCAC assist in providing lay view/input into the development of research proposals and ongoing research, and help raise awareness and understanding of research being undertaken locally. The FCAC are invited to review and feedback on our Annual Report and RIK Strategy prior to their finalization.

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.

- Research, Innovation and Knowledge Operational Group- reviewed and feedback requested and responded to (1st November 2023, by circulation)
- Fife Community Advisory Council- reviewed and feedback requested (December 2023)
- Research, Innovation and Knowledge Oversight Group- reviewed and feedback requested (11th December 2023)

This paper will also be submitted to the Executive Directors Group in the first meeting of 2024

- Executive Directors Group – for Awareness (18th January 2024)

2.4 Recommendation

This paper is provided to members for:

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

3 List of appendices

The following appendices are included with this report:

Appendix No 1 - Research, Innovation and Knowledge Annual Report 2022-2023: available at this link: RIKAnnualReport_22-23.pdf

Report Contact
Professor Frances Quirk
Assistant Director Research, Innovation and Knowledge
Email frances.quirk@nhs.scot

AREA CLINICAL FORUM (Meeting on 7 December 2023)
No issues were raised for escalation to the Clinical Governance Committee.

Fife NHS Board

Unconfirmed

MINUTES OF THE NHS FIFE AREA CLINICAL FORUM HELD ON THURSDAY 7 DECEMBER AT 2PM IN THE BOARDROOM, STAFF CLUB, VHK

Present:
Aileen Lawrie (Chair)
Jackie Fearn, Consultant Clinical Psychologist
Robyn Gunn, Head of Laboratory Services
Nicola Robertson, Associate Director of Nursing
Amanda Wong, Director of Allied Health Professions

In Attendance:
Fiona Forrest, Deputy Director of Pharmacy *(deputising for Ben Hannan)*
Laura Petrie, Senior Health Promotion Officer *(item 5.1 only)*
Katie Provan, Senior Health Promotion Officer *(item 5.1 only)*
Hazel Thomson, Board Committee Support Officer (Minutes)

1. Apologies for Absence

The Chair welcomed everyone to the meeting.

Apologies were received from Donna Galloway (Women Children & Clinical Services General Manager), Ben Hannan (Director of Pharmacy & Medicines), Janette Keenan (Director of Nursing), Ailie Mackay (Speech and Language Therapy SLT Operational Lead), Dr Chris McKenna (Medical Director), Dr 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 5 October 2023

The minutes of the previous meeting were **agreed** as an accurate record.

4. Matters Arising and Action List

The Forum **noted** the updates on the action list.

5. PRESENTATIONS

5.1 Health Literacy Network

The Chair welcomed Laura Petrie and Katie Provan, both Senior Health Promotion Officers, to the meeting. A presentation on the Health Literacy Network was provided and will be shared with members.

Discussion took place and it was reported that further work is required with partners in terms of accessing resources, shared learnings and joined up working, and it was noted that the landscape is complex. It was advised that some people will not access the service due to barriers such as mental health and anxiety. Suggestion was made to consider governance for partnership working.

Following a question regarding identifying those who are unable to explain feelings or symptoms over the phone, it was advised that further data is required to make those judgements.

Digital tools and digital poverty were highlighted, and it was reported that this affects many different groups of people. It was advised that work is ongoing with colleagues in Workforce Development as there are a large number of staff unable to use technology.

Discussion took place around the barriers and consequences of people not engaging in positive lifestyle choices and the importance of the preventative stage, and it was noted that an action plan is being developed with governance support. It was questioned how feedback can be gathered from patients.

Person-centred care was highlighted and the barriers in place in terms of flexibility. Realistic medicines was also highlighted and the need to consider utilising partners for a more supportive approach.

6. QUALITY / PERFORMANCE

6.1 Winter System Review Update

This item was deferred to the next meeting.

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

This item was deferred to the next meeting.

9. LINKED MINUTES

9.1 Allied Health Professions Clinical Advisory Forum held on 4 October 2023 (unconfirmed)

9.2 GP Sub Committee held on 19 September 2023 (confirmed) & 17 October 2023 (unconfirmed)

9.3 Area Medical Committee held on 10 October 2023 (unconfirmed)

9.4 Area Pharmaceutical Committee held on 25 September 2023 (confirmed)

The Forum **noted** the linked minutes.

10. ESCALATION OF ISSUES TO THE CLINICAL GOVERNANCE COMMITTEE

There were no matters to escalate to the Clinical Governance Committee.

11. ANY OTHER BUSINESS

11.1 Future Presentations

Suggestion was made to have a presentation on the Health and Care Staffing Scotland Act 2019.

12. DATE OF NEXT MEETING

The next meeting will take place on **Thursday 8 February 2024 from 2pm – 3.30pm** in the Boardroom, Staff Club, VHK.

AREA MEDICAL COMMITTEE

(Meeting on 10 October 2023)

No issues were raised for escalation to the Clinical Governance Committee.

Area Medical Committee

UNCONFIRMED NOTES OF THE AREA MEDICAL COMMITTEE (AMC) HELD ON TUESDAY 10 OCTOBER 2023 VIA MS TEAMS

Present:

Chris McKenna (Chair)	Medical Director
Helen Hellewell	Deputy Medical Director, H&SCP
Sally McCormack	Associate Medical Director, Emergency Care & Planned Care
Glyn McCrickard (from 1420)	Fife LMC Representative
Claire McIntosh	Chair, Division of Psychiatry
Maxine Michie	Deputy Director of Finance
Susie Mitchell	Fife LMC Chair

In Attendance:

Catriona Dziech (Notes)	Executive Assistant to Medical Director

1 APOLOGIES FOR ABSENCE

Apologies were received from Caroline Bates, Ian Fairbairn, Ian MacLeod, John Morrice, Joy Tomlinson, Morwenna Wood, Robert Thompson, Susanna Galea-Singer, Jackie Drummond

2 DECLARATIONS OF MEMBERS' INTERESTS

There were no declarations of interest.

3 MINUTES OF PREVIOUS MEETING HELD ON 08 AUGUST 2023

The notes of the meeting held on 08 August 2023 were approved.

4 MATTERS ARISING

i) Update from Realistic Medicine (RM) Team

The Realistic Medicine Team will attend AMC on 12 December 2023 to provide an update.

Dr McKenna advised the themes and output from the Realistic Medicine Event held on 20 September 2023 are being written up and will be shared with the Committee in due course. The event was well attended with representation from across the whole system. The main theme being how to take forward a value-based healthcare approach.

ii) Adverse Events Update – reinstate EC4H Courses

Dr McKenna advised these courses have been reinstated and mostly run by Palliative Care around effective communication.

iii) Adverse Events Update – SAER feedback at Grand Round Events
Dr McKenna advised he has not reached a decision on this. Item can be removed from Matters Arising.

iv) Medical Staff Committee – Consultants / Strategy progression
Dr McKenna has formally asked Phil Walmsley if he wishes to remain Chair but has had no response. Dr McKenna agreed to take forward after the meeting as he feels it is important secondary care consultants are properly represented.

5 STANDING ITEMS

i) Financial Position – Including *(IPQR)*

Maxine Michie gave the Committee an update on the financial position through a presentation of slides which sets out the financial position to the end of July 2023 and ties in with the IPQR on the agenda.

NHS Fife started the year with a financial plan and an approved overspend of just over £11m which was approved at the Board in March 2023 and also in Scottish Government. The £11m was arrived at after taking an underlying deficit of £25/26m and setting a cost improvement target of £15m for the year. This was focused predominantly on reducing spend on supplementary nursing and medical staff and other groups where spend was high and closing surge beds.

In June 2023 the Scottish Government acknowledged the challenges that all boards have with financial sustainability and the fact that as a board we are not at NRAC parity and we received £15m additional funding. £8m is for NRAC which is recurring and the rest for the New Medicines Fund, which is not recurring.

In terms of our plan the RAG status is red. At the end of July 2023, the Health Board was reporting £11m overspend but in March 2023 the H&SCP were reporting on their health delegated budgets just under £6.5m of an overspend. However, with their reserves and the totality of resources available to them, we are not anticipating any risk share arrangement this year from the H&SCP and they will use their reserves to break even in March 2024.

The current forecast for NHS Fife is a £23m overspend at the end of August. One of the biggest challenges has been the inability to gain traction on our cost improvement programme. A target had been set for £15m but by the end of August 2023 only £1m has been delivered and none of that within the two focus areas identified.

On a positive the capital expenditure plan is going well with just over £11m expenditure. £1.5m had been spent by the end of July 2023.

In the £11m reported at the end of July, £8m is acute services. This is driven by the high cost of agency and bank staff. The plan had been to reduce spend in this area, but we are actually spending more than last year for all the obvious reasons related to workforce challenges, vacancies, sickness and acute demand. One of the other challenges the Board have is our SLA agreements with other Health Boards and also the high-cost patients within the independent sector. We have lost funding for Strathcathro, which is being pursued with Scottish Government, as the annual figure is around £1.5m. In Estates and Facilities there is the huge cost in energy bills which is also driving the overspend. The £3.6m shortfall at the end of July is the lack of traction in the cost improvement plan.

In totality for the Board, that was reported to Scottish Government, there is a £17.5m overspend with about £6m of that within the H&SCP and the remained with the Board.

In terms of cost improvements, a target of £10m was set for temporary staff reductions and the surge capacity at £5m but this has had to be redressed as this will not be delivered. Other areas have come in to play such as reducing corporate overheads and medicines optimisation which should be around £1.3m. There is confidence we will deliver £15m but there will be a large operational overspend. One other thing that should be considered is finalising the major contracts review refinancing the PFI contract at VHK which should deliver significant savings over the life of the contract and spread out over the next 15 to 20 years.

The response from the Scottish Government to our projection of £23m overspend is one of the strongest letters we have received in terms of our financial position. Points highlighted in the response were:

- Actions planned to take between now and year end to as a minimum reduce the £23.2m overspend and move back towards break even
- current status on the cost improvement programme and deliverability of £15m savings
- August reported Overspend £13.6m and HSCP £8.971m

Since September there has been a reduction in the reliance of bank staff mostly across acute services. Although not enough, or at the rate we would like it to be, it is a start to bring back the overspend.

In terms of capital at the end of July we had spent around £1.5m of our allocated £11m and at the end of August this is now £2m which includes the Queen Margaret works, which was the single largest project, and has now been completed. Other works are underway looking at the green agenda and in particular green space projects and decarbonisation of our fleet. There is also significant spend on capital equipment and further

monies have been secured from the National Equipment Board with further bids being submitted for spend in 2024/25. Spend is also planned for clinical prioritisation and maintenance backlog. It is anticipated the £11m will be spent by the end of the financial year.

Dr McKenna thanked Maxine Michie for her detailed update.

The Committee agreed it would be helpful for Audrey Valente, Director of Finance in the H&SCP to attend a future meeting of the Committee to provide an update from the H&SCP perspective. This would also give an overview of the whole financial position. Dr McKenna highlighted NHS Fife has the ultimate responsibility for balancing the books of the Health Board and not just the non-delegated budget.

In taking comment it was suggested communicating the financial situation to the public to make them aware and think about how they use the services. It was agreed services are not being paired back yet and there are still opportunities to be more efficient and save money. Dr McKenna suggested any ideas should be filtered back to himself and Dr Hellewell to pass to Maxine Michie.

It was noted the H&SCP are working on a detailed plan for not keep patients in hospital any longer than they need to be. This plan includes helping people stay at home if they do not need to go into hospital. This may be more difficult to achieve because of the pressure to keep the flow going through the system along with tying in with resources within the community.

Maxine Michie asked if there is anything that can be done around SLAs and in particular the SLA with Tayside as there will be patients being referred to Tayside due to the geography of their Fife residency. We are effectively paying Tayside not only for the direct patient care, but for their overheads as well. As we have the overheads here can we create a service and bring back into Fife.

ii) Adverse Events Update – considered at the Clinical Governance Oversight Group

The Committee noted the key performance indicators for Adverse Events. Dr McKenna said the new Adverse Events policy is in place and working well. Changes have been made to how each adverse event review is undertaken with the addition of executive lead oversight and will start as soon as possible. There are ten senior clinical people within the organisation who will have executive oversight. Every review will now be countersigned by the Medical Director, Director of Nursing or Director of Pharmacy and Medicines. This new process will ensure these reports are accurate and the language used is appropriate as these reports can be viewed by other organisations such as the Mental Welfare Commission, Procurator Fiscal and families.

Training will be available for staff undertaking reviews and support provided for people affected by adverse events.

Dr Hellewell advised the H&SCP has a group which meets twice a week to look at adverse events. LAERs are also being considered once they are complete to ensure there is consistency and executive oversight.

iii) Medical Staff Committee

Covered above at Matters Arising.

iv) Update from GP Sub Committee

Dr Mitchell advised the GP Sub Committee were very impressed to have Carol Potter, Nicky Connor, and Ben Hannan from the Senior Leadership Team, along with Dr McKenna who is a GP Sub member, attend their recent September 2023 meeting to discuss parts of the contract which have not unfortunately been able to be provided by NHS Fife.

The GP Sub were very grateful to all the Senior Leadership Team who listened to their concerns and engaged with the whole committee. Dr Mitchell asked for the GP Sub's thanks to be formally minuted.

Dr Mitchell said General Practice is in pretty dire straits. The contact has not been an unmitigated disaster across the country, but pretty close in Fife. Some parts are better than others and GPs have worked collaboratively but feel that the failure of the contract is on all of them. The contract has not been funded by the Government and the money has not been forthcoming.

Going forward things will be difficult and challenging. The BMA have recently issued a safe working in general practice document which the LMC have advised all practices to consider. There is concern around the advice within the document that GPs should not see any more than twenty five patients a day which will make the situation even more difficult. Work is required with 111 colleagues to support patients when there is no capacity within Practices.

Winter is going to be an anxious time in primary care especially around some of the Covid guidance which could take out an entire team if testing is not required. Some practices have produced their own public health policy around this so they can remain open.

Dr McKenna thanked Dr Mitchell for her update and acknowledging senior management attendance at the recent GP Sub meeting. The impact of the meeting was felt, and Carol Potter has talked about the meeting at other meetings since so the strength of feeling has been conveyed.

Dr McKenna said as a Board we need to work together to plan our way out of this in the medium and long term and this is why the Primary Care Strategy produced by Dr Hellewell and her team is so important.

The Committee acknowledged the complexities across the system and the lack of respite to prepare for winter.

v) Realistic Medicine
Noted as above.

vi) Medical Workforce
Dr McKenna advised there had been an Away Day on 26 September 2023 with the senior medical leadership team from across H&SCP, Acute, Public Health and Medical Education.

Some good ideas came out of the meeting and one of the topics was medical workforce contributing to more medical workforce strategy and planning. Another issue which will be worked on is critical numbers and whole-time equivalents per head of population for senior doctors in Fife. Support to recruitment and retention will also be looked at to ensure workloads are supported in a multi professional environment. Some specialties have this right, and others are struggling so there is work to be done in these areas.

Other areas considered, aside from general practice, were Mental Health, Haematology and Medicine of the Elderly. These areas are seen as the riskier for the organisation at the moment. A&E have a plan and have trained a lot of trainees so they can recruit to the plan. In acute medicine the plan would be to recruit more physicians. There is a bit of unpicking and understanding of where we are benchmarking wise and in spite of the current financial difficulties it is felt it should not be a barrier to pursuing recruitment into those areas as it is fundamental to retention and recruitment and addressing workload issues.

Dr McCormack said within Haematology it is not just there are not enough substantive funded posts there are also vacancies within those posts so there are two separate issues. If the vacancies were all fully filled it still would not be great but a lot better than it is currently. One of the other problems is when contract Locums take up the vacancies as these can be costly. If we could get to the point where all substantive vacancies were filled there may be breathing space to strategically move forward.

Dr McKenna said as a Board we have invested into some specialties but not others and the decisions around that are largely driven by waiting times and procedures rather than understanding activity, which is not always captured in our waiting times.

Mental Health is another area where not all activity is captured e.g adult mental health, in-patient and urgent care assessment. Activity is captured in relation to CAMHs, Psychological therapies as they are on the Board's radar and included within the IPQR and are areas monitored by the Scottish Government. There is a tendency to align resource to those areas where we report performance on.

Dr Hellewell said it was worth noting Jackie Drummond has been doing a lot of work with the leads in Psychiatry as it is clear unless there is some redesign, we will not be able to fill posts. There are Locums in the specialties in Psychiatry, but this generates extra workloads to the substantive consultants because they do not undertake the add on part only the clinical work. Benchmarking has been undertaken which does suggest that the sector sizes for psychiatry are not the same as other parts of the country and we need to find a way to move to whatever redesign we are doing.

It was agreed going forward it would be helpful to include an update from the Division of Psychiatry on the AMC agenda to allow better interface between the Division of Psychiatry and the AMC.

Dr MacIntosh said Jackie Drummond has been very structured with her approach and has given a lot of thought to involving substantive consultants, particularly the clinical leads and broadened it to include newer clinical leads and developing clear work plans and ways forward. A series of events have also been organised for the substantive consultants which will look at sector sizes and equity of posts and making everything more attractive to decrease the number of locums we have.

Dr MacIntosh said the comments around activity and data are valid as there are waits that are hidden and there are a lot of people on non-urgent waiting lists for CMHT assessment.

In Psychology there is a real change with a lot more structure and positivity. There is a lot of work to be done but it is good to see it captured and shared.

In closing Dr McKenna said it was important to elevate the voice of Psychiatry within the organisation and Dr MacIntosh's attendance representing the Division would achieve this.

vii) Education & Training

Dr McKenna said the ScotCom Medical School plans are progressing, working closely with the University of St Andrews. Pending approval from the GMC, we would be talking January 2026 which allows for planning to recruit into educationalist roles. It is an exciting opportunity to give people and to recruit into some of those gaps we have and into areas where we

struggle to recruit. Services will be delivered out of two hubs, one in Dunfermline and the other in Cameron / Leven area.

The gateway doctors have successfully settled into their first four months. They are international graduates and trainees who are UK citizens. We need more work going forward to recruit these doctors as there is a real opportunity to try to understand how we can integrate international recruitment into General Practice and other specialties.

Dr McCormack highlighted we have passed the Paediatric monitoring.

Monitoring is an ongoing problem and has been redone across the board over the last few weeks. Drop-in sessions have been undertaken to ensure all procedures are followed for monitoring. Staffing models across all Directorates are being looked at as there is not enough trainees in order to staff the hospital so that is why we have the Gateway doctors. Going forward it is likely we need to have substantive members of staff that underpin these middle grade rotas in the form of AMPs and other multidisciplinary type models. Dr Hellewell advised that Psychiatry has worked with Professor Wood and there is now a lead for education and training and meetings are taking place with the trainees in Psychiatry regularly to ensure they are supported.

6 STRATEGIC ITEMS

i) GMS Implementation

Dr Hellewell said one of the strengths in Fife is to work collaboratively but there needs to be some discussion to ensure there is enough backfill to support the teams. There also needs to be discussion about how to move forward to work on the MOU2 part and other areas of the contract including looking at skill mix, retention and recruitment. It is important the finance is used properly and in the best possible way to do the most with what is available. The LMC have been good at supporting how the money is used efficiently.

Dr Mitchell said one of the challenges now is making sure there is parity across the patch. This was a contract in lieu of a pay rise and not everybody received something out of it and therefore this is being looked at to make sure it is fairer across the patch so that all GPs in Fife have something out of the contract. This is being done collaboratively with support from GP Sub as well as LMC.

7 ITEMS FOR INFORMATION

i) Notes of the GP Sub Committee: 20 June & 15 August 2023

Noted.

Dr McCormack advised a trial is underway uploading DNACPR to the portal. This is complex because the patient has to be on the ward but the

trial is being undertaken on MOE wards and the most up to date one should be on the portal. There is a tab on the portal for patients called “patient preference” where the documents will be stored. It is hoped this will be rolled out further in the future. In an ideal world, the patient should be given their DNACPR document home with them, but this will be audited because the notes are then getting checked by admin at discharge and if it is found, it will be uploaded. It is then sent to the consultant to send on to the patient. There are benefits for doing it, but it is not quite there yet. It will also be in a very specific patient preference, which is also where it is hoped people will upload anticipatory care pathways separately because otherwise, they may end up somewhere else on the portal where they cannot be found.

ii) Notes of the Clinical Governance Oversight Group: 20 June 2023
Noted.

iii) **Notes of NHS Fife Area Drugs & Therapeutics Committee: 21 June 2023**
Noted

8 AOCB

8.1 Proposed meeting dates for 2023
Noted. Calendar invites will be issued.

9 DATE OF NEXT MEETING
Tuesday 12 December 2023 at 2pm via MS Teams

AREA RADIATION PROTECTION COMMITTEE

(Meeting on 14 November 2023)

No issues were raised for escalation to the Clinical Governance Committee.

Area Radiation Protection Committee

MINUTES OF THE RADIATION PROTECTION COMMITTEE HELD ON TUESDAY 14TH NOVEMBER 2023 VIA MICROSOFT TEAMS.

Chair: Dr Chris McKenna

In Attendance:

Dr Chris McKenna (CMK)	Medical Director, NHS Fife/Executive Lead, Radiology
Jane Anderson (JA)	Radiology & Diagnostic Services Manager
Nicola MacDonald (NMD)	Head of Radiation Protection | Lead RPA/MPE | Medical Physics
Nick Weir (NW)	Head of Imaging Physics
Laura Cluny (LC)	Nuclear Medicine Physicist
Clare Parry (CP)	Medical Physicist
Simon Willis (SW)	Radiation Protection Adviser & Radioactive Waste Adviser
Nick Weir (NW)	Head of Imaging Physics
Gillian McNaught (GMN)	Principal Physicist (Modality lead MRI)
Debbie Slidders (SL)	Dental Therapy and Programme Manager

Apologies:

Donna Galloway (DG)	General Manager, WCCS

NO	HEADING	ATTACHED	ACTION

1. APOLOGIES FOR ABSENCE

As noted above

2. Minute of Meeting Held On 10/05/2023

Accepted

Action Plan

3. Annual Adviser Reports

a. **LPA (MvL)**

i. Megan van Loon is currently on ML. Kate Sexton deputising for her.

ii. A lot of good work has been done in Laser Safety, very positive.

iii. Discussion around how the medical devices committee links in to Medical Physics. Clinical effectiveness is important. Medical Physics may try and link in with this group to ensure we are aware of new devices as appropriate.

Please see detailed report.

b.

RPA (NMD)

i. Please see detailed report.

ii. Radon – just above action level so we are going to work on how to remedy this. Need to know i.e. how many staff involved and put in remedial measures. Staff need to be made aware of the issue. CMK would like to see the comm before it goes out. JA to get practice manager details for NMD. Nicola Taylor (Primary Care Manager) needs to be involved too,

c.

RWA (SW)

i. Please see the relevant report in Files section of the Team.

MRSE (NW)

2 datix incidents, metal in nose (both). 1 cardiac insert undeclared. David is really good at reviewing with the referrers.

There was a Quench at QMH. Something was wrong with the settings.

MR safety committee meeting in December.

4. Radiation Incidents (Q2 & Q3, NMD)

These were already discussed at IRMER Board.

5. A.O.C.B.

Do we think sharing the minutes of this meeting with CGC is enough. How do they do it in Lothian. The minutes go to H&S Committee not CGC. We don't want to escalate thing just make people aware of the committee and to give assurance we are compliant.

8. DATE OF NEXT MEETING

9th May Fife RPC 10:30-12

CANCER GOVERNANCE & STRATEGY GROUP (Meeting on 2 November 2023)
No issues were raised for escalation to the Clinical Governance Committee.

Cancer Governance & Strategy Group

NHS FIFE CANCER GOVERNANCE & STRATEGY GROUP (CGSG)

Unconfirmed Note of the Meeting Held at 09:30 on Thursday 2nd November 2023 via Microsoft Teams

Present:	**Designation:**
Claire Dobson (CD) Deputy Chair	Director of Acute Services
Nick Haldane (NH)	Lead Cancer GP
Ben Hannan (BH)	Director of Pharmacy & Medicines
Murdina MacDonald (MM)	Lead Cancer Nurse
Frances Quirk (FQ)	Assistant Director Research, Development & Innovation
Nicola Robertson (NR)	Director of Nursing, Corporate
Shirley-Anne Savage (SAS)	Associate Director of Quality and Clinical Governance
Sarah Scobie (SS)	Consultant – Clinical Oncologist
Apologies:	**Designation:**
Paul Bishop (PB)	Head of Estates
Nicky Connor (NC)	Director Health and Social Care
Izzy Corbain (IC)	Patient Representative
Fiona Forrest (FF)	Deputy Director of Pharmacy
Susan Fraser (SF)	Associate Director of Planning & Performance
Alistair Graham (AG)	Associate Director Digital and Information
Janette Keenan (JK)	Director of Nursing
Rishma Maini (RM)	Consultant - Public Health
Linda McGourty (LMcG)	GP
Chris McKenna (CM) Chair	Medical Director
Neil McCormick (NM)	Director of Property and Asset Management
Margo McGurk (MMcG)	Director of Finance and Strategy
Kathy Nicoll (KN)	Cancer Transformation Manager
Emma O'Keefe (EO'K)	Consultant – Dental Public Health
John Robertson (JR)	Lead Cancer Clinician - Surgery
Fiona Towns (FT)	Patient Representative
Amanda Wong (AW)	Associate Director of Allied Health Professions
In Attendance:	**Designation**
Rebecca Hands (RH)	Clinical Governance Administrator (minute taker)
Andreas Luhmann (AL)	Consultant – General and Upper GI
Iain Murray (IM)	Consultant – Respiratory Medicine

		Action
	Welcome	
	CD welcomed everyone to the meeting.	
1.	**Apologies for absence**	
	Apologies for absence were **noted** from the above named members.	
2.	**Unconfirmed Note of the previous NHS Fife Cancer Governance & Strategy Group Meeting of 17 August 2023 via Microsoft Teams**	
	The Unconfirmed Note of 17 August 2023 was **accepted** as an accurate record.	

		Action
3.	**Action Log**	
	300323#2 – Improvements gaps to be brought as they arrive. Action to be closed. 310523#2 – Will be discussed under the appropriate agenda item. 170823#1 – Taken to the CGC that is due to be held on 3 November. Action to be closed. 170823#2 – Taken to the CGC that is due to be held on 3 November. Action to be closed.	
4.	**GOVERNANCE**	
4.1	**Acute Cancer Services Delivery Group Update**	
	CD advised the last meeting did not go ahead due to the number of apologies. They have been turning their attention to a number of different things. One of them being meetings with Scottish Government colleagues around cancer performance, the first of which was around urological cancer. This was a positive meeting with a lot of good feedback. The next meeting will be about head and neck. BH advised they have had all cancer incidents securitised and a further review, and then they gave some detail with regard to that. BH advised they are regularly reviewing the high risks. SACT is remaining as a standing agenda item. They are still seeing continued pressure; however, the team are working hard to bring down the wait times for that. The CEL 30 return has been sent off to HIS which did not highlight anything of particular concern. That will continually get monitored. From a medicine and SACT point of view, they have had an external review of the oncology and haematology pharmacy services. It will be going through the Acute Cancer Services Delivery Group for support.	
4.2	**Cancer Risks**	
	Papers were shared with the group on cancer risks. The number of risks on the Cancer Risk Register is unchanged (11). No risks have changed in rating or level since the last report. There are 5 High level risks and 6 Moderate level risks. No risk has achieved its target. No risks have been closed since the last report. No new risks have been identified since the last report.	

		Action
	Operational CD advised there are some risks within acute cancer that are old and these need to be refreshed. This will be an ongoing piece of work. *Framework* SAS advised that herself and KN have worked on these risks along with support from the risk team. SAS advised they have come to this group for final agreement and for any final comment. SAS advised these have been put on the risk register. BH advised he is supportive of these risks and proposes that we keep an eye on these risks.	
5.	**STRATEGY/PLANNING**	
5.1	**Cancer Framework Annual Delivery Plan Year 2 Update**	
	SAS advised the group a SBAR has been done and a draft Cancer Framework Annual Delivery Plan 2023-24 has been brought to this group for agreement. SAS noted that this is a working document and will be subject to review and update. The actions outlined within the Cancer Framework Annual Delivery Plan have been developed through: • Outstanding, incomplete or re-reviewed actions carried forward from Cancer Framework Annual Delivery Plan 2022-23 • NHS Fife Board Annual Delivery Plan 2023-24 • NHS Fife Board Medium Term Plan 2023-25 • Framework for Effective Cancer Management Action Plan • Engagement with teams The next steps are to: • Agree if further amendments required or confirm sign off from the cancer groups • Arrange a meeting to pick up on queries raised through the MS Forms questionnaire • Review Cancer Leadership Team improvements and agree actions from MS Forms questionnaire. NR asked that the Head of Patient Relations be changed to the Head of Patient Experience. NR noted under 2.11 it mentions the Clinical Nurse Manager and perhaps they should reflect the lead nurse title in the partnership as well, or should it only reference the acute. SAS to look into this. BH noted that he was unsure about SACT comments in the paper. BH does agree that it will be challenging because of pressure, however,	

		Action
	wonders about the narrative of this. BH shared it concern with this and advised they had no really explored this fully through the operational group to what it means in terms of limited ability. SAS and BH to meet offline to discuss this further.	
5.2	**Projects Update**	
	Community Pharmacy BH advised they have been trying progress the test of change work, however, as a bit of a reset they have had Aileen Boags, Lead Pharmacist for Public Health and Community, take a look at this. She has worked with KN and others around this. BH advised a paper was brought to his SLT with the process of it coming to this group in January. Aileen has worked collaborative with KN. *RCDS Expansion* MM advised the project status report was sent out to the group. This looks at the clinical activity. MM advised in terms of sustainability of RCDS, CM had requested a report looking at clinical activity. This report has been completed; however, it is attached to the SBAR looking at the options for RCDS post March 2024. This is currently being reviewed by the planned care directorate and they are quite keen to have the evaluation that has been undertaken by Strathclyde University. They are not expecting to have this until the end of November. MM and SAS have been liaising with planned card to get this moving. *Single Point of Contact Evaluation* SAS advised the implementation of new pathways and processes are working very well and an evaluation underway. This is expected to be written by end November.	
6.	**FUNDING**	
6.1	**Funding Update**	
	SAS advised of the following funding: • Cancer Waiting Times - £685,234 + £91,000 - Funding has now been released and there has been a staff pay uplift. Slippage identified. • AO/SACT - £205,000 recurring. This has been confirmed through SCAN and awaiting release. • RCDS/RCDS Expansion - £339,581 - This has been released. • SPOCH - £107,354 - This has been released. • DCE Optimal Lung Pathway - £171,353 - This has been released. • CRUK TET funding to support Prostate Pathway - £213,000 - This	

		Action
	has been confirmed and released. The funding is for 2 years from June 2023. • Band 6 Macmillan Project Manager 1.0wte - This is to be confirmed. Funding until March 2024 for Project Manager for Cancer Framework • Band 5 Macmillan Patient Experience 0.5 wte – This is to be confirmed. 2 year funding. • CRUK TET Colorectal – This is to be confirmed and NC is looking at putting proposal together. • DCE Community Pharmacy – This is to be confirmed. Awaiting agreement for project. • DCE – Optimal Head & Neck Pathway - £2.5 million for Scotland. It has been circulated widely for next steps. SAS noted a head and neck optimal pathway has been published. There is £2.5m funding attached for Scotland. SAS advised KN has emailed service regarding options and has met with a General Manager and a Business Manager to agree a way forward. KN has offered to lead on the pathway and Carron Waterson is able to provide Project Management support. This is to be taken to the Acute Cancer Delivery Services Group. The Scottish Government have asked that one of the weekly calls focuses on Head & Neck (due to be held 29/11/23). The service template is currently being completed for this meeting.	
7.	**QUALITY/PERFORMANCE**	
7.1	**Cancer Waiting Times Q2 2023**	
	A SBAR on the cancer waiting times Q2 2023 was sent around the group. CD advised in regard to 62 day performance for the last quarter, in NHS Fife **78.8%** of patients started treatment within the 62-day standard (previous quarter **69.4%**). SCAN **79.2%** and NHS Scotland **73.7%**. CD advised in regard to 31 day performance for the last quarter, in NHS Fife **96.7%** (**92.7**% previous quarter) of patients met the 31-day standard. Fife was one of the 12 Boards to meet the standard. The issues identified were; staffing, equipment, facilities, and pathways.	
7.2	**Quality Performance Indicators**	
7.2.1	**Lung 2021**	
	IM went through the papers that were shared with the group. In NHS Fife 321 patients (299 previous cohort) were diagnosed with Lung cancer. Case ascertainment for NHS Fife is **86.4%.**	

		Action
	NHS Fife met **16** of the 25 + 3 (presented by hospital of surgery) (including sub QPIs) QPIs for Lung cancer. **QPIs not met:** • **QPI 4 Patients having Radical Treatment: PET CT Reported within 10 Days Target 95%** - This QPI was not met by any of the SCAN region health boards. This is the first year of reporting PET CT within a designated time scale. Although results in all health boards are disappointing the median number of days is not much longer and over 90% achieve this target (90% compliance) by 21 days (3 weeks). Results appear somewhat better in NHS Fife compared to other SCAN health boards/hospitals. Patients generally have investigations undertaken in the cancer network in which they reside while patients in Fife can be referred to either Lothian or to Ninewells Hospital in Dundee (outwith SCAN) for PET CT scans. If this is seen in further reports it would be prudent to separate Tayside PET for reporting. • **QPI 5 Patients with Nodal Spread on PET CT should undergo Nodal Sampling Target = 80%** - The target was not met in Fife with a shortfall of 13.3% (4 cases). Sampling was contraindicated by poor PFTs[1] for 1 patient. The remaining 3 patients all had T4 staging, i.e. the tumour was invading the mediastinum. In these cases, sampling would not have altered treatment management since already the volume of disease was felt to be too large and therefore not encompassable within a radical radiotherapy field. Further sampling was not required to delineate the palliative options. These are valid clinical reasons for not pursuing sampling in these cases and no further action is required. • **QPI 6 Surgical Resection in Non-Small Cell Lung Cancer 6 (i) NSCLC and Surgical Resection Target = 20%** - The target fell short in NHS Fife with a shortfall of 2.7%; with surgery not appropriate due to poor fitness and/or comorbid conditions. • **QPI 13 (ii) Radical Radiotherapy: 30- & 90- Day Mortality Target <5%** - 1 patient, who died within 30-day time period, had sudden collapse with suspected PE during treatment. Clinically, the death is unrelated to treatment. 1 patient, included in both 30- and 90-day analyses, passed away after a prolonged admission due to suspected infection/radiation pneumonitis. This therefore needs to be considered as a potential treatment related death.	

[1] PFTs: Pulmonary Function Tests – to assess the lungs by measuring lung volume, capacity, rates of flow and gas exchange.

		Action

- **QPI 13 (iii) Chemoradiotherapy: 30-and 90-Day Mortality Target <5%** - In NHS Fife 1 patient died within 30 days of completion of chemoradiotherapy with a further 1 patient dying within 90 days. 1 patient died within 30 days: this patient had indeterminate pulmonary lesions at presentation which although given the doubt at time of treatment, these progressed during treatment and proved to be metastatic disease. The patient died of progressive cancer. 1 patient died within 90 days following treatment for presumed limited stage SCLC but sadly showed evidence of widespread metastatic disease on early CT chest and died shortly thereafter.

- **QPI 14 SABR in Inoperable Stage I Lung Cancer Target = 35%** - The target was not met in NHS Fife with a shortfall of 10.0% (27 cases). Of these patients, 19 were for best supportive care (18 due to frailty and/or comorbidities and/or patient wishes; and 1 patient due to rapid progression to metastatic disease.), 1 patient was under a 'watch and wait' approach at the time of reporting; and the remaining 7 patients had conventional radical radiotherapy due to location (6) or tumour movement (1) making SABR targeting not technically possible.

- **QPI 15 (i) Cytology or Histology Prior to Thoracic Surgery Target = 75%** - NHS Fife had a shortfall of 10.7% (10 cases). Valid clinical reasons have been provided:

Pathology Investigation Contraindications	Fife
Too small to biopsy	-
Inaccessible to biopsy	7
Too small & inaccessible	-
High risk or pneumothorax: at biopsy	-
Attempted biopsy: insufficient or negative pathology	2
Lengthy EBUS waiting list – straight to surgery	1
Suspected carcinoid	-
Total	10

- **QPI 15 (ii) Cytology or Histology prior to Radical Radiotherapy Target = 75%** - The target was not met across the SCAN region in 2020 or 2021 and this QPI continues to be challenging. NHS Fife had a shortfall of 26.7% (15 cases);

Pathology Investigation Contraindications	Fife
Poor fitness & comorbidities	1
Too small to biopsy	-
Inaccessible to biopsy	-
Too small & inaccessible	8
High risk of pneumothorax	-

		Action

Attempted: insufficient or negative pathology	2
No reason documented	4
Total	15

7.2.2	**Oesophago-Gastric 2021**	
	AL went through the papers that were shared with the group. Case ascertainment for NHS Fife was 85.9% NHS Fife met **10** of the 18 (including sub-QPIs but excluding those reported by Board of surgery) QPIs for Oesophago-gastric cancer. **QPIs not met:** • **QPI 1 Endoscopy - Histological diagnosis made within 6 weeks of initial endoscopy and biopsy** (Oesophageal): (5 cases). 3 patients too frail for endoscopy – clinical diagnosis; one patient diagnosed by EMR; one patient diagnosed under ENT with oesophagoscopy. • **QPI 1 Endoscopy - Histological diagnosis made within 6 weeks of initial endoscopy and biopsy** (Gastric): (3 cases) – 3 patients initial endoscopy path came back high-grade dysplasia – one was diagnosed on second OGD; one diagnosed at surgery and one patient too frail for further OGD. • **QPI 3 MDT before definitive treatment** (Gastric): 1 case. Patient had best supportive care decision made on ward due to extensive disease. Not discussed at MDT. • **QPI 4 (i) TNM staging recorded at MDT prior to treatment** (Gastric): 3 cases. 1 patient died before MDT; 1 patient had no CT undertaken as too frail and 1 not discussed at MDT. • **QPI 4 (ii) TNM Treatment Intent recorded at MDT prior to treatment:** 2 cases. 1 died before MDT and 1 had best supportive care decision taken on ward not discussed at MDT. • **QPI 6: Neo-Adjuvant chemotherapy followed by surgical resection** (Oesophageal): 1 case. (Gastric): 1 case. Both were found to have unresectable disease at surgery. • **QPI 11 Curative Treatment Rates** (Oesophageal). 47 cases. (Gastric). 13 cases. • **Clinical Trial QPI uptake** 6%. For all cancer sites this QPI is being removed.	

		Action
	There were no actions specific to NHS Fife identified. BH asked where else do these QPIs go. AL advised it is shared locally and it is something that is being closely monitored by SCAN. BH advised what they are curious about for all QPIs is the common themes and pieces of governance. CD advised this is a valid point made and advised KN had mapped out the journey of QPIs in the past. CD and BH to take this offline and will discuss with CM.	
7.3	**Detect Cancer Early Submission Process and Reporting Update**	
	SAS advised historically Detect Cancer Early data for Breast, Bowel and Lung cancers were submitted to Public Health Scotland (PHS) on a quarterly basis and reported through the Integrated Performance Quality Report (IPQR). Thereafter an annual report was published by PHS. Within the new cancer strategy publication is a new earlier diagnosis vision for Scotland which the DCE programme will help to deliver over the next 10 years. The whole process is changing. Previously the DCE focus was on patients diagnosed at stage 1 with breast, colorectal or lung cancer. Going forward there will be a new focus on later stage disease. The plan is not to just look at breast, colorectal and lung cancer going forward but many other tumour groups. Data will be taken from the Scottish Cancer Registry. Progress will be monitored against the vision for the 16 tumour groups over the next 10 years and will be updated in the annual cancer incidence publications.	
8.	**CANCER RESEARCH**	
8.1	**Cancer Research Update**	
	FQ advised since the last meeting there is still currently have 21 active studies in the cancer portfolio, 10 of which are recruiting and the rest are in follow up. There have been 9 new recruit studies, 6 are data only and 3 are patients in colorectal. There are 8 cancer studies in set up that are currently in review. The pathway for cancer funding currently does not have a research funding pathway and the steps for research funding is different. FQ and KN are liaising to discuss this. FQ advised they are in active conversations at the moment with the clinical lead for the Edinburgh Cancer Centre around how they can work more closely with them to support cancer studies in Fife.	
9.	**REALISTIC MEDICINE**	

		Action
9.1	**Realistic Medicine Update**	
	This will be carried forward to the next meeting.	
10.	**LINKED COMMITTEE MINUTES**	
10.1	**Cancer Managers' Forum (28/07/2023)**	
	This was noted by the group.	
10.2	**Acute Cancer Services Delivery Group (07/06/2023 & 02/08/2023)**	
	This was noted by the group.	
10.3	**Cancer Leadership Team (25/07/2023, 29/08/2023, & 26/09/2023)**	
	This was noted by the group.	
10.4	**SCAN Regional Cancer Planning Group (18/08/2023)**	
	This was noted by the group.	
10.5	**Cancer Waiting Times Data and Definitions Group (20/07/2023)**	
	This was noted by the group.	
10.6	**SCAN Regional Data Reporting Group (05/09/2023)**	
	This was noted by the group.	
11.	**ITEMS TO NOTE**	
11.1	**30 Day Mortality after SACT**	
	SAS noted this is recent publication – high level experimental. This publication has been circulated widely through cancer groups. There are no actions directly from the report as it is very high level and Fife will interrogate information more in depth. A SBAR has been provided to the group for information/assurance that Fife has a process in place to manage patients who die within 30 days of SACT. Clarity is required from Clinical Governance about how they want it reported and how often. This will be taken to the NHS Fife Clinical Governance Oversight Group and conversations will take place with CM.	
12.	**ISSUES TO BE ESCALATED TO EDG/CLINICAL GOVERNANCE COMMITTEE**	
	No issues to be escalated to EDG or the Clinical Governance Committee.	
13.	**ANY OTHER BUSINESS**	
	No any other business.	
14.	**Date of Next Meeting**	
	The next meeting will be on Thursday 11 January 2023, 14:00-16:00 via MS Teams	

CLINICAL GOVERNANCE OVERSIGHT GROUP (Meeting on 24 October 2023)
No issues were raised for escalation to the Clinical Governance Committee.

Clinical Governance Oversight Group

Date: 12/12/2023
Enquiries to: April Robertson
Telephone Ext: Microsoft Teams

CONFIRMED MEETING NOTE OF THE NHS FIFE CLINICAL GOVERNANCE OVERSIGHT GROUP HELD ON TUESDAY 24th OCTOBER 2023 via MICROSOFT TEAMS

Attendees

Lynn Barker (LB)	Director of Nursing, HSCP
Norma Beveridge (NB)	Director of Nursing, Acute Services Division
Pauline Cumming (PC)	Risk Manager
Fiona Forrest (FF)	Deputy Director of Pharmacy & Medicines
Claire Fulton (CF)	Lead for Adverse Events
Catherine Gilvear (CG)	Fife HSCP Quality, Clinical Care & Governance Lead
Janette Keenan (JK) (Co-chair)	Executive Director of Nursing
Dr Iain MacLeod (IM)	Deputy Medical Director
Siobhan Mcilroy (SM)	Head of Patient Experience
Dr Chris McKenna (CMcK) (Chair)	Medical Director
Dr John Morrice (JM)	Associate Medical Director of Women & Children
Elizabeth Muir (EM)	Clinical Effectiveness Manager
Victoria Robb (VR)	Lead Pharmacist, Medicines Safety
Nicola Robertson (NR)	Director of Nursing, Corporate
Shirley-Anne Savage (SAS)	Associate Director of Quality & Clinical Governance
Amanda Wong (AW)	Director of Allied Health Professions

In attendance

Claire Berry (CB)	Quality Improvement Project Manager
David Comiskey (DC)	Head of Audiology Services
Nicola Maher (NM)	Programme Manager - Digital & Information
April Robertson (AR)	Clinical Governance Administrator (Minute Taker)
Dr Gavin Simpson (GS)	Consultant Anaesthetist

Apologies

Dr Sue Blair (SB)	Consultant in Occupational Medicine
Robyn Gunn (RG)	Head of Laboratory Services
Dr Helen Hellewell (HH)	Associate Medical Director, HSCP
Aileen Lawrie (AL)	Director of Midwifery
Geraldine Smith (GS)	Lead Pharmacist, Medicines Governance
Benjamin Hannan	Executive Director of Pharmacy and Medicines
Dr Sally McCormack (SMcC)	Associate Medical Director for Emergency & Planned Care
Prof Morwenna Wood (MW)	Director of Medical Education

	Items		Action
1	**Apologies for Absence**		
	Apologies for absence were noted from the above members.		
2	**Minutes of the last meeting held on 22nd August 2023**		
	The Group confirmed that the note from the meeting held on the 22nd of August 2023 was an accurate record with one modification from PC in the wording regarding the Corporate risks which was a clarification around the Covid 19 Risk.		
	2.1.1	SBAR Assurance Summary of Clinical Governance Oversight Group 22nd August 2023 **(SAS)**	

	2.1.2	Assurance Summary of Clinical Governance Oversight Group 22nd August 2023 **(SAS)**	
	SAS explained that internal auditors had requested an assurance summary reflecting the highlights from the minute which would now also be sent to Clinical Governance Committee (CGC) from every CGOG meeting. She welcomed any comments from the group. CMcK added this would now be a standing item on the agenda, providing a more summarised and "in context" document to CGC.		
3	**Matters Arising/Action List (CMcK)**		
	3.1 Deteriorating Patients (NB) NB gave an update regarding Welch Allyn test phase; explaining the funding for the first phase was in place, in principal. This will allow testing in Wards 43, 44 and Admissions Unit 1 (AU1) which is expected to provide positive results, giving proof of concept. CMcK suggested the Project Management Office (PMO) support these next phases as part of the work already being undertaken for the Deteriorating Patient's Team. IM pointed out that funding should be identified as soon as possible as this had been the barrier in initiating the "test phase". It was also noted from the action list that the following actions had also taken place. 4.10 Corporate Risk Register CMcK & PC had met and they agreed the Clinical Governance Oversight Group (CGOG) was the appropriate place to bring the corporate risks aligned to the Clinical Governance Committee (CGC) prior to being updated for CGC, to decide whether there were any additional risk mitigations which could alter the risk rating. 5.2 NHS Fife Adverse Events Themes & Trends Report A meeting took place between CMcK, CF, SAS and CG to discuss overdue actions. Consideration was given to those which were no longer relevant and therefore could be closed off. A plan was made on how to progress these open actions. A report on overdue actions will be sent out to the "services" to give them a better overview of their open actions, advise on management of these and provide guidance to support closure.		
4	**GOVERNANCE**		
4.1	NHS Fife Deteriorating Patient SBAR **(GS)**		
		GS provided the group with the background of the deteriorating patient project which is seeking to reduce cardiac arrests across inpatient areas in NHS Fife by relaunching 'Know the Score'. He then highlighted the following; • Following the workshop, a wide range of potential ways to support	

		improvement has been identified. These are being reviewed in more detail and the Deteriorating Patient Group will consider how to best progress these. • Work has started with the AU1 team, who were identified as a priority area, to explore what can be done to support them with the improvement work. A range of proposals for tests of change have been identified. • The Resuscitation Team are now delivering Know the Score education as an online webinar lasting around an hour. In addition, Derek Ramsay (Advanced Nurse Practitioner) is currently delivering 'pop up' face to face teaching sessions across the wards. The feedback received from this training is very positive with particularly good engagement by staff at the pop-up sessions. • Know the Score boxes (containing a range of materials to make it easier to implement) are being distributed to wards. • Planning for further engagement specifically around the community inpatient areas is being explored as there are unique challenges specific to this area. A date has been scheduled for this. Project support has been agreed for 6 months but the training is going to run until September 2024.	
	4.1.1	August highlight report for Deteriorating Patient **(GS)**	
		These were noted by the group.	
	4.1.2	September highlight report for Deteriorating Patient **(GS)**	
		These were noted by the group.	
	4.1.3	NHS Fife Deteriorating Patient Flash Report Workshop 23 August 2023 **(CB)**	
	CB shared with the group that the purpose of the workshop had been to explore how the care of the "Deteriorating Patient" could be improved across all of the patient settings within NHS Fife. There were 2 breakout sessions; Breakout Session 1; delegate experiences of caring for deteriorating patients Breakout Session 2; how can we accelerate improvements in the following aspects of caring for deteriorating patients From this work GS has identified a number of improvement projects which the Project Management Team will support. CB asked that this flash report be circulated as widely as possible by the group members amongst their teams. NR shared with the group that one of the pieces of work that the Organisational Learning Group was hoping to use as an action pilot was the Deteriorating Patient, she asked for GS's approval for this. GS said he would look forward to this collaboration.		
4.2	Independent Review of Audiology Services in NHS Scotland SBAR **(DC)**		
	4.2.1	Independent Review of Audiology Services Scotland **(DC)**	

	CMcK introduced DC informing the group that there had been adverse outcomes in the NHS Lothian Paediatric Audiology Services documented through the complaint process. This resulted in a review of their paediatric audiology services, revealing a number of areas for improvement. This prompted NHS Fife to develop a local action plan. Subsequently, an Independent National Audiology Review has delivered 55 recommendations to Scottish Government to improve the quality of Audiology services and provide the structure, governance and leadership required to bring sustained improvement to services. CMcK felt it was important for this to be discussed and invited DC to CGOG for the NHS Fife action plan to be shared. DC explained to the group that as a result of the Independent National Audiology Review there would be a significant impact on how the discipline of audiology is delivered within a healthcare science profile for the next generation. The overarching aims across the findings and recommendations are: • To reduce variation and ensure the delivery of safe, high-quality, patient-centred care across Scotland, with clear accountability; • To build a sustainable pipeline of talent and ensure that patients are cared for by professionals with the right knowledge and specialist skills, within services with effective, skilled leadership; • To ensure a culture of continuous improvement of quality and outcomes of care across the patient journey, with external assurance of patient safety, clinical effectiveness and patient experience; • To ensure that national structures are in place to provide strategic oversight and assurance of audiology services NHS Fife had pre-empted this report and have already undertaken work to up skill their audiology workforce over the last 18 months to ensure there is now a more robust team than previously. A response from Scottish Government (SG) is awaited This will shape how implementation and governance of these recommendations takes place. NHS Fife will endeavour to engage with any 'task force' compiled to support implementation of the recommendations. DC met with SAS to review structures with regard to governance to see if there are any areas which could be improved upon locally before the Scottish Government respond. The recommendations are weighted towards the SG taking ownership for audiology services within which there are significant resource implications. PC invited DC to share with the group the high risk that had been identified with regard to accommodation of the department. DC responded that from a quality assurance aspect, it is known that accommodation within Fife for audiology services is a significant risk. This is something which any inspection or deep dive would highlight; Investigation work is currently being undertaken by the Estates department and it is hoped that the response from SG to the audiology review could be an opportunity to highlight this further. CMcK updated that there was work currently being undertaken in Victoria Hospital phase one with regards to the ENT department and there may be accommodation	

	within for audiology services. Accommodation within Queen Margaret Hospital for paediatric audiology services and St Andrews Community Hospital were compliant.	
4.3	Hospital Standard Mortality Report SBAR **(CMcK)**	
	This was report was noted by the group and assurance taken.	
4.4	NHS Fife Clinical Governance Strategic Framework Delivery Plan 2023/24 Mid Year Review **(SAS)**	
	SAS shared the delivery plan with the group pointing out that this comprehensive update demonstrated how well many areas of work were progressing throughout the year and thanked all the contributors to the update. CMcK commented that we were in a very good position to give assurance around our clinical governance activity following questions at a national level; NHS Fife are in the fortunate position of having a published framework and workplan which can evidence our governance processes.	
4.5	NHS Fife Clinical Policy & Procedure Update **(EM)**	
	EM advised at their August meeting, the NHS Fife Clinical Policy & Procedure Co-ordination & Authorisation Group that there were two new procedures approved; • Fife Wide Procedure for Nova StatStrip Xpress2 Professional Blood Glucose Meter Point of Care Testing (Poct) • FWP-FNP-01 - NHS Fife Wide Procedure for Fit Note Provision by Advanced and Specialist Nurses There are two Fife wide procedures past their review date; • FWP-HIV-01 - NHS Fife Wide Procedure for Human Immunodeficiency Virus (HIV) Testing Procedure (01/08/2023) • RB-01 - NHS Fife Policy on Caring for Patients who refuse blood including Jehovah's Witness (19/07/2023) The group were given assurance that they have a 98% compliance rate for all clinical policies and procedures for NHS Fife.	
4.6	NHS Fife Activity Tracker **(EM)**	
	EM shared the following with the group; One new Annual Report; • Health Improvement Scotland Annual Delivery Plan issued 25 September 2023 One new standard was issued; • Bowel Screening Standards published 31st August 2023	
4.7	NHS Fife Corporate Risk Register Risks aligned to Clinical Governance Committee **(PC)**	

	PC presented a summary of the corporate risks which aligned to the CGC and their status. She explained that going forward the detail would be brought to this group in advance of CGC. Since the last report to this Group on 22 August 2023: • Six risks continue to be aligned to the CGC. • The risk level breakdown is unchanged - 4 High and 2 Moderate. • No risks have been closed. • No new risks have been identified. **Risk 3 - COVID 19** As previously reported to the Group, the risk rating has reduced from Moderate 12 (L- 3 x C- 4 to Moderate 9 (L- 3 x C- 3) due to the continued effectiveness of vaccination and the reduced impact of illness in the population. The Public Health Assurance Committee will review the risk at its meeting later in October 2023. Based on that assessment, a recommendation will be taken through EDG and the appropriate governance routes to retain or close as a corporate risk. An update will be provided to the CGC on 12 January 2024. PC asked if at the December CGOG meeting she could be allotted time to give a focus on Risk. CMcK agreed that this was a good idea. A development session took place on 23/01/2023 around the Optimal Clinical Outcomes Risk to provide further information and assurance. PC and CMcK explained there had been a deep dive completed in July for the risk around Quality and Safety. There was a view at that time, that this risk should be re-scored and reduced, however due to events in the “wider healthcare” arena, a decision was taken that the risk score would remain unchanged for now. CMcK asked the group to consider the Corporate Risks and any mitigating actions that could be added prior to the next meeting.	**PC** **ALL**
4.8	NHS Fife Health & Social Care Partnership Clinical Governance Assurance Update SBAR **(HH/LB)**	
	LB spoke to the paper informing the group that 11 papers had been presented for assurance and 7 for reassurance. This prompted a discussion between CMcK and LB on the difference between assurance and reassurance. PC added that after a recent discussion with members of the Audit & Risk Committee, it was clear that what was being sought was assurance rather than reassurance. Due to time constraints this discussion should be continued at the next meeting. CMcK asked the “NHS Scotland - Blueprint for Good Governance:” be circulated to all the CGOG members. He went on to thank LB, CG and their team for the update.	**PC** **AR**
4.9	NHS Fife Health & Social Care Partnership Inspection Update **(HH/LB)**	
4.9.1	NHS Fife Health & Social Care Partnership (HSCP) Inspection Update Appendices	

	LB informed the group that within the HCSP, Mental Health Service and Learning Disabilities received inspections almost fortnightly from the Mental Welfare Commission (MWC). The appendices provide an update on the external inspection processes in place within Fife HSCP ; a draft SOP along with flowcharts have been developed to support a standardised approach for external inspections from initial notification to completion of actions. PC asked why the MWC contact the Senior Charge Nurse and not the organisation directly when they plan an inspection. LB replied that the MWC maintain a good relationship by going right to the point of care. CMcK asked if there was assurance within these documents that NHS Fife has oversight of the inspections within HSCP. CG replied that appendices showed the scope from the notifications to the reporting of the visits. Additionally within the workplan there was guidance to ensure that there was compliance around the "papers" being reported to the correct places at the correct times. CMcK asked if within the flowchart the process for feedback / reports after CGOG be highlighted as this was something that would be expected by the Internal Audit Team. CG told the group that she had discussed the flowchart with Andy Brown (Internal Auditor) and would check to ensure the flowchart was amended if required.	**CG**
4.10	NHS Fife Acute Services Healthcare Improvement Scotland Inspection Update **(IM/NB)**	
	NB spoke to the Inspection update from the unannounced inspection to Victoria Hospital on Monday 31 July to Wednesday 2 August 2023. During the inspection, Healthcare Improvement Scotland: • inspected the ward and hospital environment • observed staff practice and interactions with patients, such as during patient mealtimes • spoke with patients, visitors and ward staff (where appropriate) • accessed patients' health records, monitoring reports, policies and procedures The action plan will be published on 26th October 2023.	
5	**ADVERSE EVENTS & DUTY OF CANDOUR STATUS UPDATE**	
5.1	NHS Fife Adverse Events KPI's **(CF)**	
5.2	NHS Fife Adverse Events Themes & Trends Report **(CF)**	
5.3	NHS Fife Adverse Events Flashcard **(CF)**	
5.4	Staff Support Following an Adverse Event **(CF)**	
	CF acknowledged that due to time pressures she was unable to present all of her papers as she normally would. However, she welcomed any feedback or	

	comments from the group. CMcK raised a question on CF's Themes and Trends Report which identified a significant increase in the incidences reported for unavailability of Urgent Care Mental Health Assessment Team (UCAT) -21 incidents were reported. He wondered how the group would receive an update from the mental health team and advised this should be looked at in greater detail at the December meeting. CF to organise a meeting with CG, HH and LB to make a plan regarding this escalation and bring it back to this group. CMcK also noted that the important work of the Adverse Events Team should be taken sooner on the agenda for the following meeting. CF shared with the group; A staff support pathway has been developed by a SLWG, led by the Adverse Events Lead and included representation from Spiritual Care, Psychology and Peer Support. The pathway has been presented to, and approved at the Staff Health and Wellbeing Group and is now ready to move into the second phase. There have been 3 areas identified to pilot the pathway, ED, AU1 and labour areas. The pilot will commence on 1st November and will run for 3 months. There will be an evaluation at the end of the pilot. There will be sessions for senior staff/managers who have utilised the pathway and staff who have received support to feedback on their experience. The questionnaire that initiated this project, where staff identified a lack of structured support following an adverse event and an uncertainty about the support services that were available, will be repeated to allow a measure of improvement. Training for senior staff/managers on how to implement and use the pathway has begun with a further 2 sessions planned. Further information including the pathway and supporting documents have been added to BLINK. CF told the group that AR would send to this group the leaflets; • Coping with stress and staff support following an Adverse Event & • NHS Fife Adverse Events Management Resource Pack - Staff Support IM questioned if there was anything further that could be done to support the staff carrying out Significant Adverse Event Reviews highlighting how the current process is causing some frustration with the teams. CF replied that the change in process effective from 1st October, in which a SAER Sponsor is assigned to every SAER will offer the review teams an additional layer of support and leadership. CF concluded the Paul Bowie (Director of Learning and Safety from NHS Education for Scotland) has offered a bespoke session on 14th December over TEAMS for the SAER sponsors called Supporting Systems Safety and Learning, for senior leaders.	**CF**
5.5	Duty of Candour Process **(SAS)**	
	SAS asked for any comments or feedback on the Duty of Candour Process to be sent to her	
6	**PATIENT EXPERIENCE**	
6.1	Patient Experience Flashcard **(JK/SM)**	
	Due to time constraints, SM was unable to speak fully to the Flashcard.	

	CMcK asked that Patient Experience be moved to the beginning of the agenda for December meeting. SM explained that the team were still working with other services, especially NB and the Acute Team, trying to streamline processes. She pointed out that there was an increase in complaints of 15% from last year which was made challenging due to staffing pressures. However, there was an improvement in compliance from last year's figures. The draft version of the dashboard is now ready for group members to look at and provide feedback on any additional data they would like to see. CMcK noted the huge amount of effort by SM and her team. He pointed out that these figures appeared to show HSCP as less compliant than Acute services. CG will discuss with LB and SM around complaints in HSCP.	**SM**
7	**STRATEGY & PLANNING**	
8	**QUALITY/PERFORMANCE**	
9	**LINKED COMMITTEE MINUTES**	
9.1	NHS Fife Clinical Policy & Procedure Co-ordination & Authorisation Group, unconfirmed 28th August 2023 **(EM)**	
	The minutes of the meeting were noted by the group and no escalation is needed.	
9.2	NHS Fife Point of Care Testing Committee - 7 June 2023 **(EM)**	
	The above meeting was cancelled.	
9.3	NHS Fife Organ Donation and Tissue Committee - 29th June 2023 **(NR)**	
	The minutes of the meeting were noted by the group and no escalation is needed.	
9.4	NHS Fife Health & Social Care Partnership Quality Matters Assurance Group - 11th August 2023 **(LB)**	
	The minutes of the meeting were noted by the group and no escalation is needed.	
9.5	NHS Fife In Patient Falls Steering Group - 9th August 2023 **(NB)**	
	The minutes of the meeting were noted by the group and no escalation is needed.	
9.6	NHS Fife Tissue Viability Working Group, Business Note - 17th August 2023 **(LB)**	
	The minutes of the meeting were noted by the group and no escalation is needed.	
9.7	NHS Fife Resuscitation Committee, unconfirmed - 30th August 2023 **(JK)**	
	The minutes of the meeting were noted by the group and no escalation is needed.	
9.8	NHS Fife Organisational Learning Group - 18th August 2023	

	The minutes of the meeting were noted by the group and no escalation is needed.	
9.9	NHS Fife Acute Services Division Clinical Governance Committee, unconfirmed - 19th July 2023 & 13th September **(IM)**	
	The minutes of the meetings were noted by the group and no escalation is needed.	
9.10	NHS Fife Deteriorating Patient Group **(IM)** - 4th July 2023	
	The minutes of the meeting were noted by the group and no escalation is needed.	
9.11	NHS Fife Health & Social Care Partnership Falls Oversight Group - 17th July 2023 (cancelled) 7th September 2023 **(LB)**	
	The above meeting was cancelled and the minute for 7th September 2023 was carried forward to December meeting.	
9.12	Fife Partnership Reviews of Children & Young People Deaths' Governance Group - 17th August 2023 **(CF)**	
	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 Terms of Reference **(SAS)**	
	This was noted by the group.	
10.2	NHS Fife Clinical Governance Oversight Group Workplan 2023 - 2024 **(EM)**	
	There was nothing to highlight from the Workplan.	
11	**ISSUES TO BE ESCALATED**	
	No issues for escalation.	
12	**ANY OTHER BUSINESS**	
12.1	CMO (2023) 17 – Anticipatory Care Planning and Future Care Planning	
	This was noted by the group and CMcK asked for any thoughts / feedback on the CMO to be sent to AR.	**AR**
12.2	Unconfirmed dates for future CGOG meetings 2024-2025	
	These were noted by the group.	
	Date of Next Meeting 12th December 2023 09:30 via Microsoft Teams	

CLINICAL GOVERNANCE OVERSIGHT GROUP

(Meeting on 12 December 2023)

No issues were raised for escalation to the Clinical Governance Committee.

Clinical Governance Oversight Group

Date: 21/12/2023
Enquiries to: April Robertson
Telephone Ext: Microsoft Teams

UNCONFIRMED MEETING NOTE OF THE NHS FIFE CLINICAL GOVERNANCE OVERSIGHT GROUP HELD ON TUESDAY 12th DECEMBER 2023 via MICROSOFT TEAMS

Attendees

Lynn Barker (LB)	Director of Nursing, HSCP
Norma Beveridge (NB)	Director of Nursing, Acute Services Division
Pauline Cumming (PC)	Risk Manager
Claire Fulton (CF)	Lead for Adverse Events
Catherine Gilvear (CG)	Fife HSCP Quality, Clinical Care & Governance Lead
Robyn Gunn (RG)	Head of Laboratory Services
Dr Helen Hellewell (HH)	Deputy Medical Director, HSCP
Janette Keenan (JK) (Co-chair)	Executive Director of Nursing
Aileen Lawrie (AL)	Director of Midwifery
Dr Sally McCormack (SMcC)	Associate Medical Director for Emergency & Planned Care
Dr Iain MacLeod (IM)	Deputy Medical Director
Dr Chris McKenna (CMcK) (Chair)	Medical Director
Elizabeth Muir (EM)	Clinical Effectiveness Manager
Nicola Robertson (NR)	Director of Nursing, Corporate
Dr Shirley-Anne Savage (SAS)	Associate Director of Quality & Clinical Governance

In Attendance

Lee Cowie (LC)	Senior Manager, H&SCP, Child/Adult Mental Health & Addiction Services
Kate Gaunt (KG)	Deteriorating Patient & Resuscitation Lead
April Robertson (AR)	Clinical Governance Administrator (Minute Taker)

Apologies

Dr Sue Blair (SB)	Consultant in Occupational Medicine
Fiona Forrest (FF)	Deputy Director of Pharmacy & Medicines
Benjamin Hannan	Executive Director of Pharmacy and Medicines
Siobhan Mcilroy (SM)	Head of Patient Experience
Dr John Morrice (JM)	Associate Medical Director of Women & Children
Amanda Wong (AW)	Director of Allied Health Professions
Prof Morwenna Wood (MW)	Director of Medical Education

	Items	Action
1	**Apologies for Absence**	
	Apologies for absence were noted from the above members.	
2	**Minutes of the last meeting held on 24th October 2023**	
	The Group confirmed that the note from the meeting held on the 24th of October 2023 was an accurate record.	
	2.1.1 Assurance Summary of Clinical Governance Oversight Group 24th October 2023 **(SAS)**	
	This was noted by the Group as an accurate summary. SAS shared that this had been very well received at the Clinical Governance Committee.	

3	**Matters Arising/Action List (CMcK)**	
	3.1 - NHS Fife H&SCP Inspection Flowcharts report procedure **(CG)** CG confirmed that the current / correct procedure was now reflected within the flowchart. 3.2 - Escalation of increased incidences reported for unavailability of Urgent Care Mental Health Assessment Team (UCAT) LB informed the group that there was an overall plan which Rona Laskowski (Head of Complex & Clinical Care Services H&SCP) and her team were leading on. Absences from work have reduced and the vacancies have reduced by around half with further staff being recruited. There is a short life working group which meets fortnightly with clinical and service management representation looking at those who attend UCAT frequently. There are complex case reviews of these clients, ensuring there is a robust safety plan. There is good engagement between Acute Services and H&SCP on the long term plan for UCAT. CMcK asked that all of this information come to the next meeting in the form of an SBAR. **3.3** - Patient Experience - Compliance from H&SCP JK shared with the group that SM has been having weekly meetings with the Community Care Directorate which has been very helpful. She has also been meeting with LC (Senior Manager, H&SCP, Child / Adult Mental Health & Addiction) and has been very encouraged by these meetings. LB added that SM has been meeting with the Heads of Service and their teams looking at the complaints and the targets required. She also attends their Quality Matters Assurance Group (QMAG) meetings and produces a report for this. She said that it should also be noted that there are some complaints which are incredibly complex and have multiple aspects to the patient's experience. CMcK noted that there had been instances where service managers had responded to complaints with no input from a clinician. He felt this was not good practice in responding to complaints. JK agreed that complaints should have some input by a clinician, for them to have ownership, lessons to be learned and any further actions to be taken. JK reminded the Group that there was a complexity scoring on which SM had done some work. They can either be negligible, minor, moderate, major or extreme. It is hoped that where the complaint is deemed to be negligible, minor or even moderate, these can quickly be dealt with. This enables the Patient Experience team to inform complainants that due to the complexity of the complaint it will take at least 40 days rather than 20. CMcK added that this was really positive development HH commented that what was required was a joint response from Service Managers and clinicians showing who was taking ownership of each part, giving a flowing response instead of separate statements. The ultimate goal was to give a response that showed that we as an organisation were taking ownership.	**LB**

	3.4 - CMO (2023) 17 - Anticipatory Care Planning and Future Care Planning CMcK asked the Group for their response to this CMO letter. GS responded informing the Group, there is currently Hospital Anticipatory Care Planning, which will be changing through the "Deteriorating Patient" work to Treatment Escalation Plan (TEP). In addition there is 'My Anticipatory Care Plan which aligns with Hospital Anticipatory Care Plan. He felt that a blanket change on the use of terminology from anticipatory care planning to future care planning could cause confusion on the use of the current tools. HH agreed with GS, adding that we would also have to consider how this would fit with how GPs work. She also commented that communication around any change was key; this should be in a staged fashion so that we gradually evolve.	
4	**NHS FIFE CORPORATE RISK**	
4.1	SBAR Update on Corporate Risks Aligned to the NHS Fife Clinical Governance Committee **(PC)**	
	PC summarised key points from the SBAR and the risks extract. Since the last report to this Group on 19 October 2023, there have been no changes to the risk profile. • Six risks continue to be aligned to the CGC. • The risk level breakdown is unchanged - 4 High and 2 Moderate. **Risk 3 - COVID 19** Proposed de- escalation as a corporate risk. The CGC supports closing the risk and moving to develop one that addresses the wider biohazard threat. The Public Health Assurance Committee (PHAC) will review the risk on 6 December 2023. Thereafter, a recommendation will be made to EDG and then CGC on 12 January 2024, to retain or close as a corporate risk. **Risk 4 - Optimal Clinical Outcomes** Following a deep dive review in May 2023 and a focused CGC Development Session on 23 October 2023, an update on the risk will be provided to the CGC following feedback from the session. **Risk 9 - Quality and Safety** The risk level will remain high pending the outcome of the review commissioned by the Chief Executive of governance arrangements associated with quality and safety data. The CGC accepted this position on 3 November 2023. **Risk 16 - Off-Site Area Sterilisation and Disinfection Unit Service** As previously reported, following the deep dive review presented to the CGC in September 2023, the risk was escalated to the September Board. It was agreed to consider the risk at a future Board Development Session on the prioritisation of capital resources more generally. The CGC had asked that the risk scoring be reviewed. The NHS Fife Decontamination Group reviewed on 10 November 2023. After examining the risk, it was agreed to maintain the current risk score. **Risk 17- Cyber Resilience** Given improved performance in this year's Network and Information Systems (NIS) audit, the potential to reduce this risk's rating will be considered. **Risk 18 - Digital & Information** The Associate Director of Digital & Information presented a deep dive on this risk	

	to the CGC on 3 November 2023. This set out the activities associated with the creation of a future Digital Strategy, and alignment to current strategic ambitions and programmes. The creation of a future strategy allows for specific consideration of the financial plan required to underpin the outcomes required by NHS Fife. **Potential Corporate Risk:** **Future Biological Threats including Pandemics - risk in development** It is anticipated the Director of Public Health will present a draft risk and an initial deep dive review, to the PHAC on 6 December 2023, EDG thereafter, and CGC on 12 January 2024.If agreed it poses a corporate risk, it will be proposed for Board approval in January 2024. **Deep Dive Reviews** Five of the six corporate risks aligned to the CGC have now undergone at least one deep dive. Based on our experience and learning over the last year, and following discussion at the Audit and Risk Committee Development Session on 12 October 2023, the Risks and Opportunities Group (ROG) made recommendations to EDG on 2 November 2023 on the role of the 'deep dive' and triggers for reviews during the life - cycle of a corporate risk. Following EDG approval, these will be submitted to the Audit and Risk Committee (ARC) to endorse on 13 December 2023.	
	4.1.1 Appendix 1 - NHS Fife Corporate Risk Register – Updated Risks Aligned to Clinical Governance Committee **(PC)**	
	This was noted by the Group and no comments made.	
	4.1.2 Appendix 2 - SBAR - Deep Dive - Digital & Information **(PC)**	
	This was noted by the Group and no comments made.	
	4.1.3 Appendix 3 - Assurance Principles **(PC)**	
	This was shared with the group for information.	
	4.1.4 Appendix 4 - Risk Matrix **(PC)**	
	This was shared with the group for information.	
	4.1.5 Risk Management – Update & Future Developments **(PC)**	
	PC shared a Power Point presentation outlining the following: The Board had approved the updated Risk Management Framework (RMF) in September 2023. The intention was to update the related Risk Register / Risk Assessment Policy. In re-drafting the policy, there was considerable duplication with the RMF. Following consultation with Internal Audit (IA) and the ROG, it has been determined that a separate policy is not required if the content is covered in the RMF. The approach now being taken forward is: • Proposal to ARC on 13/12/23 to endorse an approach to: ▪ expand Framework to capture essential policy content; subject to refinement and iteration ▪ prioritise training and development of learning resources; align with existing materials ▪ Delivery plan and training programme being developed to **enable and support** individuals, departments, services, directorates and management &	

leadership teams to:

- review and manage risks in a consistent and time effective manner

PC summarised the status of the overall corporate risk profile:

- 18 risks - 13 high and 5 moderate level
- No risks closed since inception
- COVID 19 risk to be proposed for de-escalation Jan 2024
- 1 potential new corporate risk identified relating to;

'Preparation for the Implementation of the Health for the Implementation of the Health and (Scotland) Act 2019' Care (Staffing) (Scotland) Act 2019'

- > 60% of all corporate risks above appetite - reflecting level of delivery challenge across services

PC provided an update on the ROG and its key areas of focus including:

- Corporate Risk Register
  Assurance Framework including Deep Dive Reviews
- Review of risk matrix
- Population Health & Wellbeing Strategy - Horizon Scanning - risks and opportunities
- Developing a Risk Summary Dashboard with D&I to support operational risk management

PC gave an overview of the ARC Development Session held in October 2023 which reviewed the effectiveness of the new Corporate Risk Register Process. Summary feedback:

- Positive developments
- Improved visibility of corporate risks
- Sharper focus
- Richer risk conversations
- Deep Dive reviews enhance understanding

PC concluded with a future focus;

- Risks versus Issues - Can we see the wood from the trees?
- **A Risk** is something that hasn't happened yet but has a likelihood of occurring
- **An Issue** is something that has happened i.e. already present. To be dealt with through day to day management & governance processes.
- Consider- are there gaps in your profile? **Or** Multiple similar risks - is this significant?
- Risk descriptions - Should succinctly state the risk, the cause and the effect E.g**. There is a risk that** [something could happen], because of [explain why this could happen], resulting in [describe impact if the risk happens].
- Older risks - > 5 yrs. Do these reflect the current context and operational challenge?
- Risk 'scores' - Are these valid? Do they reflect use of the matrix, consensus view? How do we know?
- Target the target! - How close are we? Achieved? If so, why still active? Potential for closure?
- If not, why? Are mitigations working? What do we need to do more of /differently? Is target realistic?
- Key Performance Indicators
- Risk Appetite - for review in 2024 and to take note of IJB risk appetite
- Implementing the Risk Summary Dashboard ... watch this space!

5	**ADVERSE EVENTS & DUTY OF CANDOUR STATUS UPDATE**	
5.1	NHS Fife Adverse Events KPI's **(CF)**	
	CF advised that emerging issues from both KPI's and Flashcard are captured within the themes and trends report.	
5.2	NHS Fife Adverse Events Themes & Trends Report **(CF)**	
	CF shared the Themes and Trends Report with the Group pointing out that in October a total of 66 incidents were reported with outcome severity recorded as major or extreme. This is the highest monthly total recorded over the last 24 months and an increase of 20 events in direct comparison to October 2022. The major / extreme events represent 3% of the total number of events reported in October. Tissue Viability (TV) events are consistenty the highest reported category of events coded as major harm. On average 12.6 TV incidents are reported as major / extreme per month. With October having a record high of 23 incidents. TV events make up 43% (140) of the total number of SAERs / LAERs that have been commissioned in 2023 to date. Reviews of Major Adverse Events; 235 LAERS and 49 SAERs Overdue in Acute Services Division SAERs 23 of 40 open LAERs 45 of 80 open Overdue in Helath & Social Care Partnership SAERs 7 of 12 open LAERs 69 of 116 open In the last 12 months the average closure time for a LAER is 240 days and a SAER is 313 days. The national target for both of these categories is 90 days. <u>Next steps</u> • Consider National Framework for Learning from Adverse Events and define local trigger list for reporting of adverse events by categories – workshops early 2024 • Review current types of reviews for commonly reported major events and explore the possibility to manage differently going forward – workshops early 2024 Appendix 1 - National framework consequence grading matrix Appendix 2 - Trigger list (adapted from current trigger list, early draft a starter for 10 CF shared the consequence ratings explaining that these would be discussed at the workshops to ensure staff understood how to grade appropriately. She also shared a trigger list explaining that this was still a work in progress; these will be explored further within the workshops looking at each speciality area thinking about what local direction should be taken for these types of events. CMcK concluded, it would be advantageous to considered another way of	

	managing LAERs, explaining that they can appear as a 'second rate' review to relatives. Sometimes comments or complaints from the family can lead to something being comissioned which is unnecessary, possibly because of the language used. Nationally many boards only carry out SAERs and no LAERs (or equivalent). He would like a decision to be made backed up by a matrix on how we manage events that do not meet the national definition for a SAER. IM added he thought getting the balance was really important, the teams dealing with the reviews are completely overwhelmed. He welcomed the idea of the workshops and getting criteria in place to provide consistency. In acute services it appeared that only a smaller number of people were contributing to these reviews which was causing them to become overwhelmed. This was very important work and it was essential things were made better for the staff running these reviews in order to obtain the quality and timeliness required. This sentiment was echoed by both the Acute and H&SCP members of the group. AL added that some investment is required for these investigations to become timely. Also that it may be good thing that we have 2 levels of reviews (SAER/LAER) as this may show that NHS Fife is learning more than other areas and acknowledging where we need to improve. CMcK concluded by saying a meeting with key stakeholders from CGOG would be organised to rationalise the matrix of decision making around when a SAER would be commissioned and focus on what the Health Improvement Scotland (HIS) matrix looks like in comparision with the NHS Fife matrix. The group should also consider if there is a simplified approach that can be taken to allow for a prompt response and indentify whether there is a need for escalation of the adverse event. He asked CF to arrange a meeting for the new year.	**CF**
5.3	NHS Fife Adverse Events Flashcard **(CF)**	
	This was noted by the group.	
6	**PATIENT EXPERIENCE**	
6.1	Patient Experience Flashcard **(JK/SM)**	
	NR shared this item in the absence of SM pointing out from the complaint dashboard that the total number of stage 2 complaints open is 82. For the last 2 years these have never been below 145. The creation of the dashboard has allowed the officers to focus on clearing the backlog of complaints. Using the dashboard, complaints can be filtered by Acute, H&SCP and directorate level as well as demonstrating where the complaints are in the process e.g. awaiting statements, sign off, drafting etc. It also shows the detail of each complaint and has transformed the way the patient experience team work. CMcK acknowledged that SM had done a huge amount of work in bringing this all together. The dashboard was immensely helpful in looking at the data and he has asked Digital & Information (D&I) if something similar can be produced for adverse events which would allow the quick extraction of information. JK commented that due to the work carried out by SM there had been a huge improvement in complaints management despite a very small team.	
7	**GOVERNANCE**	

7.1	(SBAR)Mortality in Nosocomial COVID-19 Cases **(CMcK)**	
7.1.1	Mortality in Nosocomial COVID-19 Cases **(CMcK)**	
	CMcK told the Group he had commissioned this report and it has been in progress for around a year. It has been a difficult report to write as it had to be very clear and transparent to the board and ensure that it comprehensively described the learning that has occurred as a result of a very difficult time during the pandemic. The report goes into the detail in relation to the numbers of patients who died after acquiring Covid in hospital. He asked that the Group take time to fully read the report and feedback any inaccuracies or any enhancements required. This is primarily an infection prevention report which relates to our response to outbreaks, the cohorting of patients and our compliance with the guidance available at the time. It also outlines the challenges experienced and the learning taken should this kind of situation ever be faced again in the future. It is really important that all of this information is shared and that we are as open and honest with what happened within this board as possible. CMcK asked SAS if she wanted to highlight anything from the report as she had been involved in its creation along with Julia Cook (Infection Control Manager) SAS commented that there was a lot of complex data which she had tried to condense and make readable. There is a comprehensive section within the appendix around the lessons learned which she encouraged group members to comment on. It has been agreed to call the document 'Healthcare acquired infections' instead of Nosocomial for the purposes of the board. She welcomed any comments / feedback prior to it going to CGC in January. CMcK concluded by asking JK to pass on the Group's gratitude to Julia Cook and again asking for any feedback to SAS.	
7.2	NHS Fife Health & Social Care Partnership Clinical Governance Assurance Update SBAR **(HH/LB)**	
7.2.1	NHS Fife H&SCP Integrated Joint Board 10, Risk Register **(HH/LB)**	
	HH told the group this report relates to: Fife HSCP Quality Matters Assurance Group Clinical Quality (QMAG) meeting on 6th October and an overview of the 3 Quality Matters Assurance Safety Huddles (QMASH) held between 11th August and 6th October. Due to time constraints HH did not go through all of the information on the SBAR but was happy for any feedback. CMcK asked what the QMASH meetings involved. CG explained that the group chaired by LB met every 2 weeks to look at the live data, themes and trends. HH added theses short focused meetings were to ask questions and trying to get ahead of matters arising instead of waiting for any issues to appear in other data sources. HH asked if the future Inspections could be part of this assurance statement instead of a separate item on the agenda. CMcK replied that Internal Auditors has asked for the inspections to come to CGOG, however, if they came as part of the assurance statement then this should be acceptable. CG added that Andy Brown (Internal Auditor) was content with Inspection Reports becoming part of the Assurance Statement SBAR.	

	She also explained the provision of the Risk Register was at the request of Internal Controls Evaluation (ICE) with regard to adult and child protection, more narrative will be provided at the next CGOG (February) meeting. CMcK stated that there was an expectation that Acute Services provided a similar assurance update to this group.	**NB/IM**
7.3	NHS Fife Health & Social Care Partnership Clinical Governance Inspection Update SBAR **(LC)**	
	LC spoke to the SBAR pointing out the very positive comments from the Mental Welfare Commission (MWC) around Ward 1, Queen Margaret Hospital, Dunfermline. There were no recommendations coming into ward 1 this year, compared to last year which is a significant turnaround. There are a number of areas commended by MWC including; • Leadership • MDT Recordings • Multidisciplinary Working, • Equipment • Activity co-ordinators have impacted on the quality of care within the wards • Environment of the ward; The inspectors stated that they were "speechless" regarding the environmental improvements within the ward, and explained that on entering the ward it feels calm, organised and recognises the effort that has been put into changing the ward environment over a short space of time. They also stated that it was clear to the commissioning team that the leadership team are "motivated, energetic and determined. The monetary and more importantly the time investment from the leadership and staff within the ward were all noted in the report. **Cairnie Ward, Stratheden Hospital**, **Cupar** had also received favourable feedback. The MWC were complimentary regarding the care provided and shared the positive feedback they had received from patients and relatives. **Documentation** The Inspectors commented on the excellent Multi-Disciplinary Team patient records making specific reference to the medical entries and exemplary continuation notes. They were impressed with the person-centred care planning and the evidence that staff had taken time to find out about each individual person's character and interest before they became unwell. They noted the positive work done around psychological formulation which ensured the care plans were holistic. They did highlight that they would like to see the work done in the formulation linked to the daily continuation note in order to evidence the positive care that is being delivered. **Recommendations:**	

	• This will again focus on the environment. The inspectors referenced Ward 1 and the changes made there and acknowledged that financial investment would be required. MWC were aware of the work being done around activities and up-skilling staff and are also aware of the work to ensure that Activity Coordinators are in place, however to ensure there is some traction they have indicated that this will feature as a recommendation.	
7.3.1	Mental Welfare Commission for Scotland, draft report on unannounced visit to Radernie Unit, Stratheden Hospital 15th May 2023	
	The draft report was noted by the Group.	
7.3.2	Mental Welfare Commission for Scotland, draft report on announced visit to Elmview and Muirview Wards, Stratheden Hospital 20 July 2023	
	The draft report was noted by the Group.	
7.3.3	Mental Welfare Commission for Scotland, draft report on announced visit to Hollyview Ward, IPCU, Stratheden Hospital, 27th July 2023	
	The draft report was noted by the Group.	
7.3.4	Mental Welfare Commission for Scotland, report on announced visit to Lomond Ward, Stratheden Hospital 2nd March 2023	
	The report was noted by the Group.	
7.4	Deteriorating Patient October Highlight Report **(EM)**	
	EM highlighted from the report the work that was being established and ongoing in Admissions Unit 1 looking at ways to improve. Also, the training Derek Ramsay (Advanced Nurse Practioner) was providing was being very well received on the wards.	
7.5	Deteriorating Patient November Highlight Report **(EM)**	
	EM pointed out the key pieces of work to note; There had been a visit from Professor Jason Leitch (Scottish Government's National Clinical Director) where the combined work of the Deteriorating Patient within the Acute and H&SCP was presented. He was very interested to learn about the work around the partnership's SBAR tool trying to prevent patients from having to attend the Acute setting. The work / learning of the Deteriorating Patient was also presented at the Organisational Learning Group (OLG) which was very well received. NR added that the excellent report by Tom McCarthy (Portfolio Manager) on the Deteriorating Patient work was a first test of how the OLG will take things forward. They will now have discussions around what they do with the learning and how this can be spread throughout the organisation. NR asked if the cascade training of the deteriorating patient work was progressing well.	

	NB responded that she did not feel this training was reaching its full potential. There are secondment posts out to advert to support the cascade training. There is still a lot of work to be done which is mainly down to resources.	
7.6	NHS Fife Clinical Policy & Procedure Update **(EM)**	
	EM advised at their October meeting, the NHS Fife Clinical Policy & Procedure Co-ordination & Authorisation Group that there was **one** new procedure approved; • FWP-PBIARD-01 – NHS Fife Pre-Birth Inter-Agency Referral Discussion There are **five** Fife wide procedures past their review date; • FWP-AHPNMSPP-01 - NHS Fife Wide Procedure for the Management of Nursing, Midwifery and Allied Health Professional Students within the Practice Learning Environment (01/10/2023) • FWP-ARTHROP-01 - NHS Fife Wide Procedure Management of Patients with BMI>40 being considered for Lower Limb Arthroplasty (primary and revision surgery) (16/10/2023) • RB-01 - NHS Fife Policy on Caring for Patients who refuse blood including Jehovah's Witness (19/07/2023) • FWP-HP-01 - NHS Fife Wide Adult In-patient Hydration Procedure (08/10/2023) • FWP-BBMHB-01 Fife Wide Procedure for Babies Born to Mothers with Hepatitis B Infection and/or Babies Born into a household where a member (other than the mother) is known to be infected with Hepatitis B (01/04/2023) These procedures are on the agenda for NHS Fife Clinical Policy & Procedure Co-ordination & Authorisation Group, Monday 18th December 2023 for discussion. The group were given assurance that they have a 95% compliance rate for all clinical policies and procedures for NHS Fife.	
7.7	NHS Fife Activity Tracker **(EM)**	
	EM shared the following with the group; **One** new Inspection Report; • Victoria Hospital - safe delivery of care inspection report: October 2023 **One** new Annual Report; • Death Certification Review Service Annual Report 2022-2023 issued 10 October 2023 **New** standards issued;	

	• Bowel Screening Standards issued 31 August 2023 • Healthcare Improvement Scotland Annual Delivery Plan issued 25 September 2023 • Core Screening Standards issued 28 September 2023 • Congenital heart disease (CHD) standards issued 29 November 2023	
8	**STRATEGY & PLANNING**	
9	**QUALITY/PERFORMANCE**	
10	**LINKED COMMITTEE MINUTES**	
10.1	NHS Fife Clinical Policy & Procedure Co-ordination & Authorisation Group, unconfirmed - 23rd October 2023 **(EM)**	
	The minutes of the meeting were noted by the group and no escalation is needed.	
10.2	NHS Fife Organ Donation and Tissue Committee - 28th September 2023 **(NR)**	
	The minutes of the meeting were noted by the group and no escalation is needed.	
10.3	NHS Fife Health & Social Care Partnership Quality Matters Assurance Group - 6th October 2023 **(LB)**	
	The minutes of the meeting were noted by the group and no escalation is needed.	
10.4	NHS Fife In Patient Falls Steering Group, unconfirmed - 8th November 2023 **(NB)**	
	The minutes of the meeting were noted by the group and no escalation is needed.	
10.5	NHS Fife Acute Services Division Clinical Governance Committee, unconfirmed – 22nd November 2023 **(IM)**	
	This meeting minute was carried forward to February meeting	
10.6	NHS Fife Deteriorating Patient Group **(IM)** - 4th July 2023	
	The minutes of the meeting were noted by the group and no escalation is needed.	
10.7	NHS Fife Health & Social Care Partnership Falls Oversight Group - 7th September 2023 & 16th October 2023 **(LB)**	
	The minutes of the meeting were noted by the group and no escalation is needed.	
10.8	NHS Fife Food, Fluid and Nutritional Care Steering Group, unconfirmed, 11th October 2023 **(NB/ER)**	
	The minutes of the meeting were noted by the group and no escalation is needed.	
10.8.1	NHS Fife Food, Fluid and Nutritional Care Steering Group, Draft Terms of Reference	
	These were noted by the Group.	
11	**ITEMS TO NOTE / INFORMATION**	

10.2	NHS Fife Clinical Governance Oversight Group Workplan 2023 - 2024 **(EM)**	
	There was nothing to highlight from the Workplan.	
12	**ISSUES TO BE ESCALATED**	
	No issues for escalation.	
13	**ANY OTHER BUSINESS**	
13.1	Confirmed dates for future CGOG meetings 2024-2025	
	These were noted by the group.	
	Date of Next Meeting 13th February 2024 09:30 via Microsoft Teams	

DIGITAL & INFORMATION BOARD

(Meeting on 19 October 2023)

No issues were raised for escalation to the Clinical Governance Committee.

Digital & Information Board

Fife NHS Board
UNCONFIRMED

MINUTE OF THE DIGITAL AND INFORMATION BOARD HELD ON WEDNESDAY 19TH OCTOBER 2023, 0900, VIA MS TEAMS

Present:

Chair - Dr Chris McKenna	Medical Director
Alistair Graham	Associate Director, Digital & Information
John Chalmers	Clinical Lead, Digital & Information
Janette Keenan	Director of Nursing
Margo McGurk	Director of Finance & Strategy
Audrey Valente	Chief Finance Officer on behalf of Director Health & Social Care
Matt Valenti	Partnership Representative
Miriam Watts	General Manager on behalf of Director of Acute Services
Duncan Wilson	Lead Pharmacist on behalf of Executive Director of Pharmacy & Medicines

In Attendance:

Lynn Barker	Director of Nursing
Claire Granger	Business Manager, Digital & Information
Marie Richmond	Head of Digital Strategic Delivery, Digital & Information
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
Andy Brown	Principal Auditor
Margaret Guthrie	Head of Information Governance & Security / DPO
Helen Hellewell	Associate Medical Director
David Miller	Director of Workforce
Sharon Mullan	General Practitioner
Torfinn Thorbjornsen	Head of Information Services, Digital & Information
Joy Tomlinson	Director of Public Health

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 – 19/07/23

Minutes were reviewed and agreed. Updates were provided for completed action.

3 Matters Arising

3.1 Red Team Exercise Output

A presentation was delivered by A Young and an overview of item was provided noting within the NISD Directive we conduct Penetration Tests (pen tests). This is where someone would try and exploit our IT estate. On this occasion we went even further, and conducted a team exercise, red against blue team. A Young provided further information to slide noting that across our IT estate there are

high numbers of IT equipment, and these are all connected via complex levels of security. An overview was provided to this.

The red team exercise is undertaken to simulate the end-to-end process of a human operated cyber-attack. This will test the vulnerabilities of IT Estate. We have taken knowledge from previous attacks e.g., HSE and SEPA attacks a few years back and an attack at a neighbouring Board last year, but this was unsuccessful.

A Young noted we are testing our estate to see how we respond to any possible attack and take recommendations on what we can do to improve. We are also carrying out these tests to see how the NSS Cyber Centre in Dundee handles.

A Young provided a scenario of how an attacker would compromise the IT estate. A phishing email would be sent, they would then wait for this email to be responded and would then exploit this target and take the data, corrupt and possibly then demand a ransom.

Within our simulation we set up an account and undertook this scenario. The red team was against the blue and over a number of weeks we simulated various attacks. Over these weeks we were receiving updates on the attacks. We had Cyber and Technical teams responding. We notified NSS Cyber Centre this was happening, and we had an apprentice join this team from a liaison point of view. The result from this pen test, access was gained to legacy systems. An exercise was also undertaken in person as well as virtually. This person carried out a recce of site and he came back the next day with his findings. This person was able to access Hayfield House, as a door was left open. He managed to speak to staff and gain access to offices. Nothing detrimental happened from this exercise but good lessons were learned. A Young advised that communications are required to the organisation and with Security on what more can be done to tighten up on the security procedures.

Within summary of this exercise the red team did succeed but we received the necessary alerts warning us to this action. We went a little further than normal and allowed the red team access, so we could see what would happen, what alerts we would receive and finally what recommendations we could take. We have taken an action list from the exercise and are now actioning these findings.

Dr McKenna expressed his concerns regarding the above access to Hayfield House and people can wonder and have access so easily. Dr McKenna did note to Board if we should have been alerted to this exercise and the findings prior to this Board meeting. This is a real concern as we had a similar situation in St Andrews. L Barker provided background noting an individual claimed to be a Nurse and accessed wards. This was reported to ICO and SAER was undertaken and signed off. We have been liaising with ICO regarding the report and are meeting next week on the output and engaging with M Guthrie.

Further discussions were held on the findings of the report and actions that have been undertaken with reiteration to staff on the security procedures.

A brief conversation was held on wider communications to reiterate that staff should have the confidence to question and challenge anything that looks unusual. Some suggestions were provided increasing security e.g., security passes have expiration dates and standardising the protocols around security badges.

Dr McKenna noted he is concerned with these results and will take offline for further conversations on how we approach.

Action – Dr McKenna to speak with C Potter, N McCormick, and K MacGregor regarding what can be done on property access and communications on security. **CMCK**

It was noted this needs to be escalated to EDG for assurance. **AY**

Action - A Young to produce SBAR.

3.2 Electronic Health Record Steering Group – Update

M Richmond noted to Board the first meeting was held on 4th October where a presentation was provided on the vision of the Electronic Health Record and discussion on the term of reference (ToR). Ongoing discussions on the ToR for the systems we have and the purpose of the systems.

This was a successful meeting and hope this meeting will drive the organisation forward.

Dr McKenna thanked M Richmond.

4 Risk Management

4.1 Risk Management Report

A Graham delivered a presentation to provide an overview the latest risks for October.

A brief update was provided noting the below:

- There has been a fair amount of movement with risks.
- 9 high risks have improved their risk rating since the last reporting.
- There are currently 9 high risks, 21 moderate risks and 6 low risks.
- 1 high risk 5416 is at their acceptance phase.
- There are a number of new risks - M365 project, EMISS and the Pharmacy Stock Control due to delay with HEPMA.
- Advised in previous item the risks from the pen test and the NISD Audit with work already underway.

A Graham provided comparison to the Risk Profile from July to October, and we can see mitigations are being applied. These allow for assurance.

Work is continuing on the Dashboard and this ties into the work for ICO and NIS.

A query was raised regarding the risk graphic and there is only 1 risk in territory as a corporate risk, could a review be undertaken to ensure nothing else should be in territory. A Graham noted this is worth considering and will review.

No other comments were raised.

5 Performance

5.1 D&I Performance Summary

A Young presented D&I Performance Summary from the last quarter, noting the below:

- EOL server removal, team has been working hard but requires capital funding and team resources, we are managing but this is an ongoing battle. This is also in tune with previous item as the red team were able to gain access via these servers.
- Performance for the last qtr. overall is very good.
- Cyber Security Score is dependant on the timing of patches. We patch every Tuesday, and this score can fluctuate due to this. This is monitored and have no concerns.

C McKenna queried the rise in risk, A Young noted we are reviewing these risks, and these came from the Cyber Resilience Team nationally. 4 risks are aligned to NISD Directive. It is timings of score and nothing of concern.

No other comments were raised.

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 Strategic Delivery update. A brief update is noted below:

- **CHI Replacement** - Due to go live on 1st November. Overall delivery is going well, however there are some areas of concern, but these are National. Conversations continue to resolve.
- **Digital Pathology -** Programme will be put on hold at present due to the prioritisation of the LIMS Project.
- **eRostering** – Continues to be rolled out in other departments but will need to pause in January 24 due to other BAU resource. Discussions will continue within the eRostering Board.
- **GPIT** – Request for Proposal completed and currently in review by National. Cohort agreed and expected response mid-November when another meeting will be arranged with Group. A Full Business Case will then go to Board. Awaiting feedback from supplier Cegedim.
- **M365 –** Continue to progress with elements. Use of M365 on personal devices being tested and is going well.
- **Morse Phase 2** – Work continues to integrate other services. There have been some system challenges with the data migration but working on these issues.
- **HEPMA** – Discussions continue with CLO and CMM on the final draft contract. Meeting arranged for Friday to review final draft of contract.
- **Other projects** – 4 smaller projects completed, and team continue to work hard on other projects.
- **Business Analysts** – a number of items are completed; 2 BA's are leaving and recruitment to replace will commence soon.
- **New Business requests** – These have slowed down but there are still a large number to work through.

M Richmond provided a brief overview on other projects and the continued work with team.

Dr McKenna queried milestone date regarding the GPIT Programme. M Richmond confirmed this is development by December and not migration.

Dr J Chalmers advised the Board that PACS reprovisioning will commence soon, but further communications will follow, and information will be provided to Group. M McGurk noted the contract has been signed and will be awarded at the end of October. PACS needs to be added onto to the list of projects.

M McGurk raised concerns on the volume of work ongoing and the financial position. Is there a need for discussions on the prioritisation on projects as there's more projects in the pipeline. A discussion was undertaken on the volume of projects to be completed and it was agreed that a development session would be arranged for further conversations to continue.

M McGurk queried updates provided by M Richmond, a few of these queries are listed below

- A discussion was held on Morse and queried the configuration issue with forms. M Richmond replied they are working closely with the H&SCP regarding forms and on review a Governance Group could have been established and taken wider. Feedback is going to the EHR Group. Lesson have been learned but feedback has been good and is well used.
- HEPMA, timeline has been marked as Red, M Richmond confirmed this is red from when the report is generated, and conversation have only commenced. Due to unavailability, this is currently with CLO. There have been issues but these are being worked through. It is hoped the meeting arranged on Friday there will be no challenges with contract, and this can then go through the relevant Governance.
- Infusion pumps are currently red, M Richmond noted significant funding is required, Medical Physics are identifying the funding source.
- LIMS project in green status, M Richmond advised from there prospective she believes will hit deadline. There have been challenges but with LIMS Programme Board is going well. On discussion will move this to amber.

Continued discussions were held on the volume of work and the prioritisation of projects, it was noted a number of projects are National so these are required, and we are limited on what we can do. Negotiations can sometimes be discussed but are generally mandatory. The only project with NHS Fife is HEPMA. It was agreed to continue discussions within the development session.

Action – MR, development session to be organised. **MR**

No other comments were raised.

6.2 Digital Strategy Update

A presentation was delivered by A Graham to provide an update on the Digital Strategy. Brief overview was provided, some of these points are noted below:

- An analysis of the Strategy has been undertaken.
- Within the strategy there are 5 categories, within these there are 49 deliverables against these categories and then a further 25 additional items above these.
- How do we tune our own strategic framework and align to other Strategies.
- Reviewing other strategic programmes and conversations undertaken with other Groups.

A Graham noted an update will be presented to Clinical Governance Committee in November.

M Richmond advised work undertaken has been a good piece of work and helpful as all the different strategies all have the same themes.

A conversation was held, and it was agreed that a workshop would be arranged to inform of all the projects within D&I. This will inform the revised strategy. It was suggested that other stakeholders should be part of workshop and aim for the end of year.

Action – MR, Workshop to be organised. **MR**

7 Business Cases / Proposals

No items on Agenda for discussion.

8 Finance Update

8.1 Capital and Strategic Funds

A Graham provided an update to Capital and Strategic funding noting this for information. We are fully committed but conversations ongoing.

9 Escalation to Clinical Governance Committee (via EDG)

Item 3.1 to be escalated to EDG, with a paper provided that describes the actions and a presentation to guide through the pen test.

Strategy update to be provided to next Clinical Governance Committee, as part of the work plan.

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
TBC

IJB QUALITY & COMMUNITIES COMMITTEE (Meeting on 2 November 2023)
No issues were raised for escalation to the Clinical Governance Committee.

IJB Quality & Communities Committee

Fife Health & Social Care Partnership

Supporting the people of Fife together

UNCONFIRMED MINUTE OF THE QUALITY & COMMUNITIES COMMITTEE
THURSDAY 02 NOVEMBER 2023, 1400hrs - MS TEAMS

Present:	Sinead Braiden, NHS Board Member (Chair) (SB) Councillor Rosemary Liewald Councillor Lynn Mowatt Councillor Sam Steele Ian Dall, Service User Rep, Chair of the PEN (ID) Paul Dundas, Independent Sector Lead (PD) Morna Fleming, Carer's Representative (MF) Colin Grieve, Non-Executive Board Member (CG)
Attending:	Nicky Connor, Director of Health & Social Care (NC) Dr Helen Hellewell, Deputy Medical Director (HH) Lynn Barker, Director of Nursing (LB) Roy Lawrence, Principal Lead for Organisational Development & Culture (RLaw) Catherine Gilvear, Quality Clinical & Care Governance Lead (CG) Lynne Garvey, Head of Community Care Services (LG) Lisa Cooper, Head of Primary Care and Preventative Care Services (LC) Fiona McKay Rona Laskowski, Head of Complex and Critical Care Services (RL) Jennifer Rezendes, Principal Social Work Officer (JR) Vanessa Salmond, Head of Corporate Services (VS) Lesley Gauld, Team Manager, Strategic Planning (LG) Leesa Radcliffe, Clinical Services Manager (LR) Audrey Valente, Chief Finance Officer, HSCP (AV)
In Attendance:	Jennifer Cushnie, PA to Deputy Medical Director (Minutes) Aylene Kelman, Clinical Director, HSCP
Apologies for Absence:	Councillor Margaret Kennedy Kenny Murphy, Third Sector Representative (KM) Christine Moir, Head of Education and Children's Services (Children and Families/CJSW and CSWO) Amanda Wong, Director of Allied Health Professionals (AW)

No	Item	Action
1	**CHAIRPERSON'S WELCOME AND OPENING REMARKS**	

	The Chair welcomed everyone to the HSCP Quality & Communities Committee. SB thanked HSCP staff who continue to work in what continues to be an extremely challenging working environment. SB advised there has been last minute apologies from Amanda Wong who was to present the paper on AHP Professional Documents, this item will be deferred to the next meeting.	
2	**ACTIVE OR EMERGING ISSUES**	
	Helen Hellewell stated there were no emerging issues to advise the Committee of.	
3	**DECLARATION OF MEMBERS' INTEREST** No declarations of interest were received.	
4	**APOLOGIES FOR ABSENCE** Apologies were noted as above.	
5	**MINUTES OF PREVIOUS MEETINGS HELD ON 07 SEPTEMBER 2023** The previous minutes from the Q&CC meeting on 07 September 2023 were reviewed and no alterations or corrections were requested. The minutes were taken as an accurate record of the meeting.	
6	**ACTION LOG**	
	The Action Log from the meeting held on **07 September 2023** was approved as accurate and updates noted.	
7	**GOVERNANCE**	
7.1	**Quality Matters Assurance** The report was brought for assurance by LB. LB gave an overview of the current clinical and care governance arrangements, systems and processes which are in place across the Partnership and outlined the matters discussed at Fife HSCP QMAG. The paper also represents the 4 Quality Matter Assurance Huddles which have been held in the last reporting time. LB advised there were 12 items submitted for Assurance to the last QMAG meeting in August, incorporating the 3 portfolio delivery units, and 7 papers for reassurance. She brought attention to the MWC reports and inspections which have taken place over the past year, with an in-depth presentation made by Lee Cowie, Acting Senior Manager, Mental Health, Learning Disability & Addictions Services. LB stated, feedback received from MWC was extremely positive. LB advised QMAG also reports through SLT. It was asked if the reports are available in the public domain, it was confirmed these are published and are available.	

	RL will forward the appropriate MWC link to Cllr Mowatt. SB commented she was very interested to hear of the work taking place around the Partnership at the Development Session and spoke of the usefulness of having context to compare findings. NC stated, as the Performance Framework continues to grow, it will be looking at performance and quality data, giving more context to bring the data alive for the Committee. SB told of her intention to visit some of the Mental Health site in the coming months. The Committee were Assured by the report.	**RL**
7.2	**AHP Professional Documents** SB advised, unfortunately AW, who was to present the AHP Professional Document Report, had been taken ill and sent her apologies. It was agreed the Paper will be deferred to the next meeting.	
7.3	**Mental Health Strategic Priorities Progress Assurance** RL brought the report to Committee for Assurance. She advised, there has been a suite of National Public Documentation and today's report give a refresh of Fife's position to give assurance to Committee of the progress to date. The report also shows next steps in terms of a formal consultation around priorities and outcomes from a needs assessment, which has just come to conclusion. RL advised, a further report with a delivery plan will come forward in April 2024 for discussion and debate. SB felt assurance was taken from the presentation to IJB and agreed, there has been considerable changes made to MH support since the Pandemic. SB queried if the Audit Scotland Adult Mental Health paper was now available, RL will share the report. JR was fully supportive of the positive Human Rights based approach, which is being taken, with a very wide reach. The Committee took assurance from the report.	
7.4	**Risk – IJB Quality & Communities Risk Register** This report was deferred to the next meeting on 17.01.24.	
8	**STRATEGIC PLANNING & DELIVERY**	
8.1	**Year 1 Workforce Annual Report & Year 2 Workforce Action Plan**	

	RLaw introduced the first Annual report which comes to Committees for discussion and decision as it progresses to IJB. Also the Year 2 Workforce Strategy which was endorsed last year. He added, there have been regular updates coming to IJB throughout the year. RLaw described how the documents link with the Workforce Strategy. RLaw spoke of the Audit report on Workforce to conclude soon and come to the next cycle of Committees which will give more detailed scrutiny on the work which has taken place. He invited feedback. PD thanked RLaw for the report and was grateful for the opportunity to contribute to the section relating to the independence sector, giving increased balance to the report. He spoke of work with RLaw's team giving a refresh to one of the Actions within the Action Plan. If accepted, this will be presented to the Board and will come forward to Committees. He felt it was a really worthwhile piece of work. RLaw thanked PD and felt adding in from different parts of the Service, across the Partnership was very important and gave a positive impact for all Partners. SB commented she was enthused to read the stories around the Princes' Trust and Care Academy attractive school leavers. She asked if this is a big programme and is it enough for the challenges being faced. RLaw spoke of work taking place to understand the data and working with corporate partners to obtain maximum impact. SB asked if the Committee was content to approve the Action Plan, the Committee agreed they were happy to approve.	
8.2	**Transformation – Business Cases** SB stated the Business Cases were being brought to the Committee for information. NC advised, a presentation and overview will be given of each of the cases. The focus for the Committee will be on quality, safety and the elements which are within the Q&CC's remit. Further opportunity will be given for discussion as the Business Cases move through the process. **Community Rehabilitation and Care Model** LG introduced the first Business Case – Community Rehabilitation and Care Model. A slide presentation was shown whilst LG spoke of the strategic need for change and began by describing the current situation within Home First and the problems being experienced. Examples and evidence of the following was described - outdated dependency on rehabilitation in an in-patient setting, too many people making long term decisions and too many people presenting with decompensating long-term conditions. LG described person-centred actions which could be put in place to combat some of these problems with a	

	community-based approach. Support for early intervention and complex care teams was outlined. LG spoke of many people requiring a double-up package of care due to moving and handling considerations. Two carers undertake the delivery of the care which has considerable cost implications and can be difficult to organise and plan, reducing the number of people who can receive care at home and ultimately will impact whole system flow. LG referred to a growing, ageing population, increasing demand for the services being provided across the whole of HSCP. Projections show the number of people over age 75 will increase by 31% by 2028 and 74% by 2043. LG spoke of re-purposing the bed-base and focus moving from bed-base to what else can be done. LG described how through making use of advanced equipment and improved moving and handling techniques there is an opportunity to consider changing from double up packages of care to a single-handed care model, where appropriate. Management of a re-imagined system and how this could become a reality was outlined and the many benefits to patients, families and carers described. Professional Leads were invited to give their views. JR gave assurance she is involved in a lot of the work which will ensure people's human rights are upheld as they are supported to transition from a stay in hospital to home, as safely and sensitively as possible. LB was supportive of the proposed change which has been in due, as previously highlighted, for some time. She commented the contemporary modernising of care delivery is the correct thing to do as an organisation which delivers care to people who need it. HH was fully supportive and advised all evidence shows people recover better from home, when it is safe for them to do so, surrounding by their loved ones. She gave assurance medical teams will be working to support this model of care. SB commented the presentation was very powerful and she felt there is no argument against the change, however, down the line she could imagine possible challenge from the local press and public. She felt Comms will play an important role and this has fallen short in the past. Cllr Liewald was supportive, she felt OT provision will play an important role and must be 100% correct. She stressed situations where a person goes into hospital and rehabilitation does not go to plan and the person never returns to home must be avoided at all costs. Rehabilitation will be vital with the person returning to their own home with equipment and home modifications put in place. MF felt assured the EQiA gives assurance the carer will be fully involved in all discussions regarding what is required when a loved one returns home. She also felt, care must be taken around Comms as the public may perceive this as 'cuts'. Cllr Steele thanked LG for the presentation and video hit home. She agreed with the comments made regarding media interpretation of the	

	change to Service. She queried the % of people awaiting 'on going care arrangements', will this include housing modifications. LG advised this was true. She wanted to give assurance to MF, as part of the PDP work which takes place in hospital as part of discharge planning, states "does this person agree to the plan of care". Regarding Comms, she was aware Dunfermline may be a 'hot spot', along with NE Fife, and there is no change to the bed base, Dunfermline will have the same as St Andrews. The Central Belt is more likely to see a change where there are far more community hospital and care home beds. Comms will be supported by the fact, there is infra-structure in place to safely support changes. PD fully endorsed the change and pointed out, this was coming from his background in Care Homes and Care at Home, and felt assured by the backing from Professional Leads. He advised there may be a risk Care at Home staff perceive rehabilitation as being passed on, adding pressure to existing pressures. Managing this going forward will be important. LG valued PD's input felt his input has been vital to the work which has taken place during the past year. She asked if the Committee felt it would be helpful to have a booklet with illustrations is used to addressed queries and some of the concerns. SB queried if social media, TV and other methods of CG felt most of his points have been covered, however, wanted to express the importance of the Comms, he felt the sooner the word goes out to the public, the better, and the reason behind and how transformation is needed, not just about savings. MF agreed and suggested little video clips showing patient experience, members of staff out in the Community. Cllr Mowatt thanked LG and everyone who has made an input. She expressed concern regarding staff, she asked if she could have a copy of the slides. NC advised the slides will be used in other Committees and may be tweaked before circulation. She asked MF if she would be interested in helping to inform content for videos. The benefit of booklets with pictures was discussed and felt to be very useful. SB advised the Committee was supportive of the work around Care at Home.	
	Model of Care for People Requiring Overnight Support RL introduced the Business Case which was a proposed Model of Care for People Requiring Overnight Support. A slide presentation supported RL's narrative. RL outlined the current model of care used, which is delivered through a carer staying overnight in a patient's home, either sleeping or awake, depending upon the support needs. The current model of care is labour intensive and costs over £12M per annum. RL advised, for the reasons above, it is intended to move to a new model of care and support through a combination of technology and	

	care staff attending as and when required, however, individual assessment will take place with each patient to assess suitability. The reason for change is to promote independence, to be less restrictive, provide proportionate care, maintain the dignity and privacy and to deliver with the current workforce and also financial. It will also assist delivery of the national health & social care outcomes and assist delivery of Getting It Right for Everyone model. RL explained graphs showing where the 421 individual care arrangements are, age ranges and variation of support arrangements. The service is normally delivered from 2200hrs-0800hrs, traditionally delivered by in-person care. A number of individuals are supported by more than one person, approx. 18 who have a sleeping and one awake member of staff. These are unlikely to be changed. RL explained the various care arrangements, shared care, individual care and the reasons why overnight support is required. Through research of Partnerships across Scotland it has been found an alternative model of care is being used by some. This offers support which introduces Technology Enabled Care. Information shared by Glasgow City and Edinburgh has allowed Fife to learn from their experiences. The primary feedback received from Partnerships is communication is key, going slowly to build confidence and trust, and to ensure the pace is comfortable for patients. Locally, in Fife, the model has changed for 21 service users over the past 2 year, moving away from sleep-over to a responder type service using technology. The many benefits of the technology solutions were outlined and the positive effect on staff wellbeing and retention were described. Looking ahead, RL outlined how the change in model would impact on Families / Carers / Service Users, Providers and the Partnership. The project is expected to take 3 years to complete due to the complexities and new posts will be required to manage the implementation. Ultimate savings were outlined to the Committee. RL gave an overview of the perceived Risk and mitigating actions which will be put in place to manage and overcome/prevent them, although RL indicated further work is required. RL finished her presentation by stating, gradual delivery of the transition to technology-based care and a responder service will support the delivery of the national HSC outcomes, the GIRFE aspiration of person centred and proportionate care and also deliver best value with the deployment of the workforce and financial commitments to this aspect of care. Questions were invited. PD thanked RL for the presentation and the work undertaken so far. He stated he has supported hundreds of sleep-overs over the years of both children and adults, and has been very close with the families and carers and welcomed the new model. He spoke of the many benefits and also the creation of dependency reducing the persons ability to thrive, reduces growth and self confidence and being able to take a greater level of control in their personal life. He was fully supportive of the model and the stages of testing. He did feel there may be some levels of challenge from families who have fought long and hard to get	

	their level of support in place for their loved one. He also acknowledged the challenges of getting the model right with shared resources. Very complex but believed it was the right thing to do. Cllr Liewald thanked RL for the report and the huge amount of work which has gone into it. She agreed with PD, there may be a large percentage of push back given some of the complexities. She felt it would be interesting to see how the 15min response works. She was assured to know there will be individual assessments carried out on each individual case and was happy to know where it was believed the level of support currently being provided cannot be changed, it will be maintained. She shared her feeling of nervousness around the model, although she can see advantages, she had concern around the response staff and where they would be based. SB expressed her concern around the Risks. CG commented on the complexity of the model which he felt would be demand led and spoke of the service's ability to be nimble moving forward. He acknowledged technology enabled care is having a massive impact throughout the country and will be key in deliver. He voiced concern around the response times, particularly with other services being in the news at the moment, which is put down to budgetary cuts. RL did not disagree with anything being said and advised emphasis will be placed on safety. She spoke of the sophistication of the technology and the various packages of care which will be provided to suit individual needs. Cllr Steele commented she was a learning disability nurse for 25 years and she spoke of the difficulty of making changes to the care of individuals with Learning Disabilities or Autism, which does not only affect the individual, but also their families. JR spoke of Human Rights and the GIRFE aspiration of proportionate care, the importance of good relationships with individuals receiving care. She stressed the importance of social work and HSCP workforces working together to make individuals feel safe and ensuring the correct degree of support is provided. NC acknowledged the caution coming from the Committee and she asked to sense-check if the Committee is content, from a Quality & Communities perspective, to put support behind the model, as it is tested and build it up. She was thoughtful of some of the positive stories which have come from families and individuals who have experienced a change of model. She felt this was something which should come back to the Committee.	
	Care at Home – Packages of Care LG introduced the Business Case – Care at Home – Packages of Care. A slide presentation was shown whilst LG spoke of the strategic need for change and began by describing the current situation where a high number of service users require a double-up package of care due to moving and handling considerations associated with specific equipment. She outlined the considerable cost implications and logistical issues with two carers required to travel and attend a patient	

	at each visit. LG gave background to why the double-up packages of care have been used and spoke of the proposed change to a single handed care model with specialist equipment installed in service users' homes, the training which will be provided to carers and the risk assessments required in detail. Benefits of the new model to patients, their families/carers and to HSCP were described. Managing the change and the risks associated if change is not implemented were explained. A comparison of costs was provided and how savings can be achieved whilst improving the quality of care to service users. Details of expected timescales and means of consultation were given. Questions were invited. MF thanked LG for her presentation and she felt anything which can cut down the amount of traffic in people's homes is positive and the benefit of freeing up a carer is very beneficial. She asked if a fit and able unpaid carer would be able to use the equipment. LG advised they would and felt the model could make a positive difference for unpaid carers too. PD advised through his experience of speaking with recipients of this type of care, it has been fed back, they have had a positive experience with one carer, in some cases their family member has been able to deliver the care which has been more dignifying for them, rather than a stranger. He mentioned there are 3 collaborative provider members working with Lorna going forward to look at the maximum impact across the whole system. Cllr Liewald was fully supportive and felt it will have a very positive impact on service users. She queried if there has been enthusiasm to undertake the training required to operate the new equipment. LG advised, it has been welcomed, not just from carers but from OTs. Cllr Mowatt asked if there was expected to be some % of 680 people who will retain double carer support. LG advised, there will be a large % who will still require 2 carers. There will be work carried out to ensure the correct support is provided for individuals. SB confirmed she was hearing the Committee is supportive of the model.	
	Reimagining the Third Sector FMcK introduced the final Business Case – Reimagining the Third Sector. FMcK advised, this work follows on from the initial work carried out with Third Sector Partners to look at realignment of programmes to meet changing needs since Covid. FMcK advised, as organisations have their own offices and buildings, there has been work to look at how buildings can be utilised better to reduce costs. She spoke of the possibility of third sector providers delivering on behalf of HSCP and what capacity may be available to do so. Recommissioning of services between partners to increase opportunities to reduce unnecessary costs was described, also an	

	evaluation framework to ensure best value, via service level agreements. FMcK also spoke of a payment 'holiday' for organisation with substantial reserves over their organisations reserves policy, as linked to Office of the Scottish Charity Regulator. Questions were invited. Cllr Liewald applauded the work being carried out and gave it her full support. SB advised the Committee are supportive and asked if there is an appetite within the Third Sector. FMcK confirmed there has been real buy in by thinking about best value and ensuring the money being spent is meeting needs. She spoke of buildings which can be shared for use with shared costs, being fully utilised. There was discussion around ensuring services being delivered is what is needed and feedback through locality planning. Drop in sessions have been arranged to discuss the proposed Business Plans.	
8.3	**PC Improvement Plan** LC introduced the Primary Care Improvement Plan which was brought to Committee to inform and ensure commitment to ongoing delivery of the Plan. LC outlined the background within the Paper which detailed the current position and she drew attention to Appendix 1, showing the Plan for 2023-2024. LC stated, a workshop with wide stakeholder attendance and engagement was involved in the design of the Plan for 2023/24, which in turn, supports the ambition for the PC Strategy. LC described how through the delivery of the Plan, GPs will be released to focus on complex care needs. She spoke of MDT work, CTAC, Pharmacotherapy and Risk. LC advised, a position from Scottish Government was awaited around transitionary payments, this caused delay in bringing the report forward as changes to the Plan may have been required. However, this did not transpire. An update on current progress, qualitative feedback from service users and staff involvement in delivery was given. LC stated, a further workshop will be convened to involve stakeholders in delivery of 2024/25 and she spoke of GMS involvement in design of the Plan. SB was pleased to hear Scottish Government is fully supporting. LC advised, Scottish Government provide Directions and resources, which are worked in line with. Cllr Liewald, thanked LC for a very comprehensive report and felt it was presented in an easy to read format, giving good understanding of the work taking place. She felt it very useful when passing on information and helped answer queries received from constituents.	
9	**LEGISLATIVE REQUIREMENTS & ANNUAL REPORTS**	

9.1	**Armed Forces Covenant Duty** FMcK introduced the report which was brought to Committee for discussion and decision. She explained, The Armed Forces Act 2021 came into force in November 2022, building on existing legislation and introducing the Armed Forces Covenant Duty which makes it a statutory duty to consider the principles of the Armed Forces Covenant and any supporting guidance, when planning, funding and delivering specific functions in healthcare, education and housing. FMcK told of a short life working group, which has been set up to ensure that the requirements of the Covenant are fully embedded across policies and practices. She touched on some of the work taking place, ie making employees aware of their responsibilities relating to the Armed Forces Covenant Duty and understand how this relates to their work activities/services. Also, EQiA will be updated to include specific reference to the needs of the Armed Forces Community. FMcK described an App (Connect App) which has been developed nationally and is being utilised in Fife to accommodate a local directory of services and support which is available to the Armed Forces Community. Input to the App will come from Fife Council, NHS Fife and Fife HSCP. As part of a communications plan to raise awareness, a Sway has been developed providing guidance and signposts the local directory held on the App. FMcK spoke of further work which will be taken forward. Cllr Liewald and FMcK spoke of the Rosemount Centre in Lochgelly where great work takes place offering support to veterans.	
9.2	**Director of Public Health Report 2023: Children and Young People in Fife: The Building Blocks for Health** This report was deferred to the next meeting on 17.01.24.	
9.3	**Pharmaceutical Care Services Report 2022/23** HC introduced the Pharmaceutical Care Services Report which was brought to Committee for Assurance and is presented annually. HC stated Pharmacy, in line with Pharmacy Regulations, are legally obliged to submit the Report, which sits within the complexity of both Primary Care and Independent Contractors. She advised, in terms of Community Pharmacy, provision is delegated to IJB, however, the Regulations and Pharmacy Regulations are enacted by the Health Board. The Paper reports on Pharmaceutical Services provided by Community Pharmacy across 86 sites in Fife. The report will go to IJB on 24.11.23. HC told of the very robust public engagement process involved where the report goes out to a number of groups and panels for a period of 4 weeks, feedback is then incorporated into the report. The report	

	describes all the core services and additional services provided by Community Pharmacy and the positive impact they have on customer care. The report also assesses any unmet need across the Board in terms of Pharmaceutical services. HC highlighted several points from the report, including in Fife there is 88.5% of the Fife population living within 1mile of their nearest pharmacy, a good spread and geography and the services they provide are wide and varied and very much welcomed by the public. Each of the areas within the report, pharmacy first plus is the envy of the other 3 nations, seeing 22.5K patients per month who go through the service. In terms of some of the newer services, HC drew attention to the Appendices within the report. LB commented the report is excellent and well received at SLT and other Committees, she felt it was comprehensive and easy to follow.	
9.4	**Care Inspectorate Grades for Social Care Services** This report was deferred to the next meeting on 17.01.24.	
10	**LIVED EXPERIENCE**	
10.1	**Lived Experience – Head and Neck Cancer** This presentation was deferred to the next meeting on 17.01.24.	
11	**EXECUTIVE LEAD REPORTS & MINUTES FROM LINKED COMMITTEES**	
	11.1 Quality Matters Assurance Group Confirmed Minute from 18.08.23 **11.2 Strategic Planning Group** Unconfirmed Minute from 05.09.23 **11.3 Clinical Governance Oversight Group** Unconfirmed Minute from **11.4 Fife Drugs and Therapeutics Committee** Unconfirmed Minute from 16.08.23	
12	**ITEMS FOR ESCALATION** Community OT Service Waiting Times - SB asked if a PMO approach can be taken and NC will have a meeting with the Team. An update will come back to Committee.	
13	**AOCB**	
14	**DATE OF NEXT MEETING**	

	17th January 2024, 1000hrs, MS Teams	

HEALTH & SAFETY SUBCOMMITTEE

(Meeting on 8 December 2023)

The undernoted items were raised for escalation to the Clinical Governance Committee:

(1) Radon Gas (see item 8.1 Radon Monitoring)

(2) Reinforced Autoclaved Aerated Concrete (RAAC) SBAR (separate paper)

Health & Safety Subcommittee

Minute of the H&S Sub-Committee Meeting
Friday 8 December 2023 at 12.30 pm on Teams

Present
Neil McCormick, Director of Property & Asset Management (Chair) (NMcC)
Janette Keenan, Director of Nursing (JK)
Conn Gillespie, Staff Side Representative (CG)
Dr Chris McKenna, Medical Director (CMcK)
Rona Laskowski, Head of Complex Critical Care Services, Fife HSCP (RL)

In Attendance
Billy Nixon, H&S Manager (BN)
Anne-Marie Marshall (Manual Handling Team Lead (A-MM)
Paul Bishop, Head of Estates (PB)
Ian Campbell, Interim Head of Spiritual Care (IC)
Claire Dobson, Director of Acute Services (CD)
Lynne Parsons, Employee Director (LP)
Andrea Barker, Executive Assistant to the Director of Property & Asset Mgmt (Minute)

The order of the minute may not reflect that of the discussion
The meeting was recorded on Teams

No.		Action
1	**Welcome & Apologies** NMcC welcomed members of the Sub-Committee to the meeting. A welcome was extended by the Sub-Committee to Claire Dobson, Director of Acute Services (CD) and Lynne Parsons, Employee Director (LP) for their attendance today. Apologies were received from David Miller.	
2	**Minute/Matters Arising**: The Minute of 8 September 2023 was **approved** as an accurate record.	
3	**Governance Arrangements**: There were no Governance Arrangements to report.	
4	**Operational Updates** 4.1 H&S Incident Report (Sept-Nov 2023) The H&S Incident Report for the period September to November 2023 was distributed and **noted** by the Sub-Committee.	

Musculoskeletal (staff)
15 reported incidents in the quarter, of which:

One incident - no harm
10 incidents - minor harm
3 incidents - moderate harm
One incident - major harm

Total of 30 incidents for the period April to November 2023

Riddor (all)
12 reported incidents in the quarter, of which:

One incident - no harm
4 incidents - minor harm
3 incidents - moderate harm
4 incidents - major harm

Total of 28 incidents for the period April to November 2023

Self-Harm (patients)
100 reported incidents in the quarter, of which:

58 incidents - no harm
28 incidents - minor harm
5 incidents - moderate harm
5 incidents - major harm
4 incidents - extreme harm

Total of 189 incidents for the period April to November 2023

Sharps (staff)
31 reported incidents in the quarter, of which:

16 incidents - no harm
13 incidents - minor to moderate harm
2 incidents - outstanding

Total of 88 incidents for the period April to November 2023

Slips, Trips & Falls (staff)
20 reported incidents in the quarter, of which:

4 incidents - no harm
12 incidents - minor harm
4 incidents - moderate harm

Total of 42 incidents for the period April to November 2023

Violence & Aggression (staff)
420 reported incidents in the quarter, of which:

286 incidents - no harm
115 incidents - minor harm
19 incidents - moderate harm

Total of 975 incidents for the period April to November 2023

	NMcC raised the question of whether the RIDDOR reportable incidents tie in with any significant adverse events reviews ie recorded under significant adverse events reporting process (SAER)? CMcK responded by advising that this is dependent on the individual and the complaint type in terms of the adverse event matrix and how it is graded. CMcK added that a local refresh of what truly is a significant adverse event and what is not will soon be underway. He added that if it was a major event then this would be recorded on Datix and subject to submission to the Executive team for decision making. IC raised the question as to how wide the Incident Report is circulated in terms of staff wellbeing particularly around violence and aggression and patient self-harm. He added that it would be beneficial to those who co-ordinate peer support to be more specific in terms of areas of need. The Sub-Committee **agreed** that the Patient Self Harm Incident section and the Violence & Aggression section of each quarterly Incident Report be circulated directly to Peer Support by BN. **Action** – IC **agreed** to send over the contact details for Peer Support to Billy Nixon. 4.2 Sharps Review Update BN **updated** the Sub-Committee that he is in the process of carrying out Sharps Audits to ensure that Risk Assessments are up-to-date. The Sub-Committee **agreed** that in terms of a better reporting system, particularly around the identification of hotspot areas, then this would be a helpful exercise especially with learning across the organisation. 4.3 Ligature Risk Assessment Review A-MM **updated** the Sub-Committee with details on the Ligature Risk Assessment Programme which commenced in January 2023, adding all Risk Assessments are up-to-date with the exception of Ward One, QMH, which will be completed by the end of the year. In terms of the Programme of Work being undertaken: • Works in Ward 3, QMH continue and once this is complete Ravenscraig Ward will be relocated there. Ravenscraig will then become a decant ward. • In relation to timescales, it is hoped that Ward 3 will become fully operational by the end of May 2024 which is slightly later than the original intended date in February 2024. • RL advised that she has reached out to Health Improvement Scotland in order to keep them involved in the process and to demonstrate that by going through the analysis, be assured that is not a major service change involved. Consideration is being given to mitigating any unintended impact on stakeholders, supply chain etc.	**IC**

- RL advised that Comms and HR colleagues are engaged in the planning and management of the movement of patients on the workforce.

- A-MM added that an active risk management exercise in terms of moving patients is planned for staff.

- Patient requirements will be assessed and appropriate mitigations will be in place for required anti-ligature works.

- Once Ward 3 is finished, it will be an exemplar ward of which we can follow. Works in Ward 1, Lomond Ward and Ward 2 will then commence.

The Sub-Committee was pleased with the efforts being made to mitigate the risks around the environment for mental health patients.

4.4 Violence & Aggression Management Review

(a) BN **updated** the Sub-Committee advising that the Violence & Aggression Policy was due for review in December 2023.

He added that the 'draft' Policy will be circulated to the Sub-Committee for comment and approval before the end of the year.

(b) V&A Policy and Escalation Skills Workshops are now bookable on Turas. These Workshops are scheduled to take place until the end of 2024.

(c) Other bookable courses on Turas include De-escalation, Low Level Handling, and a 2-day Physical Intervention Course.

(d) Suitable space for V&A training remains a concerns and BN **agreed** to speak with Jim Rotheram regarding the availability of a regular suitable venue.

4.5 Working at Heights Review

BN **updated** the Sub-Committee by advising that the Working at Heights Policy was due for review in February 2023. This has since been reviewed and approved by the General Policies Group. The next review will be in February 2025.

4.6 Reinforced Autoclaved Aerated Concrete (RAAC) Update

The RAAC Update SBAR was circulated to the Sub-Committee for information and NMcC gave an **update** on the status of RAAC within NHS Fife:

- RAAC in buildings surveys being carried out as part of a National Programme.

- 27 NHS Fife buildings were surveyed, of which one was removed, namely the Linen Room at Cameron Hospital as it is not currently in use.

- Five buildings were deemed to be of low risk (surveys still to be carried out).

- Following surveys, 5 blocks were found to have RAAC present, one at QMH, one at KHC and 3 at Lynebank. Of these five, two of which had RAAC present in perfect condition, however, these will be reviewed annually.

- We have requested a further 3 areas be investigated on the National Programme, namely: Tarvit Ward at Adamson Hospital, the main block in Cupar Health Centre and the main block in Glenrothes Hospital.

- Nationally, at the end of November 2023, all the high and medium likelihood buildings in Scotland had been investigated. The remaining lower risk buildings will now be surveyed.

- From the surveys undertaken, there are in the region of 500 additional builds that have been identified and these will be prioritised on the National Programme in terms of high, medium, and low risk, as before.

To summarise, NMcC **assured** the Sub-Committee that NHS Fife has been fortunate to date in terms of risk, all identified blocks have been small areas which have been locally addressed to mitigate any risks to patients, visitors and staff.

In terms of **assurance**, a paper on RAAC has been written and will be discussed at the following meetings/committees:

a. Capital Investment Group on 8 November 2023
b. H&S Sub-Committee on 8 December 2023
c. ASD&CD LPF on 21 December 2023
d. Staff Governance Committee on 11 January 2024
e. Clinical Governance Committee on 12 January 2024
f. APF on 24 January 2024

4.7 Skin Health Surveillance Arrangements Update

DM had submitted his **apologies** to this meeting of the Sub-Committee.

The Sub-Committee **agreed** for the Skin Health Surveillance Group to report into the H&S Sub-Committee and for the escalation of any relevant content.

In terms of the overall role of skin surveillance, the Sub-Committee **agreed** that further discussion would be required as there would have to be a transfer of staff resource.

NMcC will pick up with DM at a later date.

4.8 Manual Handling Report (Aug - Oct 2023)

The Manual Handling Report (Aug - Oct 2023) was distributed to the Sub-Committee and A-MM gave a verbal overview to the Sub-Committee.

Attendance for Scheduled Patient Handling Training

- 500 members of staff attended Patient Handling training
- 156 members did not attend
- One was withdrawn

Induction - Patient Handling - Bank Staff

	Aug '23	Sept '23	Oct '23
Withdrawn			1
Did not attend		3	1
Attended	8	8	13

Induction - Patient Handling - NHSF

	Aug '23	Sept '23	Oct '23
Withdrawn			
Did not attend	8	6	2
Attended	40	32	37

Patient Handling Update - Bank Staff

	Aug '23	Sept '23	Oct '23
Withdrawn			
Did not attend	4		3
Attended	12	16	20

Patient Handling Update - Community

	Aug '23	Sept '23	Oct '23
Withdrawn			
Did not attend		2	2
Attended	20	8	14

Patient Handling Update - Hospital

	Aug '23	Sept '23	Oct '23
Withdrawn			
Did not attend	41	42	31
Attended	84	65	94

Patient Handling Update - Minimal Handling

	Aug '23	Sept '23	Oct '23
Withdrawn			
Did not attend	3	3	1
Attended	6	7	15

Patient Handling Update - Physiotherapists & Occupational Therapists

	Aug '23	Sept '23	Oct '23
Withdrawn			
Did not attend	3	1	
Attended	17	10	12

Scheduled Courses Delivered/Cancelled

- 77 courses were delivered during the period
- 2 courses were cancelled

Induction - Patient Handling - Bank Staff

	Aug '23	Sept '23	Oct '23
Delivered	1	1	1
Cancelled			

Induction - Patient Handling - NHSF

	Aug '23	Sept '23	Oct '23
Delivered	4	3	3
Cancelled			

Patient Handling Update - Bank Staff

	Aug '23	Sept '23	Oct '23
Delivered	2	2	3
Cancelled			1

Patient Handling Update - Community

	Aug '23	Sept '23	Oct '23
Delivered	2	1	2
Cancelled			

Patient Handling Update - Hospital

	Aug '23	Sept '23	Oct '23
Delivered	13	11	19
Cancelled			1

Patient Handling Update - Minimal Handling

	Aug '23	Sept '23	Oct '23
Delivered	1	1	2
Cancelled			

Patient Handling Update - Physiotherapists & Occupational Therapists

	Aug '23	Sept '23	Oct '23
Delivered	2	1	2
Cancelled			

Scheduled/Additional Patient Handling Courses

- 79 scheduled courses were delivered during the period
- 17 additional courses were provided

Induction - Patient Handling - Bank Staff

	Aug '23	Sept '23	Oct '23
Scheduled	1	1	1

Additional			

Induction - Patient Handling - NHSF

	Aug '23	Sept '23	Oct '23
Scheduled	4	3	3
Additional			

Load Handling Update

	Aug '23	Sept '23	Oct '23
Scheduled			
Additional		1	

Patient Handling Update - Bank Staff

	Aug '23	Sept '23	Oct '23
Scheduled	2	2	4
Additional			

Patient Handling Update - Community

	Aug '23	Sept '23	Oct '23
Scheduled	2	1	2
Additional			

Patient Handling Update - Hospital

	Aug '23	Sept '23	Oct '23
Scheduled	13	11	20
Additional	2	3	3

Patient Handling Update - Minimal Handling

	Aug '23	Sept '23	Oct '23
Scheduled	1	1	2
Additional		2	

Patient Handling Update - Physiotherapists & Occupational Therapists

	Aug '23	Sept '23	Oct '23
Scheduled	2	1	2
Additional	2		4

- The Manual Handling team continue to work closely with individual wards to identify ways of increasing training attendance figures ie deliver training in wards, provide additional training dates etc.

- Single-handed Care Project - this new project will be taken forward through the HSCP. Good headway is being made with this and the Manual Handling team will be trained on delivering courses in January 2024.

- Lateral Lifting Project, Acute Medicine - awaiting one piece of equipment for hospital training then this course can be rolled out to

	the higher risk areas for patient falls. This will offer an alternative lifting method to the one currently in use. • Bariatric Project - on-going. Thanks were extended to A-MM and the Manual Handling team for their efforts.	
5	**NHS Fife Enforcement Activity** There was no enforcement activity to report within NHS Fife. Enforcement activity is taking place in Dumfries & Galloway - patient slips trips and falls and is on-going in the Highlands.	
6	**Policies & Procedures** 6.1 H&S Policies & Procedures BN **advised** the Sub-Committee that most of the H&S Policies and Procedures are now up-to-date. See items 4.4 and 4.5 above. 6.2 Violence and Aggression Policy Work continues on the Violence and Aggression Policy by Bill Coyne which was due for an update on 1 December 2023. This will be ready for submission to the General Policies Group by the end of the year. 6.3 Control of Vibration Policy Barry Williams, Assistant H&S Advisor is working on the update which was due for renewal at the end of October 2023. This will be ready for submission to the General Policies Group by the end of the year.	
7	**Performance** 7.1 ASD&CD H&S Committee Update The ASD&CD H&S Committee Minute of 29 November 2023 was emailed to the Sub-Committee. Members of the H&S Sub-Committee **noted** receipt. CD gave an **update** to the Sub-Committee on the status of the ASD&CD H&S Committee. The first meeting of the ASD&CD H&S Committee took place on Wednesday 29 November 2023 with Claire Dobson and Andrew Verrecchia co-chairing the initial meeting. It was **noted** that BN has agreed to chair the meeting moving forward, once established. She added that there is a very active LPF which has resulted in duplication on agendas, however, the main focus will relate to health and safety.	

	The Sub-Committee took **assurance** from this update and offered support, where required. 7.2 HSCP H&S Assurance Group Update The HSCP Health, Safety & Wellbeing Minute of 28 November 2023 was emailed to the Sub-Committee. Members of the Sub-Committee **noted** receipt.	
8	**Any Other Business** 8.1 Radon Monitoring NMcC gave an **update** to the Sub-Committee on Radon Gas monitoring within NHS Fife. He added that both he and CMcK have been informed about an issue on our estate with respect to Radon gas which is naturally occurring gas. There are 46 sites which are monitored in total. Of these sites: • 32 do not require any monitoring (no gas present) • 10 sites have a very low level (re-monitored in 10 years) • 3 sites had a slightly elevated level (re-monitored in 5 years) • One had significantly higher levels - Kinghorn Medical Practice The basement of Kinghorn Medical Practice has a higher amount of Radon than we would expect, and it has breached the higher number where it is then required to be reported to the Health & Safety Executive. We have radiation protection advisory support (working for NHS Fife and based at Lothian Health Board) who have been out and looked at the building in question. They have made recommendations in terms of bringing the ventilation system in the basement up to the required specifications. It appears that following previous modifications to the building the ventilation system was not working that well. Once the basement had been brought up to the recommended standard, re-monitoring will be carried out by the team. There is one group of staff who currently use the basement and advisory information leaflets have been distributed to the group by the Radiation Protection team. The Radiation Protection Advisor will disclose the raised levels of Radon to the Health and Safety Executive as required. **Action** - PB **agreed** to provide an update on radon levels at the next Sub-Committee meeting. CMcK added that in terms of reporting, this incident would be raised at the Radiation Protection Committee. If there was a requirement for escalation, then the committee would make that decision. Thereafter, reporting to the Clinical Governance Committee, where necessary.	**PB**

9	**Date & Time of Next Meeting** Friday 8 March 2024 at 12.30 pm on Teams	

Infection Control Committee

INFECTION CONTROL COMMITTEE (Meeting on 6 December 2023)
No issues were raised for escalation to the Clinical Governance Committee.

Fife Health & Social Care Partnership | NHS Fife

Infection Prevention and Control Team

Infection Control Committee Minutes (unconfirmed

06th December 2023 at 1400 via Teams

Item No	Subject	
1Jamie Gunn	**Attendees**	
	Janette Keenan, Director of Nursing (Chair)	**JK**
	Stephen Wilson, Consultant Microbiologist & Lead for Decontamination & Builds	**SW**
	Amy Mbuli, Lead Infection Prevention & Control Nurse	**AM**
	Elizabeth Dunstan, Senior Infection Prevention & Control Nurse	**ED**
	Keith Morris, Consultant Microbiologist	**KM**
	Midge Rotherham, Support Services Manager	**MR**
	Priya Venkatesh, Consultant Microbiologist	**PV**
	David Griffith, Consultant Microbiologist	**DG**
	Claire Connor, Dental Practice Co-Ordinator	**CC**
	Pauline Cumming, Risk Manager	**PC**
	Paul Bishop, Head of Estates	**PB**
	Catherine Gilvear, Head of Quality, CCG	**CG**
	Jamie Gunn, Health Protection Nurse Specialist.	**JG**
	Sharon McDonald (notes of meeting)	**SM**
	Apologies Julia Cook JK asked that everyone introduce themselves for the benefit of AM.	
2	**Minute of Previous Meeting** CG asked that she be added to the attendees from the previous meeting. SM actioned. Minutes were approved.	
3	**Action List** Framework ToR to be updated in real time. – complete IC Net and LIMS risk to be added to the risk register – complete Hygiene to be added to the risk register – complete Safe and Clean and Hand Hygiene audits – in discussion, hoping to move to a system called MEG.	
4	**Standing Items**	
4.1	**Risk Register** PC reported an update on the number of risks being presented today: Hand hygiene audit governance and the LIMS risk. Risk opened on 13th November and relates to boarding of patients into surgical short stay. Outlines the advice on who might be accommodated within this unit. KM contributed to this work, further reporting he had a walk around and confirmed it's not a suitable area for patients staying overnight. It was never designed for adult overnight inpatient and because of that, there are risks. In extreme circumstances we have to use it, but must limit the type of patients that can go there.	

	KM reported he was at a meeting last week and has been led to believe that funding for ICNET has been provided for the next 3 years, although he hasn't seen anything official. JK SEND meeting on Friday, where surveillance will be discussed. ED reported that she hasn't heard any confirmation either. PC also reported the new risk around the IPC Team workforce. One other risk has increased in risk level since the last report to the group, the microbiology staffing levels, going from a moderate 12 to a high 15. JK reported the newly formed Infection Prevention Workforce Strategic Plan steering group; Local Integrated Service Delivery Plan group, first meeting November 2023. DG and PV added to the discussion. JK will pick up a conversation with Belinda Morgan and Donna Galloway. DG's understanding is that the conversation has been going on since Craig Ferguson left 2 years ago. The most recent development was there we were hoping to advertise for a joint Microbiology ID Consultant, but his understanding is that funding from the acute side wasn't confirmed and we haven't been able to advertise at this stage so are exploring other options. Confirmed microbiology is extremely short staffed and with no immediate prospect of rectifying. PC had a call with Belinda and Claire Dobson and was looking at the risks within Donna's directorate and is planning to pick up. PC no risk has reduced since the last report. No risks have been closed and none are overdue. The position on risks that have already reached their target remains the same as it was at the October meeting. Details of all risks are in Appendix 1. PC the offsite Sterilisation Disinfection Unit, is now a corporate risk and was reported to the Clinical Governance Committee back in September and the Committee were assured around patient safety elements, but are concerned that, despite mitigations in place, couldn't address all the issues that we are coming up against, lot of those are out with our control and the risk was subsequently escalated to the Board. The decision, which is part of a broader discussion around capital resources and capital funding, is that there will be a board development session held in the new year. This is one example of the increasing visibility, of the corporate risks. PB added that Carol Potter is planning to write to the Chief Executive at Tayside. KM asked if we could escalate risk to the Scottish Government. This is not just a Fife issue, it is Scotland wide. There no resilience in our contamination capacity. Many of the decontamination units we have are old and beyond their service state. He stated that if one of the major units went down it would be a real problem. We have sent instruments down South but is unaware of how much capacity there is nationally. PB added that he has been on a National Group for the last 3 years dealing with this and are at a stage now of putting an impact assessment into SG highlighting exactly what KM has said, so they are approaching the Scottish Government now to see if it's possible to get funding for either new CDUs or funding to make the ones we have less likely to be problematic by investing. Looking to try to get Fife as one of the areas that could actually build a CDU that would benefit Scotland as well as ourselves. **Deep Dive Risk Review** PC work has been commissioned as set out in the paper. PC added points to consider going forward to review risks, JK confirmed that would be very helpful to bring up in the New Year.
4.2	**HAIRT Board Report** ED highlighted the report. Our main 3 targets. We have the 3 organisms infection rates to reduce the incidence of: *Staph. aureus* bacteraemia, *C. difficile* and E. coli bacteraemia. **SAB** Awaiting Q3 national report, from Q2 data NHS Fife SABs rates sitting below the national average for the healthcare associated (HCAI) SABs but sitting above for community onset (CO). **CDI**

	NHS Fife is below national comparators for CO CDIs, but above for HCAI CDIs, but that seems to be a general increase nationally. **ECB** NHS Fife below the national average for both HCAI and CO Quarter 2 2023. **Screening Programmes** NHS Fife compliance rates are above the national rate for screening for both MRSA and CPE screening. **Urinary Catheter Improvement Group (UCIG)** UCIG update provided. Three main things that have come back are: education, training and awareness of the policies and procedures, or lack of awareness at times. JK added that she is on the D&I Board and will speak with Marie Richmond to find out where we are on the waiting list for the eCatherter insertion on maintenance onto Patientrack. KM added that he hasn't been able to attend the Patientrack meetings lately but is going to try to make that commitment going forward and to push the eCatheter bundle. JK asked if there is an increase in the number of catheters that we are using in the community or in hospitals due to rise in number of patients? ED is not sure but will ask Candice Ross as she has oversight of the MORSE system as well. **CAUTIs** We compare our data with the national data as to how many of our ECB are associated with a CAUTI. For all hospital acquired ECB in Q3 it looks like 27.3% of these are due to a catheter and for healthcare associated ECBs 35.3% are associated with a catheter. We would like to be able to reduce the number of these. **Hand Hygiene** Still no centralised dashboard, therefore no data to report. We can still submit to LANQIP but the system is no longer maintained. There is no backup and no administration for it. Another reason we hope to implement MEG. **Estates and Domestic Monitoring** Q2 is GREEN KM asked if there were any plans to rethink the size of the HAIRT. Are there any plans to change it? ED reported there is a template. JK added that the Clinical Governance Committee are always very complimentary as it gives them the level of assurance they are looking for. Also brought up the dashboard and whether there is something that can be looked at. AM discussed previous dashboard she helped create which provided assurance without one big paper, but each system has to work for the Board.
4.3	**Care Home Update** Huge amount of work going on with the bladder and bowel team and Infection Control Team trying to improve the care and reduce the number of catheters that are inserted and maintained with the care home teams. AM reported the Care Home Team have been working on winter preparedness presentations and training throughout the care homes and completing IPC yearly walkabouts to offer assurance. AM also highlighted the collaboration that they've been working with through the community and through both care home liaison and nurse team is being built on and they have a very good working relationship throughout Fife. JK added that not every Board has specific infection control nurses as part of their care home collaborative teams and are envious that we have the level of expertise.
4.4	**NHSS National Cleaning Services Specification** ED reported for Fife for Q2 it is 95.9% MR reported Q2 figures are similar to Q1 but we are above national average for Scotland MR has asked Dan to do a pull together in our areas which have scored below 90% (amber range) and that would be anything between 70-90%. VHK had 5 areas but only 4 were non patient and one was a clinical department. St Andrews had 2 areas and they were both non patient. Stratheden had one and it was a patient ward. QMH had one and it was an in-patient ward. For the QMH that was identified, it's a high scoring 80%, marginal fail, there is an action plan in place. The only other that was a patient facing area was renal at QMH. It gets 2 audits per month and again they were high. One was 89.06% the other was 86%. More auditing is being carried out and scrutiny of score trends in low 90s. Some of this can be dependent as it's only a sample area of the ward/department being audited. The national system doesn't allow you to differentiate between clinical and non-clinical areas.

4.5	**Learning Summary** PC re renal SAB. This summary captures some detail from a SAB cluster review in March following the identification of a significant number of dialysis related SABs, 6 cases in all with varying patient outcomes. No singular root cause was identified and it was recognised that the patient group was particularly high risk. Actions identified: updating all policies; having standard SOPs in place; competencies for nursing staff around the management of dialysis lines to be reinstated.
4.6	**National Guidance** AM – COVID testing, and isolation is well embedded having changed back in October and is in line with the NIPCM. Symptomatic patients only, who meet the screening criteria are to be tested. The only exception is Ward 10 at the VHK, where they are LFTd on admission or prior to transfer. **NIPCM** At the end of October there was an update to the surgical hand antisepsis in line with feedback received where some units were moving to water free (trough sinks had been removed), the first surgical antisepsis and the process around that. Winter prep messages came out on 11th October from the ARHAI/NES and they focus on hand hygiene, stay at home if you are unwell, vaccination, cough etiquette and standard infection prevention and control precautions. JK reported a push from the vaccination team around staff but has not had any update.
4.7	**HEI Inspections Fife** **MH** ED reported from health inspections in February there was a requirement for NHS Fife to ensure that a RA for patients who may present a cross infection risk is in place. We have trialled this and it appears to be working with a sticker system in patient notes and we can discuss with the nurse in charge the risk or mitigations they need to put in place and give them a RA tool as well. This is ongoing but won't be a quick process to resolve. **Safe Delivery of Care Inspection** JK – The inspection took place between 31st July and 2nd August and was published in October. NHS Fife have submitted an action plan with an oversight group
4.8	**Quality Improvement Programmes** **PWID** ED covered already in HAIRT. **UCIG** PC added that she will be meeting with Candice and Sally next week to discuss the driver diagram.
4.9	**Education** ED – Presentations and training on water safety for staff developed. Training on CPE and antimicrobial stewardship in ongoing. IPCT aiming to provide more face to face training. Out of hours training to capture domestic colleagues is a challenge as out with IPCN working hours. A lot of training completed for NES SIPCEP. Full summary is within attachment. JK noted that the Practice Development Unit now has a Learning for Life webpage with the prospectus for all training on offer, not just through PPD. Is there anything we could add to that website? ED added that all IPC training is available to book on TURAS Learn.
4.10	**Infection Prevention & Control Audit Programme Update** ED – We have a 2 yearly rolling audit programme of clinical areas. We have one part-time IPCN dedicated to auditing with the other IPCNs supporting whenever possible. Full summary of areas covered. Programme currently on track.
4.11	**HAI-SCRIBE** AM – working to SFHN30. It is a collaboration and important for multidisciplinary working. It's important this remains on the risk register as many pieces of work and refurb aren't under any collaboration or meeting. AM and MB are working on a template SCRIBE and RAMs so there will be a baseline of documents for routine works in a number of areas, to help support time and engagement.
4.12	**Capital Planning** **Mental Health** AM – we have a regular subgroup meeting. The building permit, submitted on Wednesday and the project is ongoing.
4.13	**Infection Prevention and Control Annual Work Programme Update** AM – this is for approval. JK is happy to approve.
5	**New Business**
5.1	**Incidents/Outbreaks/Triggers**

	At time of reporting, which went up to October, we had no norovirus outbreaks, however, we did have one in November. No flu outbreaks. **COVID-19** 19 new outbreaks since last reporting, that's been across sites at QMH, Glenrothes, Lynebank, Cameron and VHK. AM added that the hypothesis was unknown and potentially asymptomatic carriers of COVID and symptomatic relatives then finding out they were COVID positive. **SSI** National programme continues to be paused. Local data; C-sections, the obstetric team are monitoring and reporting any SSIs to IPCT.. Recent ask by the orthopaedic teams to resume SSI Surveillance for the NTC as they have identified some SSIs. IPCT working with the clinical team. On review of data shows incidence rates is no higher than pre pandemic rates. **Legionella** PB reported there is still a lot of work going on around this. Still getting counts of legionella in some testing but control measures are being looked at.
5.2	**The HCAI Interim Strategy Development** JK provided a verbal report, the strategy launch on the 19th of June; Year 1 – deliverables for national level (SG, ARHAI and NES etc) Year 2 – focus on delivering locally at Board level
5.3	**The IPC Workforce Strategy 2022-24** JK - Met last month and went through the recommendations that are against the Board. Chris Conroy is setting up a SLWG in the Partnership and Primary Care looking at dental services.
5.4	**ICNET AND LIMS** ED – weekly meetings for LIMS, which needs to be integrated to replace the current LIMS system
5.5	**ICNET CONTRACT** JK will get an update on Friday from the Chief Nursing Officers Directorate
6	**Infection Control Committee's Sub Groups – Minutes/notes of meetings**
6.1	**Infection Prevention & Control Team** Nil to raise.
6.2	**NHS Fife Decontamination Steering Group** Nil to raise at ICC.
6.3	**NHS Fife Antimicrobial Management Team** JK, DG, Julia Cook and Ben Hannon are to meet regarding pharmacy support and antimicrobial management.
6.4	**NHS Fife Water Safety Management Group** Nil to raise.
6.5	**NHS Fife Ventilation Group** Nil to raise.
6.6	**NHS Fife HAI Scribe Planning Group** Nil to raise.
6.7	**Quality Reports** Nil to raise.
7	**Any Other Business**
	PHS alerts discussed
8	**Date of Next Meeting**
	7th February 2024 | 1400-1600 | Via Ms teams

INFORMATION GOVERNANCE SECURITY & STEERING GROUP

(Meeting on 10 October 2023)

No issues were raised for escalation to the Clinical Governance Committee.

Information Governance Security & Steering Group

NOTE OF THE INFORMATION GOVERNANCE AND SECURITY STEERING GROUP HELD ON TUESDAY 10TH OCTOBER 2023, 1000, VIA MS TEAMS

Present:

Chair - Margo McGurk	Director of Finance & Strategy/ Deputy Chief Executive
Alistair Graham	Associate Director Digital & Information
David Miller	Director of Workforce
Joy Tomlinson	Director of Public Health
Dr Chris McKenna	Medical Director
Helen Hellewell	Associate Medical Director
Janette Keenan	Director of Nursing
Frances Quirk	Assistant RIK Director
Duncan Wilson	Lead Pharmacist on behalf of Director of Pharmacy & Medicines

In Attendance:

Andy Brown	Principal Auditor
Margaret Guthrie	Head of Information Governance and Security
Peter Donaldson	Information Security Manager
Gillian MacIntosh	Head of Corporate Governance
Allan Young	Head of Digital Operations, Digital & Information
Claire Neal	(Minute) PA to Associate Director, Digital & Information
Kirsty MacGregor	Associate Director of Communications
Apologies:	
Susan Fraser	Associate Director of Planning and Performance
Claire Dobson	Director of Acute Services
Audrey Valente	Chief Finance Officer on behalf of Director of Health & Social Care
Sharon Mullan	General Practitioner
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 24th July 2023**	
	Minutes were reviewed and M McGurk advised there were corrections required. M McGurk will provide these and C Neal will review, update and forward to Group. Actions were discussed and updated accordingly. AP Ref 10. A Graham noted further clarity to be given to the Steering Group on the likely requirement to include a disclosure in the Board's Governance Statement. A Brown advised various criteria can be used to reach that view where an incident is likely to reach the level of disclosure. G McKinnon advised that a statement is included in the assurance reports at the end of financial year. This is then reported to committees. G McKinnon happy to liaise and if this can be completed in a better way. A Brown advised it would be effective for the groups and committees to know of any potential disclosure issues as they appear throughout the year.	**CN**
3	**MATTERS ARISING**	
	3.1 ICO Reprimand	

	M Guthrie provided a brief background to item and noted feedback to a few of the points raised by the ICO. The report was reviewed and considered by the SLWG supporting the Significant Adverse Event Review (SAER). The SAER group prepared a report that was provided to the ICO. M Guthrie and M Campbell have met with ICO regarding the incident and to provide clarity on items raised. M Guthrie advised there are certain parts she has appealed against, and she hopes to hear from the ICO within two weeks regarding the outcome. ICO informed this incident would be published on their website. M Guthrie has asked for notice of intention to publish in advance by the ICO. M McGurk confirmed the need to know in advance prior to ICO publishing. K MacGregor noted we need to consider a communication approach. M Guthrie confirmed the request has been made to the ICO that we be informed prior to publication. M McGurk queried point 5 in report, NHS Fife is to provide an update to ICO no later than 6th February. Minutes from the SLWG were submitted to ICO and the ICO have confirmed we have taken this seriously and are working to ensure actions are completed. An update will be provided to the ICO prior to 6 February 2024. M McGurk noted this group should receive the associated report from the SAER group when complete. This would allow the group to confirm whether it requires to be disclosed in the Board's Governance statement and for escalation to the Clinical Governance Committee. . A brief discussion was undertaken regarding points in paper and D Millar confirmed there is an Identification checking policy. K MacGregor requested the ICO lead contact name prior to publication. It was noted this publication requires to align with NHS Fife internal communications to ensure staff are supported. M Guthrie advised will forward when it is confirmed. **Action** – M Guthrie to forward ICO Lead to K MacGregor. M Guthrie advised that any updates will be provided to the Group. It was agreed that a meeting would be arranged to discuss further. **Action** – M Guthrie to arrange. A discussion was held on the mandatory training timeline, which is 3 years and discussed whether this should be increased to more frequent training. M Guthrie advised the benefit in a more frequent refresh period for staff has previously been discussed at this group. The group considered this in the context of current mandatory compliance figures within NHS Fife. The Information Governance team can be available to provide an additional level of training. C McKenna noted the SAER has been undertaken with L Barker leading. SLWG has been reviewing, and M Guthrie confirmed this has gone to Group for comment and proof of this has been supplied to ICO. Group can take assurance the SAER has been completed and a number of recommendations have been actioned. M McGurk requested any updates to be provided to Group and for that to be before next scheduled IG&S Steering Group meeting. **Action** – M Guthrie to provide update when available to Group. It was noted Group are content with the information supplied, recognising this is likely to require further escalation to the CGC. No further comments were raised.	**MG** **MG** **MG**

	3.2 NISD/ Cyber Resilience Framework – Audit A presentation was delivered by P Donaldson to provide an update to the Group on the NIS Audit 2023. The audit was completed in August 2023, and we have now received the final report. P Donaldson provided an overview of the key messages from report. A few are listed below: • NHS Fife was a high performing Board. • Overall compliance of 87% which has increased from 76% from controls applied in 2022. • 10 categories and 41 subcategories rated at 80% compliance or above. • The only area with compliance below 30% was security in Cloud Services. P Donaldson advised the the low compliance on Cloud Services requires action from NSS. Meetings were held with NHS Fife and NSS to discuss the required NSS improvements and timelines. P Donaldson provided further information on areas for development within the presentation, noting the Information Asset Register and policies for Mobile and personal devices are ongoing and being reviewed. M McGurk requested if an audit update report can be forwarded to the Clinical Governance Committee and for the final audit report to be distributed to the group for assurance. P Donaldson noted he will check the report and speak with necessary parties to see if can be forwarded. **Action** – Offline conversation with PD and AG for onward reporting. A Graham noted the sensitivity of report but will review and any items will appear in the IG&S Steering Group Annual Assurance Statement. M McGurk thanked P Donaldson and the wider D&I Team for their hard work and achieving the improvement in compliance. A Graham also noted recognition for all the hard work that is involved in the NIS audit. No further comments were raised.	**PD/AG**
4.	**Risk Management**	
	4.1 Risk Management Dashboard A Graham delivered a presentation and provided a brief overview of the dashboard. A Graham advised rather than a Risk Management Report, we are currently working on a Data and Insight Hub. A Graham provided background to each slide and information that will be contained in the hub. There are currently 47 risks, there are no overdue risks at present, but some are due for review in October. Risks are being monitored to ensure they remain at their current reported risk rating and also that the target level remains appropriate. A Graham provided feedback on risks that have been reported for some time and risks that are likely to materialise into issues. These risks are discussed at the Risk and Opportunities Group and are reviewed. One new risk has been added in relation to the EMIS stock control system.	

	M McGurk advised the Group that discussion were took place yesterday with A Graham regarding this report and a review is underway of the excellent work achieved over the last 12 months. J Tomlinson noted this is great work and can see the benefits and cost efficiencies also. When do we change risks to issues? A Graham replied this is identified in some guidance currently being considered by the Risk and Opportunities Group and how to make the distinction between risks and issues. A Brown reiterated comments from above and advised the work within business continuity is also encouraging. A Brown asked if it is it possible to see risks that have moved against their target. A Graham advised this wasn't currently possible however will be reviewed as this work progresses. M McGurk asked if a paper could be produced for EDG for ongoing discussions on operational risks management. **Action** – AG to produce paper and present to EDG. M McGurk thanked A Graham and Torfinn Thorbjornsen for their hard work. No other comments were raised.	**AG**
	4.2 Draft Risk Management Operational Guidance A Graham noted this item supports the Dashboard work that has been discussed in the previous item.	
5	**Information Governance and Security Assurance and Accountability Framework**	
	5.1 IGSAAF – Report A Graham introduced item firstly apologising for the delay in this paper being circulated and for the Group not having prior time to review. A Graham noted report has been brought to Group for assurance. A brief update was provided noting the below: • Purpose of report is to align the activities against the categories from the ICO and NIS Audit. • This report reviews both Audits and aligns to the 10 categories outlined in paper. • Cyber score is higher than we would like but the score is dependent on when we run our security updates and when the patches are completed this can affect the score, but nothing concerning. • One risk has been added and one closed. Within October there are 31 risks which are out of tolerance, these are being monitored. • Policies and Procedures are continuing to be monitored and updated with GP/I6 and GP/D3 been approved. • Training and awareness has increased by 4% so is now at 54%. Work is continuing to monitor this. A brief discussion was held on thinking about escalating the Corporate Compliance training issue. It was agreed an offline conversation would be undertaken with D Miller and M Guthrie. M Guthrie provided an update to the ongoing work on Subject Access Requests (SARS). There is now a system in place to generate reports and the project has been going well. There are some areas that are slower to progress, but we hope to be able to use the feedback to try and encourage other areas to get involved. It is hoped that compliance will	

	increase, and complaints of delays will decrease. Initial feedback received from service users is good, they are finding it easier to use and the single point of contact is helpful. Weekly meetings are held with team to monitor, and we now have designated members of staff within the IG&S department should staff have any queries. A Graham provided feedback to other items within report. M McGurk thanked M Guthrie for the detailed report and providing an update but requested that this be forwarded to Group in advance of meetings in future. No other comments were raised. Assurance was taken by the Group	
6.	**DOCUMENTS FOR APPROVAL/COMMENTS**	
	No items within Agenda	
7.	**ITEMS FOR ESCALATION TO CLINICAL GOVERNANCE COMMITTEE**	
	M McGurk noted papers go to EDG in the first instance and then consider whether they should also go to CGC. Group noted the requirement for papers to be sent to EDG in relation to:- • Operational Risk Management Approach • NISD Audit outcomes Proposal on escalation of the ICO Reprimand would be confirmed once the IG&SSG had received the final reports from the SAER Group. **Action** AG to complete paper. No more other comments were raised.	**AG**
8.	**AOCB** J Tomlinson noted she had received an email regarding the criminal investigations into COVID deaths and they were looking into the use of the Egress digital system to support the secure transfer of information. A brief discussion was held by Group. M Guthrie confirmed the item would be progressed within the IG&S team. A Young advised that Egress was a secure email platform but happy to support any work that is required. No other competent business was raised. M McGurk thanked all for attending and for the continued work hard.	
9	**DATE OF NEXT MEETING:** TBC	

RESEARCH, INNOVATION & KNOWLEDGE OVERSIGHT GROUP

(Meeting on 11 December 2023)

No issues were raised for escalation to the Clinical Governance Committee.

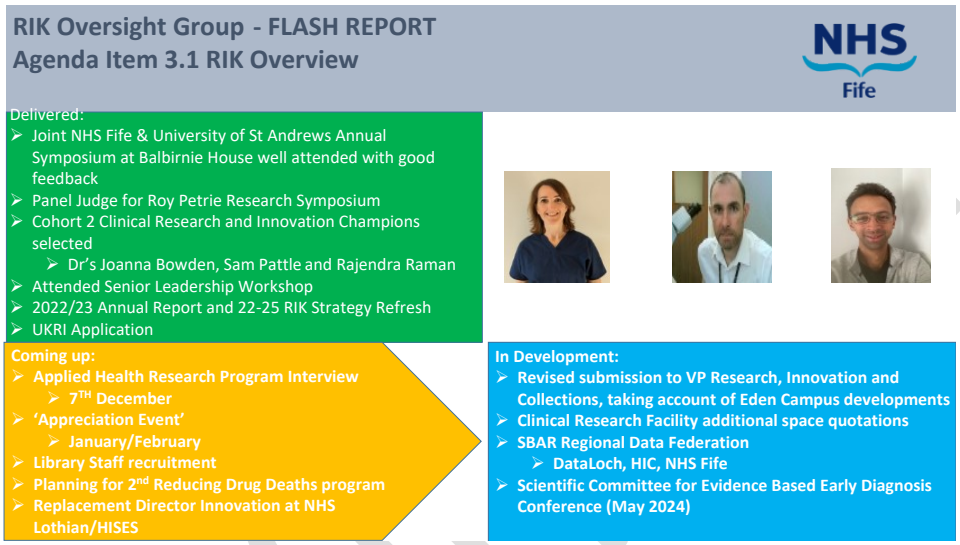
Research, Innovation & Knowledge Oversight Group

NHS Fife Research, Innovation and Knowledge

RESEARCH, INNOVATION & KNOWLEDGE OVERSIGHT GROUP MEETING
MINUTES
Microsoft TEAMS,

	11 DECEMBER (14.00 – 15.00)	**ACTION**
	Present: Dr Chris McKenna, Medical Director, Executive Lead for Research, Innovation & Knowledge (CMcK) Prof. Frances Quirk, RIK Assistant Director (FQ) Anne Haddow, Lay Advisor (AH) Dr Grant Syme, Physiotherapist Consultant (GS) Alistair Graham, Associate Director, Digital & Information (AG) Karen Gray, Lead Nurse (KG) Doreen Young, Head of Practice & Professional Development (DY) - representing Nicola Robertson Ramsay Khadeir, Senior Project Manager, Reducing Drugs Death programme (RK) 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 Neil Mitchell, Innovation Manager Shirley-Anne Savage, Associate Director of Quality and Clinical Governance Prof. Colin McCowan, Head of Population Health and Behavioural Science Division, University of St. Andrews Benjamin Hannan, Executive Director of Pharmacy and Medicines	
2.0	**STANDING ITEMS**	
2.1	**OVERSIGHT OF R, I K OVERSIGHT GROUP MINUTE** CMcK welcomed all to the meeting and asked if with the low numbers in attendance if the meeting was quorate? FQ added that there would be nothing requiring approval at today's meeting, The Annual Report and Strategy documents were for noting. The RIK Oversight Group Minutes were accepted with no amendments. **Actions:** Action.5.2 Innovation Scout proposal – FQ advised that Neil Mitchell has recently met with Fiona Schaefer from Innoscot Health and are hoping to have a paper ready for the first meeting in 2024. CMcK added that if	

	there would be any financial input required this would not go ahead, no business cases are being accepted at the present time.	
2.2	**OVERSIGHT OF RIK OPERATIONAL GROUP MINUTE AND ACTION LIST** For noting - Nothing from this meeting required escalation.	
3.0	**STRATEGIC PRIORITIES/INITIATIVES**	
3.1	**RIK OVERVIEW**	



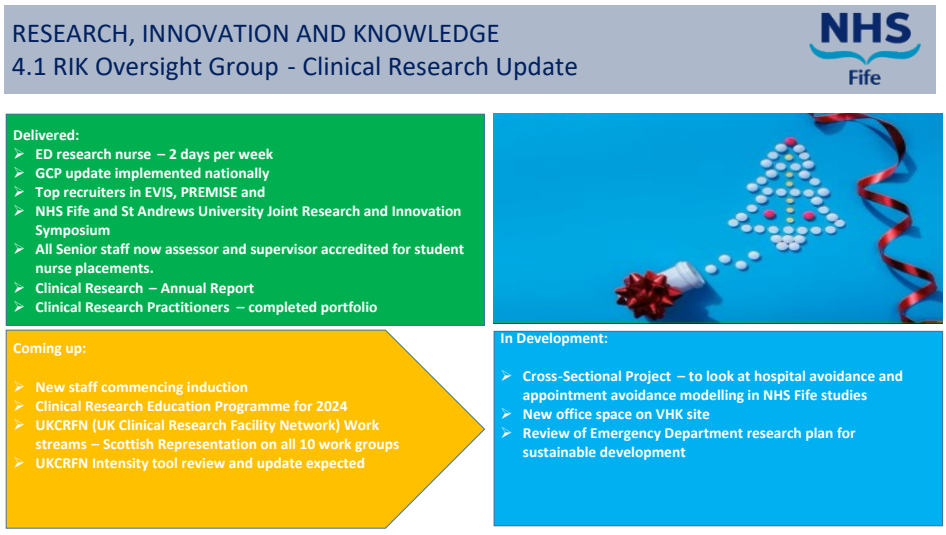
FQ highlighted the 2nd joint St. Andrews/NHS Fife symposium which took place on 25th October with 130 people in attendance with positive feedback.

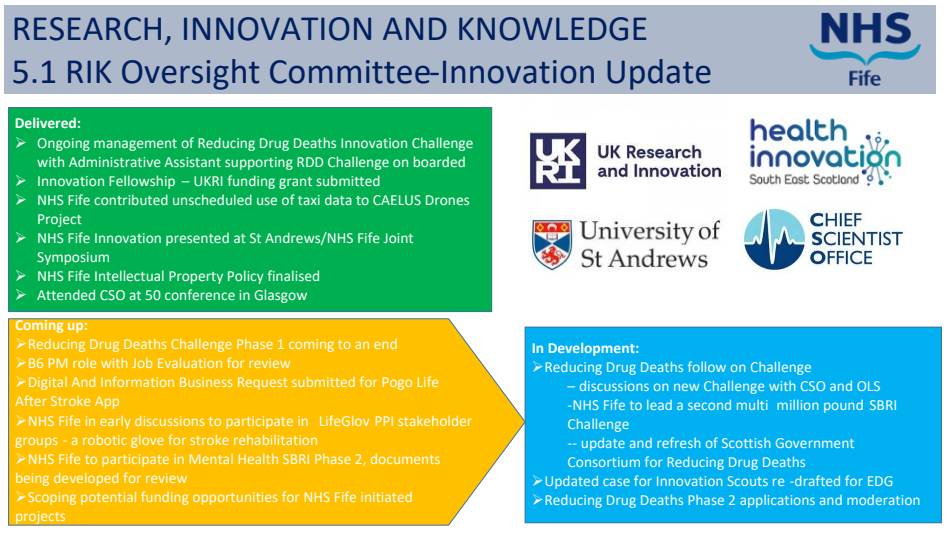
FQ added that the Orthopaedic Dept have restarted the Roy Petrie Research symposium which took place on 31st October within the National Treatment Centre at VHK, FQ had been invited to be a panel judge along with representatives from St. Andrews and other health boards, podium and poster presentations were given by the Orthopaedic Registrars, and 4 awards were given, talks also took place regarding potential collaborations.

FQ noted that the 2nd cohort for the Clinical Research and Innovation champions have recently been selected, Dr Jo Bowden, Sam Pattle and Dr Rajendra Raman will commence on a half day per week in 2024.

FQ attended the first Senior Leadership Workshop, which had been a good opportunity for face-to-face engagement amongst the Senior Leadership Team of NHS Fife.

FQ noted that the content for the RIK 22-23 Annual Report and the 22-25 RIK strategy had been finalised, copies were available on the Teams channel for review and feedback by 21st December.

	FQ advised that interviews had taken place with the CSO for the Applied Health Research programme, a joint venture with St. Andrews University for funding of £1m over five years, the interview went well with good feedback received. FQ discussed that the Senior Leadership Team are in the process of planning an "appreciation event" for the department, similar to the "thank you" event which took place in November 2022, this will be funded internally. FQ advised that there is still an evaluation process ongoing for a new job description for a Library & Knowledge Services Manager. FQ and KG had visited an area within VHK which could be potential additional office space for the department, ongoing discussions will take place regarding suitability and costs for refurbishment. FQ added that the Mackenzie Early Diagnosis Institute at St. Andrews University will be hosting an international event in May 2024, an Evidence Based Early Diagnosis Conference, FQ will be part of the scientific committee.	
3.2	**DRAFT RIK ANNUAL REPORT 2022-23/RIK STRATEGY**	
	FQ advised that these documents had been placed on the RIK Oversight Group Teams channel for review/feedback.	
4.0	**RESEARCH AND DEVELOPMENT**	
4.1	**CLINICAL RESEARCH UPDATE**  KG advised that there has been successful collaboration with the Emergency Medicine Dept and they will now have a research nurse two days per week helping to identify and recruit study patients.	

	KG noted that NHS Fife had been the top recruiters for the EVIS, PREMIS and ASPIRED studies. KG also noted that all Senior Research Nurse's are assessor and supervisor accredited for the student nurse placements. KG added that our two Clinical Research Practitioners have now completed their portfolio. KG advised that 3 new members of staff have started in the department today and will commence their induction programme. KG noted that the RIK Education Programme for 2024 was now available and will now include Principal Investigator training as well as Consent Training. KG advised that she is part of a cross sectional project looking at hospital/appointment avoidance for trial patients.	
5.0	**INNOVATION**	
5.1	**INNOVATION UPDATE**  RK updated from NM's report that NHS Fife have submitted a grant application for up to £300,000 for Joyce Henderson's Innovation Fellowship project to allow her to conduct a research project with the handheld ultrasound device and applications. RK advised that since NHS Fife signed the Accession agreement for the CAELUS drones project, Estates have provided the use of taxi data. This has been sent to the central project team to be used in the 'Digital twin' analysis. The CAELUS team have had some follow up questions which we are working on with the Estates team who hold the information.	

	RK noted that the NHS Fife Intellectual Property Policy has been updated and approved and is now in use. NM attended the CSO at 50 conference at the Queen Elizabeth Hospital in Glasgow. Innovation was a central theme to this year's conference and updates were given from a national and global perspective. RK advised that as of 31st December, phase 1 of the Reducing Drug Deaths Challenge will end, and the final phase 1 steering group will take place at the end of January. Planning for phase 2 is underway and applications and moderation for phase 2 will be in the first half of 2024. RK also advised that NHS Fife have been working on the Pogo Life After Stroke application. Stroke clinicians were involved in the development of the app along with Pogo Studios and Chest, Heart and Stroke Scotland (CHSS). A Business Request, along with the Data Protection Impact Assessment, System Security Policy (SSP), and New System Assessment Questionnaire (NSAQ), has been submitted to Digital and Information for review. RK added that NHS Fife will participate in the Mental Health SBRI phase 2 with a company called Wysa. This is led by NHS Lothian. The app will be deployed in schools and will not integrate into NHS Systems, however in order to provide some reassurance to our educational colleagues and the CAMHs service clinicians the Innovation team have requested Digital and Information review the app. A business request will be submitted with the associated documents in due course. RK advised that NHS Fife are in discussions with the Chief Scientist Office Innovation team and the Office for Life Sciences to scope out a second Reducing Drug Deaths Challenge, to run shortly after the start of phase 2 of the current SBRI Challenge on Reducing Drug Deaths. This would mean that NHS Fife would be managing 2 multi-million pound national innovation challenges. NHS Fife was chosen to work on this because of our work with the first Reducing Drug Deaths Challenges in order to take the learning and knowledge gained forward into a second Challenge.	
5.2	**REDUCING DRUG DEATHS CHALLENGE**	

	Small Business Research Initiative (SBRI) funded by CHIEF SCIENTIST OFFICE / Office for Life Sciences  RK advised that an Administrative Assistant has recently been recruited to the team. RK also noted that there were currently 11 phase 1 feasibility projects in place, 3 of these feasibilities are working with NHS Fife as their test bed innovation hub. All 11 companies took part in a webinar to present their projects to each other. RK advised that so far, a total of £419,970 has been paid out for successful milestones that have been achieved, this is following the monthly reports from the companies advising that they have met their contractual agreements. RK noted that planning is underway for phase 2 which commences on 03rd June 2024.	
5.3	**INNOSCOT HEALTH ANNUAL REPORT**	
	FQ advised that this was attached for noting.	
6.0	**LIBRARY & KNOWLEDGE SERVICES**	
6.1	**LIBRARY STAFFING REVIEW** This had been discussed in 3.1.	
7.0	**PARTNERSHIP UPDATES**	
7.1	**DOCTORAL TRAINING PROGRAMME** FQ advised in CMcC's absence that Dr Nina Mackenzie a Psychiatry Trainee in NHS Lanarkshire has accepted the offer of a position to start 01st August 2024. She will be supervised by Alex Baldachinno, Frances Quirk & Peter Donnelly and will be looking at multimorbidity in the alcohol misuse population.	
7.2	**JOINT RESEARCH OFFICE**	

	An Applied Health Research programme application to the CSO was submitted in September, the topic is identifying people in the last year of life using Emergency Care services looking to create referral pathways to existing services that might better meet the patient's needs, interviews will be taking place during December, with outcome by the end of the year.	
7.3	**NHS FIFE & UNIVERSITY OF ST. ANDREWS PARTNERSHIP** FQ advised that strategic discussions have lapsed recently and hopefully will be reinstated in due course. CMcK advised that NHS Fife Chief Executive, Carol Potter has been in discussion with St. Andrews University Deputy Principal and Vice-Principal (International Strategy and External Relations) Prof. Brad MacKay, hopefully this will move forward in due course.	
7.4	**R&D/FIFE COMMUNITY ADVISORY GROUP**. AH updated from her report (attached to the Agenda) and advised that the RIK Annual Report and Strategy have been sent to all members of the FCAC for comments. AH also advised that Katie MacLeod, FCAC Coordinator would be leaving her post at the end of December, AH thanked her for all her support to the members and hope her position would be filled quickly.	
8.0	**AOCB** Nil	
9.0	**DATE AND TIME OF NEXT MEETING** TBC	

RESILIENCE FORUM (Meeting on 10 October 2023)
No issues were raised for escalation to the Clinical Governance Committee.

Department of Public Health

Cameron House, Cameron Bridge, Leven, KY8 5RG

Confirmed Minutes of NHS Fife Resilience Forum held on Tuesday 10th October 2023 at 1100hrs via Microsoft TEAMs

Chair:
Joy Tomlinson, Director of Public Health, NHS Fife **(JT)**

Present :
Malcolm Landells, Resilience Advisor (East) Scottish Ambulance Service **(ML)**
Aileen Boags, Lead Pharmacist, Pharmacy, NHS Fife **(AB)**
Janette Keenan, Director of Nursing, NHS Fife **(JK)**
Lorraine King, Business Manager, NHS Fife **(LK)**
Ian Campbell, Healthcare Chaplain, NHS Fife **(IC)**
Allan Young, Head of Digital Operations, NHS Fife **(AY)**
Maggie Currer, Consultant Emergency Department, NHS Fife **(MC)**
Lynne Parsons, Employee Director of NHS Fife **(LP)**
Craig Burns, Emergency Planning Officer, NHS Fife **(CB)**
Donna Galloway, General Manager, NHS Fife **(DG)**
Margo McGurk, Director of Finance / Deputy Chief Executive, NHS Fife **(MMcG)**
Kirsty MacGregor, Associate Director of Communications, NHS Fife **(KMcG)**
Susan Cameron, Head of Resilience, NHS Fife **(SC)**
Jimmy Ramsay, Head of Sustainability, NHS Fife **(JR)**

In Attendance:
Stevie Rutherford, Personal Assistant, NHS Fife (Minute Taker) **(SRR)**

1. Welcome and Introductions
JT opened the forum and welcomed new colleagues along.

2. Apologies
Nicola Taylor, Kathryn Hastie, Euan Reid, David Miller, Derek Selbie, Fiona McKay, Hazel Close, Olivia Robertson, Paul Bishop and Kevin Reith

3. Minutes of previous meeting (08th June 2023)
The minute was agreed as an accurate record of the meeting.

3.1 Action Tracker from 08th June 2023

Action Tracker was presented on screen.
Severe Weather Framework – SC reported that a stakeholder meeting arranged, this action is ''in progress''.

Business Continuity Planning – update to Business Continuity Management Systems action point on agenda for meeting discussion

Vulnerable Person's – Patient at Risk Database, work is ''in progress''.

Bomb Threat & Suspicious Package – this action was on agenda for meeting discussion in agenda
Lockdown –is on the agenda for stakeholder feedback.

ACTION – SC to add a ''Target End Date'' into the action tracker. **SC**

4. Matters Arising

4.1 Lessons Learned, Cyber Desktop Event

AY will include this in digital update which is on the agenda.

4.2 Feedback on Draft Incident Management Framework

Incident Management plan was ratified by EDG on 10 August with a 12 month review date.

SC updated meeting reps that the Incident Management Framework document will be uploaded onto staff link soon where Executive Director Group will additionally be able to access their action cards using mobile phones and staff link app as well as desktop

The documents will be uploaded to the Executive Director & Scientific Tactical Analysis Cell (STAC) virtual incident room for use in incident response. Hard copies have been made available with major incident equipment store in Seminar room 4 Education Centre VHK. All incident response documents are backed up on a USB memory stick.

Psychology Teams are reviewing local NHS Fife procedures for incident management & recovery support the psychosocial impact of major incidents and psychological first aid support required for patients & staff. Planning will take around 12 months to complete in line with agreed document review timescales.

JT asked if colleagues search online for the framework, or solely on staff link at present. SC reported that she had a meeting yesterday with Rebecca Connor and she is looking to mirror the Executive Director virtual incident room folders. On staff link it has been identified that there is an old and new version of Major Incident plans that will be rectified to reflect current NHS Fife Incident Management Framework guidance

Staff link will mirror what is included already in the virtual incident executive command and control room. SC will provide an update when this is actioned to enable executives to be able to pull on this when needed.

CB reported that he will be running a series of training events for general managers and executives, and will cover staff link, T: drive and Executive virtual control room, and will notify everyone where the new document will be saved.

ACTION – SC to circulate the link around to all Resilience Forum members when available. **SC**

5. Resilience Governance & Assurance

5.1 Business Continuity Systems Management (BCMS) & Risk Profiling Datix

SC provided an update on the assurance of Resilience capabilities procedure. This procedure was not working for NHS Fife proving difficult for everyone involved it was a very "reactive process". Part of the procedural requirements included a report to be annually presented to the forum via General Manager where it relied on hard copy signatory responses.

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SC described a new approach, using Datix systems to facilitate an electronic Business Continuity Management Systems risk profile for NHS Fife. SC explained all Business Continuity plans need to be updated every 12 months or sooner if an incident has occurred.

SC described the new approach which uses a business analysis risk profile in Datix, that feeds a corporate dashboard. The information within Datix is summarised on the dashboard, which has been developed by NHS Fife Data & Insight Hub team, additionally provided an ability to run advanced "proactive forecasting" reports and provides a systems platform for evidencing in actions the testing & exercising of plans in situ.

SC commented that the resilience team will send managers a monthly link to the dashboard as a prompt to check their plans status and send a revised copy of their plans to the fife.resilience@nhs.scot mailbox.

SC reported that a BCMS Standard Operating Procedure is nearing completion for the dashboard. Before launching the dashboard managers are being consulted as a check and balance is being carried to ensure current compliance data held for business continuity is current & accurate.

MMcG – informed the forum that Alistair Graham presented work completed by his team yesterday at the Audit and Risk development session. The new dashboard combines a number of key data sets for NHS Fife which will allow greater insight into risk management for the organisation. It will allow the organisation to bring together all aspects on one dashboard, risk management, complaints etc as well as business continuity plans.
SC shared the dashboard onscreen to give colleagues an overview.

5.2 Q1 Resilience Report

SC reported the Quarter 1 report was themed to EPRR Risk for NHS Fife alongside a service update for business continuity Emergency Planning risk profiling is being taken forward locally aligned to the national Scottish EPRR Risk register.

SC gave a verbal update on national risk assessment process in Scotland, there are a couple of changes that have been made nationally around the pandemic preparedness with emerging infectious diseases risk assessments and with animal health risk assessments.

SC explained that she cannot share the national risk register with the forum but can say there is work ongoing nationally to review the risk profile which ties into the UK national risk register

SC described work is ongoing in relation to mortuary and forensic body management, progress has been made, with potential new premises in Edinburgh district. SC informed the forum that the Regional Mass Fatalities group cell in any major incident event may require to be enacted as part of incident response .

SC reported updates for CHEMET, Scottish Fire and Rescue Services within Public Health under item 3. Changes in national guidance in August 2023.

6. Whole System Overview

6.1 H&SCP

LK reported she continues to oversee the business continuity plan assurance visits alongside LG and AS, and further reported that at least two out of three members of staff are always involved at the assurance meetings.

The Heath and Social Care Resilience Partnership Framework has started its journey through various committees for approval, no feedback at the present time.

LK provided a brief update on the Patient At Risk Database (PARD), but this is only focussed on Fife Council services at present.

LK reported an DPIA is in place for the current manual 'persons at risk' process and includes sharing date externally with any partners involved in a response who are validated to support the response.

This is currently just for council services in line with the ask from Scottish Government in terms of readiness and ability to identify / produce a list of people who may require additional support from emergency responders during the response to an incident.

Going forward the Short Life Working Group (SLWG) will look at how the current manual process can be automated / tool developed. We also need to look at how this could extended into health side of partnership. A SLWG group will take place soon.

6.2 Acute Service

DG noted considerable work with Susan Cameron's team, testing business continuity plans and exercising at present.

DG noted that the whole system, is extremely busy and the OPEL score has been purple since September 2023.
Risks around Project HYDRA and work ongoing.

Laboratories, present a major risk, as the laboratory computer system which

populates the results to go out to various areas is being replaced, but the replacement programme is not going the way it was hoped, and is overdue, and the transaction needs to be safer moving forward.

6.3 SAS

ML reported continued pressure on turn around times, SAS Chief Executive has been in discussions with NHS Chief Executives and ways to improve services moving forward.

Winter Planning, how we can deal with demand, infection control procedures and general information. Internal tabletop discussions in place.

ML will attend the Eastern Hooley and fuel resilience workshops. SAS have been updating their communications document and JT requested ML come back to another forum to give an update.

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6.4 Climate Change Risk Analysis (CCRA) Sustainability NHS Fife

JR reported climate change risk assessment has been completed and incorporated 51 risks, support from national sustainability manger had been taken. Risks have been allocated to each owner, and it was highlighted that some were broader than others and had more of an impact.

JR advised that he has been working alongside SC and how we can integrate the climate change into resilience planning and have viability to the boards, via the risk process.
He is also working with Fife Council as they are going through their own climate change mitigations and adaptation.

In terms of risks, JR commented that the 2 highest risks are overheating in wards and flooding.

The Sustainability Officers are meeting with specialists at the Botanic Gardens in Edinburgh to learn more on the nature-based flood mitigation. Once the meeting has taken place, information will be relayed to Fife Council, and this forum.

Next steps, SC met with Kathryn Hastie – Sustainability Office and potential extra risks were identified.

SC recommended that CCRA and Sustainability becomes a standing item on the agenda and this was agreed.

ACTION – SC to meet with Kathryn Hastie **SC**

6.5 Digital Sit Rep

AY provided a brief presentation, National security system sees threat as high, and it was reported that there are around 25 cyber incidents per month. Following onto vulnerabilities standing at around 10 new cases per month. Continuing to improve ‘’manage and ‘’respond’’ capability and focus on service catalogues.
Continuing work on ‘’manage and response’’ capability – focus and service catalogue.

Exercise and penetration test outcomes are ongoing, and a desktop exercise had been carries out earlier this year, the report is only just back. AY will respond to this at the next forum meeting.

7. Emergency Plans

7.1 SBAR CBRN/HAZMAT Facilities

The draft SBAR which was circulated to the forum in advance of the meeting. This examines issues relating to the decontamination facility in phase 3 at VHK, but the drains are not configured to segregate waste water like it needs to be, estates looked into this further and Equans have advised that in the structure requirements back in 2008 the decontamination was based on self presented cases only as Fife Fire and Rescue and Scottish Ambulance Services would carry out decontamination at scene them bring patients to us at the acute hospital, they would be contaminated with no hazardous substances, this appears to be a pre planning error. VHK have a gold standard facility with adequate heating and lighting, next door to PRPS suit room. Drains are not configured to pull substances away. If we need to put substances down the drain we are required to check with Scottish Environmental Protection Agency (SEPA) before doing so. SC further reported, part of the assessment and controls we have is a Hazmat tent, but feedback now is that this is superseded in its lifespan, in terms of our C Norris, we now have a piece of equipment that is not within n its lifespan, and we need to look at replacement permanent solution etc.

SC reported in the assessment of the SBAR, we have broken it down and what it would cost to replace the Hazmat tent. SC further reported she visited Ninewells Hospital, Dundee to view their Hazmat tent. Overall she feels we can now upgrade our tent as the best solution and requested feedback from forum members.

JR, reported he has significant experience and involvement over the years with the hazmat tent, and not sure he agrees with the lifespan of the tent, as JR reports having several other assets which are over the lifespan/cycle. They can be used if maintained properly. JR reported the tent is around 15years old, and instead of spending £40,000 on a new tent could evaluate the tent or go to the manufacture and seek their guidance.

MC, reported this will likely be on the balance of how much it costs, could we perhaps upgrade the internal facility and bring patients straight into the

building and shower them in the facility, but appreciate it would be a costly outlay. The showering area would need to be blocked off for a significant period of time and as things stand, we are stacking ambulances over the area we would need to dig up to complete this task of upgrading.

MC further reported another scenario which had happened during covid that the PRPS suits exceeded the manufacture lifespan but at that time their were no other suits available to purchase. The manufacture sent a member of staff out to VHK to check the suits over for practical use, and added another 5 years onto their lifespan. MC further reported the downside of the tent is the environmental factors, in terms of disrobing could we purchase a smaller tent as a solution. SC reported we need other lighting or heating if another tent was an option.

CB, reported we need to think about the material and the degradation of the material.

ACTION – SC to check with manufacture on tent lifespan and group to risk assess the material. **SC**

7.2 Lockdown

Part a NHS Fife Lockdown Framework

Part b 2023 Lockdown Assurance Checklist

CB, reported on the Lockdown Framework, it is now at a point to go to SLT to obtain ratification. Framework will also be taken to the Acute SLT on 07th November and H&SCP at a later date. CB advised the forum that another 4 weeks of stakeholder feedback would be welcomed into the Resilience Inbox.

ACTION – forum members are asked to provide feedback on the draft framework by 07th November 2023 **CB**

7.3 Suspect Package Bomb Threat

Part a Bomb Threat – Suspect Item Response Plan

Part b Bomb Threat & Suspect Item – Framework Document Assurance

SC – reported that the draft framework document will be presented to SLT A SLWG group have already met and stakeholder feedback would be appreciated. Stakeholder checklist has been opened up to colleagues in Police Scotland, FFRS, estates for their input.

JT noted that some additional guidance for managers about the risk assessment process for ward evacuation will be required. CB commented that the lockdown framework may link in to cover this.

Recent live exercise around CBRN was carried out in Lothian, JT observed this and noted that one of the points made during the exercise was the

decision making pathway for evacuation. MC supported this and noted that there are significant risks associated with an evacuation of clinical areas.

ACTION – CB to implement a Flow chart and action card **CB**

ACTION – SC to meet with MC **SC**

8. Training & Exercising

8.1 PREVENT

CB, reported that as taken place at the Victoria Hospital, Kirkcaldy and around 30 staff attended. Future dates identified.

12th October and 01st November, at QMH – Common Room and 05th December at VHK. All links sent to staff link to upload.

8.2 Forth Ports Operation Waypoint

CB reported that this event will take place on 23 November 2023. The scenario will entail evacuation of 3000 passengers on a ferry in Rosyth, mass casualties, 48 major injuries.

This will be a tabletop exercise, led by the coast guard, cruise and travel company assigned. Several tables including police, Health and social care, NHS Fife will attend.

8.3 EOSRRP Eastern Hooley

CB reported this will take place on 24th October 2023 on Microsoft Teams. Representatives include, SEPA, Met Office.

ACTION – SRR reminder email **SRR**

8.4 EOSRRP Fuel Resilience Workshop – 14th December 2023, Tulliallan Police College, Kincardine

Colleagues from Fife, Forth Valley and Lothian and Borders will attend at Tulliallan in Kincardine. Benchmarking and reflecting on all plans.

8.5 Regional Resilience Events Brief

CB – reported events brief goes out including any major events such as Alfred Dunhill Cup, Bonfire, St Andrews Day, Christmas etc. Fife Council travel outlays, potential routes would be provided by Fife Council. November update has been given by Fife Council

ACTION – CB to circulate the events calendar for Oct and Nov **CB**

8.6 Radio Handset Training / Raynet

CB – Reported that IBIS training has been undertaken, and he wanted to push hard on this moving forward.

2-way radio training and sessions and the use of IBIS radios with Police Scotland to be setup.

9. Any Other Business

9.1 Loggist's network NHS Fife

SC – identified colleagues in acute and NHS teams from H&SCP partnership, we are building up a cohort of Loggist's.

SBAR will go to SLT, recommending a protected half day once a year for Loggist's to update their skills will be provided, accredited certificate will be issued.

10. Date of next meeting:

07th December 2023 at 1400hrs

10.1 Schedule of Meetings for 2024

13 March 2024 at 1430hrs
13 June 2024 at 1430hrs
11 September 2024 at 1430hrs
12 December 2024 at 1430hrs