NHS Fife Clinical Governance Committee

Fri 05 May 2023, 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 March 2023

Enclosed *Arlene Wood*

Item 03 - Clinical Governance Committee Minutes (unconfirmed) 20230303.pdf (12 pages)

10:00 - 10:10
10 min

4. Matters Arising / Action List

Enclosed *Arlene Wood*

Item 04 - Clinical Governance Committee Action List - 20230505.pdf (2 pages)

10:10 - 10:10
0 min

5. ACTIVE OR EMERGING ISSUES

None

10:10 - 10:50
40 min

6. GOVERNANCE MATTERS

6.1. Annual Assurance Statements & Reports from Clinical Governance Subcommittees & Groups

Enclosed *Gillian MacIntosh*

Item 06.1 - SBAR Annual Assurance Statements & Reports from Clinical Governance Subcommittees & Groups.pdf (39 pages)

6.2. Draft Clinical Governance Committee Annual Statement of Assurance 2022/23

Enclosed *Gillian MacIntosh*

Item 06.2 - SBAR Draft Clinical Governance Committee Annual Statement of Assurance 2022-23.pdf (26 pages)

6.3. Corporate Risks Aligned to Clinical Governance Committee

Enclosed *Chris McKenna / Janette Keenan*

- Item 06.3 - SBAR Corporate Risks Aligned to CGC.pdf (7 pages)
- Item 06.3 - Appendix 1 Summary of Corporate Risks Aligned to the CGC.pdf (5 pages)
- Item 06.3 - Appendix 2 Deep Dive Review - Optimal Clinical Outcomes.pdf (3 pages)
- Item 06.3 - Appendix 3 Assurance Principles.pdf (1 pages)

6.3.1. Deep Dive - Optimal Clinical Outcomes

Chris McKenna

6.4. Delivery of Annual Workplan 2023/24

Enclosed *Elizabeth Muir*

- Item 06.4 - Delivery of Annual Workplan.pdf (7 pages)

10:50 - 11:30
40 min

7. STRATEGY / PLANNING

7.1. Corporate Objectives 2023/24

Enclosed *Carol Potter / Margo McGurk*

- Item 07.1 - SBAR Corporate Objectives 2023-24.pdf (4 pages)

7.2. Advanced Practitioners Review

Enclosed *Janette Keenan*

- Item 07.2 - SBAR Advanced Practitioners Review.pdf (6 pages)

7.3. Update on the Role of Assistant Practitioner

Enclosed *Janette Keenan*

- Item 07.3 - SBAR Update on the Role of Assistant Practitioner.pdf (9 pages)

7.4. Public Protection, Accountability & Assurance Framework

Enclosed *Janette Keenan*

- Item 07.4 - SBAR Public Protection, Accountability & Assurance Framework.pdf (4 pages)
- Item 07.4 - Appendix 1 NHS Public Protection Accountability and Assurance Framework.pdf (23 pages)
- Item 07.4 - Appendix 2 PPAAF Gap Analysis.pdf (18 pages)

11:30 - 12:20
50 min

8. QUALITY / PERFORMANCE

8.1. Integrated Performance and Quality Report

Enclosed *Chris McKenna / Janette Keenan*

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

8.2. Healthcare Associated Infection Report (HAIRT)

Enclosed *Janette Keenan*

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

8.3. Medical Devices Update

Enclosed *Neil McCormick*

- Item 08.3 - SBAR Medical Devices Update.pdf (4 pages)
- Item 08.3 - Appendix 1 Terms of Reference for Medical Devices Group.pdf (5 pages)

8.4. Integrated Unscheduled Care Report

Enclosed *Chris McKenna*

- Item 08.4 - SBAR Integrated Unscheduled Care Report.pdf (16 pages)

8.5. Fatal Accident Enquiry

Enclosed *Chris McKenna*

- Item 08.5 - SBAR Fatal Accident Enquiry.pdf (3 pages)
- Item 08.5 - Appendix 1 Determination - Cowan.pdf (16 pages)
- Item 08.5 - Appendix 2 Draft Response Letter to Fatal Accident Enquiry.pdf (1 pages)

12:20 - 12:30
10 min

9. PERSON CENTRED CARE / PARTICIPATION / ENGAGEMENT

9.1. Patient Experience & Feedback Report

Enclosed *Janette Keenan*

- Item 09.1 - SBAR Patient Experience and Feedback Report + Appendix 1.pdf (15 pages)
- Item 09.1 - Appendix 2 Patient Experience & Feedback Q4 Report.pdf (18 pages)

12:30 - 12:50
20 min

10. ANNUAL REPORTS

10.1. Adult Support & Protection Biennial Report 2020-22

Enclosed *Janette Keenan*

- Item 10.1 - SBAR Adult Support & Protection Biennial Report.pdf (8 pages)
- Item 10.1 - Appendix 1 Biennial Report.pdf (90 pages)

10.2. Radiation Protection Annual Report

Enclosed *Chris McKenna*

- Item 10.2 - SBAR Radiation Protection Annual Report.pdf (2 pages)
- Item 10.2 - Appendix 1 Radiation Protection Report.pdf (4 pages)

12:50 - 12:55
5 min

11. LINKED COMMITTEE MINUTES

11.1. Area Medical Committee held on 14 February 2023 (unconfirmed)

Enclosed

- Item 11.1 - Minute Cover Paper.pdf (1 pages)
- Item 11.1 - Area Medical Committee 20230214 (unconfirmed).pdf (5 pages)

11.2. Area Radiation Protection Committee held on 31 August 2022 (unconfirmed)

Enclosed

- Item 11.2 - Minute Cover Paper.pdf (1 pages)
- Item 11.2 - Area Radiation Protection Committee 20220831 (unconfirmed).pdf (3 pages)

11.3. Cancer Governance & Strategy Group held on 30 March 2023 (unconfirmed)

Enclosed

- Item 11.3 - Minute Cover Paper.pdf (1 pages)
- Item 11.3 - Cancer Governance Oversight Group 20230330 (unconfirmed).pdf (10 pages)

11.4. Clinical Governance Oversight Group held on 14 February 2023 (unconfirmed)

Enclosed

- Item 11.4 - Minute Cover Paper.pdf (1 pages)
- Item 11.4 - Clinical Governance Oversight Group 20230214 (unconfirmed).pdf (11 pages)

11.5. Digital & Information Board held on 19 April 2023 (unconfirmed)

Enclosed

- Item 11.5 - Minute Cover Paper.pdf (1 pages)
- Item 11.5 - Digital & Information Board 20230419 (unconfirmed).pdf (7 pages)

11.6. Fife IJB Quality & Communities Committee held on 10 March 2023 (unconfirmed)

Enclosed

- Item 11.6 - Minute Cover Paper.pdf (1 pages)
- Item 11.6 - Fife IJB Quality & Communities Committee 20230310 (unconfirmed).pdf (6 pages)

11.7. Health & Safety Subcommittee held on 10 March 2023 (unconfirmed)

Enclosed

- Item 11.7 - Minute Cover Paper.pdf (1 pages)
- Item 11.7 - Health & Safety Subcommittee 20230310 (unconfirmed).pdf (4 pages)
- Item 11.7 - Appendix 1 Health & Safety Terms of Reference.pdf (3 pages)

11.8. Infection Control Committee held on 5 April 2023 (unconfirmed)

Enclosed

- Item 11.8 - Minute Cover Paper.pdf (1 pages)
- Item 11.8 - Infection Control Committee 20230405 (unconfirmed).pdf (5 pages)

11.9. Information Governance & Security Steering Group held on 11 April 2023 (unconfirmed)

Enclosed

- Item 11.9 - Minute Cover Paper.pdf (1 pages)
- Item 11.9 - Information Governance & Security Steering Group 20230411 (unconfirmed).pdf (6 pages)

11.10. Medical Devices Group held on 8 March 2023 (unconfirmed)

Enclosed

- Item 11.10 - Minute Cover Paper.pdf (1 pages)
- Item 11.10 - Medical Devices Group 20230308 (unconfirmed).pdf (9 pages)

11.11. Research, Innovation & Knowledge Oversight Group held on 27 March 2023 (unconfirmed)

Enclosed

- Item 11.11 - Minute Cover Paper.pdf (1 pages)
- Item 11.11 - Research, Innovation & Knowledge Oversight Group 20230727 (unconfirmed).pdf (7 pages)

11.12. Resilience Forum held on 1 March 2023 (unconfirmed)

Enclosed

- Item 11.12 - Minute Cover Paper.pdf (1 pages)
- Item 11.12 - Resilience Forum 20230103 (unconfirmed).pdf (6 pages)

12:55 - 13:00
5 min

12. ESCALATION OF ISSUES TO NHS FIFE BOARD

12.1. To the Board in the IPQR Summary

Verbal *Arlene Wood*

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

Verbal *Arlene Wood*

13:00 - 13:00
0 min

13. ANY OTHER BUSINESS

13:00 - 13:00
0 min

14. DATE OF NEXT MEETING - FRIDAY 7 JULY 2023 AT 10AM VIA MS TEAMS

Fife NHS Board

Unconfirmed

MINUTE OF THE NHS FIFE CLINICAL GOVERNANCE COMMITTEE MEETING HELD ON FRIDAY 3 MARCH 2023 AT 10AM VIA MS TEAMS

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

In Attendance:
Nicky Connor, Director of Health & Social Care
Claire Dobson, Director of Acute Services
Susan Fraser, Associate Director of Planning & Performance
Alistair Graham, Associate Director of Digital & Information
Ben Hannan, Director of Pharmacy & Medicines
Helen Hellewell, Associate Medical Director
Gillian MacIntosh, Head of Corporate Governance & Board Secretary
Margo McGurk, Director of Finance & Strategy *(part)*
Elizabeth Muir, Clinical Effectiveness Manager
Sally McCormack, Associate Medical Director for Emergency Care and Planned Care *(observing)*
Neil McCormick, Director of Property & Asset Management
Gill Ogden, Head of Nursing (for Norma Beveridge)
Shirley-Anne Savage, Associate Director of Quality and Clinical Governance
Hazel Thomson, Board Committee Support Officer (Minutes)

Chair's Opening Remarks

The Chair welcomed everyone to the meeting. A welcome was extended to Dr Sally McCormack, Associate Medical Director for Emergency Care and Planned Care, who is participating in the Developing Senior Systems Leadership course, and joined the meeting as an observer.

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

1. Apologies for Absence

Apologies were received from members Aileen Lawrie (Area Clinical Forum Representative), David Miller (Director of Workforce), Carol Potter (Chief Executive) and attendees Norma Beveridge (Associate Director of Nursing), Iain MacLeod

(Deputy Medical Director) and John Morrice (Consultant Paediatrician and Associate Medical Director).

2. Declaration of Members' Interests

There were no declarations of interest made by members.

3. Minutes of the Previous Meeting held on 13 January 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.

4.1 Healthcare Improvement Scotland (HIS) Safe Delivery of Care Inspections

HIS's Director of Quality Assurance wrote to all NHS Scotland Boards on 22 November 2022 to highlight general concerns raised via recent Safe Delivery of Care Inspections of acute hospitals. The Acute Services Division considered the concerns and guidance shared via the letter, to ensure that the learning was acted upon. The Director of Acute Services provided an update on the situation and action plans that are in place to address potential overcrowding, staffing levels, supporting staff health & wellbeing and assuring visible leadership, and also specific actions around medicines governance, as described in the paper. It was noted that the Acute Services Division would be unable to deliver the actions on their own, since it requires a whole system response, and that close working between the Health & Social Care Partnership is ongoing.

The Medical Director provided assurance that appropriate steps are being taken across the whole organisation to address the findings from the guidance. It was noted that Winter 2022/23 has been an exceptionally challenging time, and discussions are ongoing to address managing the services during extremely busy periods.

A Haston, Non-Executive Member, questioned what the two requirements from the HIS inspection of Victoria Hospital in May 2021 were, and how those were addressed. The Director of Acute Services advised that one issue was around the over-capacity of bays within the surge ward, with it being noted that this continues to be an issue, due to the number of patients being cared for in that ward. It was noted that an annexe has been added to the ward to create more capacity. The other requirement was a technicality around the documentation of patient results in a case record and it was reported that this issue was resolved quickly.

S Fevre, Area Partnership Forum Representative, questioned the percentage data for supplementary staffing, and he also queried if safe staffing is defined by staff opinions or a numerical measurement. The Director of Acute Services reported that supplementary staffing has been significant in AU1 due to staffing level challenges, however the situation is being actively managed going forward. It was also reported that safe staffing is defined through both quantitative and qualitive data, and staff look at a range of measures within their areas. A description was provided on the frameworks and systems in place to support safe staffing and to keep the services clinically safe.

S Fevre, Area Partnership Forum Representative, requested a description around the visibility of ideas and initiatives, which is stated in the paper as being worked on by the Senior Leadership Team (SLT). The Director of Acute Services explained the number of ways in which SLT are visible and engaging with staff.

C Grieve, Non-Executive Member, requested assurance around compliance with fire training, and the Director of Property & Asset Management agreed to provide further detail, for assurance, outwith the meeting.

Action: Director of Property & Asset Management

Following a query from the Chair around sustainability and compliance, the Director of Acute Services reported on the various methods of monitoring compliance and advised that mock inspections will be taken forward as an additional action, and will include the compliance aspect, which requires further work. The Director of Pharmacy & Medicines provided an overview on the compliance for medicines, noting that this is closely monitored and that the policies and procedures for medicines are comprehensive.

The Committee took **assurance** and **noted** the Acute Services Division's reflections in response to the HIS letter, as well as the actions underway to support patient care and staff wellbeing.

4.2 Resilience Annual Report

The Director of Public Health spoke to the paper and reported that substantial work has been carried out around refreshing our major incident planning process and concluding our annual business continuity assurance process. It was advised that due to the pandemic and a restructuring within the Resilience Team, which has impacted the timing of the report coming to the Committee, a formal Annual Statement of Assurance will be presented to the Committee at the May 2023 meeting, and then on an annual basis.

A Haston, Non-Executive Member, queried where assessment of risk will sit within the new framework and was advised that this will be incorporated within the Major Incident Plan.

Following a question from the Chair, it was advised that an interim internal audit was carried out in 2021/22, and the majority of actions have been completed, with other actions realigned following agreement from the auditors. It was also advised that a statement of assurance is provided to the Committee on an annual basis.

The Chair requested detail on the percentage and scope of staff trained in resilience. The Director of Public Health noted that consideration will be given to the number of individuals included in resilience training going forward.

For assurance, the Director of Public Health explained the timings for concluding the Major Incident Plan, and the operational aspects in support of this. She also advised that the various elements of business continuity will be concluded by the end of March 2023.

The Committee took **assurance** on the overview of progress within business continuity and emergency planning. The Committee **agreed** that the Annual Statement of Assurance will be presented in May 2023, then annually to the Clinical Governance Committee thereafter, and that a mid-year progress report will be provided for assurance.

Action: Director of Public Health

5. ACTIVE OR EMERGING ISSUES

The Chair advised the Committee that there are no active or emerging issues to report on to this meeting.

6. GOVERNANCE MATTERS

6.1 Committee Self-Assessment Report 2022/23

The Board Secretary advised that a self-assessment is carried out for all the Board's Standing Governance Committees on an annual basis. This paper provides the feedback for the Clinical Governance Committee.

An overview on the themes of the self-assessment was provided, and it was noted that there were some common themes identified across all the Board's Standing Governance Committees self-assessment outcomes. Work in the next year will attempt to address members' comments as part of a continuous improvement exercise.

A Haston, Non-Executive Member, expressed an opinion that she felt a committee review for new Members would be beneficial to add to the induction process, to help new appointees receive feedback on their initial period serving on a committee. The Board Secretary agreed this could be built into the process.

It was advised that a Committee Induction Handbook will shortly be produced for each of the Board's Standing Governance Committees, to help enhance new members' training around individual Committee's areas of remit.

6.2 Annual Review of Committee's Terms of Reference

The Board Secretary advised that the changes proposed to the Terms of Reference (ToR) are tracked within the paper and reflects a change to the risk management processes in relation to the replacement of the Board Assurance Framework with the Corporate Risk Register. It was also advised that an increased expansion of the Committee's role in relation to adverse events and duty of candour has been added, along with an addition of a specific clause on the Committee's remit in review of the patient experience.

It was explained that the patient representative position on the Committee has remained vacant since 2021, with no clear route for recruiting to that post in a way that the incumbent could reflect the overall patient voice. The Director of Nursing reported that consideration is being given to other ways of having a patient perspective, along with patient stories, on the Committee and suggested that this is trialled at the next Development Session on Addictions Services.

K MacDonald, Non-Executive Member, asked if consideration was being given to having a Patient Forum, which includes patients and clinicians. The Director of Nursing advised that there are a few specialised groups that include patients thereon, and she agreed to bring information back on those groups to the Committee.

The Chair questioned if there was anything that could be offered within the Health & Social Care Partnership in relation to the patient voice, that would also support this Committee. The Director of Health & Social Care advised that she engages on a regular basis with the Director of Nursing and opportunities are being explored. Assurance was provided that there is a robust mechanism in place to support participation and engagement, at locality and service level.

The Board Secretary advised that it had been explicitly highlighted by the outgoing Patient Representative that the broader patient voice was difficult to be expressed through an individual patient representative, and a new model should ideally be explored. The Medical Director suggested capturing all the activity in relation to the patient voice and stories and presenting it to the Committee on annual basis, with regular updates on specific areas. The Director of Pharmacy & Medicines supported this approach.

The Director of Nursing advised that work is being piloted around the patient experience, which includes ongoing conversations with patients and capturing their feedback. Further detail will be available through the Patient Feedback Quarterly Report.

After discussion on these points, the Committee **approved** a final version for further consideration by the Board.

6.3 Corporate Risks Aligned to Clinical Governance Committee

The Medical Director introduced this item and advised that there has been no significant change since the risks were last reported to the Committee. He also noted that the most prominent aspect is around the risk appetite aligning to the level of risk, due to the sustained level of operational challenge the services are experiencing. It was advised that we need to define our risk tolerance and work is ongoing in this area.

C Grieve, Non-Executive Member, questioned how assurance is provided for risks that are sitting at red status and outwith our risk appetite, and the measures that are put in place to tolerate the high level risk.

The Chair requested progress on the requirement to clearly define the clinical, safety & quality issues around the digital and information quality risk. The Associate Director of Digital & Information confirmed this will be updated.

Action: Associate Director of Digital & Information

6.3.1 Deep Dive – Covid-19 Pandemic

The Director of Public Health spoke to the root causes of Covid-19, and advised that the paper describes the core principles, noting the fundamental risks remain. It was reported that a large amount of work is being carried out through the Covid-19 inquiries in Scotland and the UK, and that this work will support lessons learned for the future.

An overview on the management actions was provided. It was also advised that the risk level has been reduced due to the protections afforded by vaccinations and increasing immunity within the population.

The Chair queried the specific level of assurance provided to the Committee on the deep dive. The Director of Finance & Strategy advised that levels of assurance had not reached the point of being identified, and that this will be actioned, through discussion with the Executive Directors' Group, going forward.

Action: Director of Finance & Strategy

The Chair agreed to forward on further comments to the Director of Public Health in relation to further action to be taken to establish the level of assurance and the evidence.

Following a query from the Chair, the Director of Public Health advised that the levels of controls are applied continuously and are difficult to assess as a risk due to the various aspects.

It was agreed to apply a recommendation, on the deep dives that have been carried out, to date, and bring back to the next Committee meeting for further discussion.

Action: Director of Public Health

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

7. STRATEGY / PLANNING

7.1 Draft Population Health & Wellbeing Strategy

The Director of Finance & Strategy reported that the draft strategy was discussed in detail at the Board Development Session held on 28 February 2023. The Director of Finance & Strategy fed back to the Committee on the key points raised at the Board Development Session, which were: reviewing the wording to be more explicit on the unique contribution from NHS Fife to population health and wellbeing; increasing the dominance and importance of the Integration Joint Board Strategic Plan; and building in an annual or bi-annual review of the strategy to ensure it is kept current and responsive. The Associate Director of Planning & Performance added that more emphasis will be added to the strategy on partnership working, and more work will be carried out in relation to women and children services.

The Associated Director of Planning & Performance provided assurance that the photographs within the strategy are being reviewed and that the other comments raised by Board members will be reflected in the revised version that will go to the Board for final approval at their meeting on 28 March 2023.

The Committee:

- Took **assurance** from the process undertaken to develop the NHS Fife Population Health and Wellbeing Strategy and the ongoing engagement work; and

- **Endorsed** this strategy for discussion and final approval at the March NHS Fife Board Meeting

7.2 Strategic Planning & Resource Allocation 2023/24

The Director of Finance & Strategy reported that the corporate objectives for 2023/24 initial proposal is presented to the Committee to provide assurance that the process is underway. A final proposition will be presented to the Board and Committees in the next meeting cycle.

It was advised that work is ongoing in relation to the corporate objectives for 2023/24, which will shape the Annual Delivery Plan, and will link into our strategic ambitions and the Scottish Government's directions. An updated version of the corporate objectives will be presented to the Committee at the next meeting.

It was reported that there are corporate objectives that have been carried forward from the current financial year, which is not unexpected due to them being medium term in nature. It was noted that redefining the focus of these objectives will be carried out. It was also noted that there are a few new objectives.

The Chair queried the actions in place in relation to the statement about ensuring links between financial sustainability and the Integrated Performance & Quality Report, which are detailed in the internal audit report 2021/22. The Director of Finance & Strategy agreed to take this forward and noted that an aspect of the financial sustainability programme is a formal impact assessment of areas being considered, to ensure sign off of any unintended consequences.

Action: Director of Finance & Strategy

The Committee took **assurance** and **discussed** this initial proposal in relation to the Corporate Objectives for 2023/24.

7.3 Cancer Framework and Delivery Plan

The Associate Director of Quality & Clinical Governance reported that the 2022/23 workplan was developed alongside the Cancer Framework to ensure that some areas of work could progress. An overview on the objectives was provided, and it was noted that they have been aligned to one of the eight commitments. It was advised that the 2023/24 workplan is currently being drafted and assurance was provided that this will include areas of work carried forward from 2022/23.

A Haston, Non-Executive Member, requested clarity on progress of the Physically Activity Strategy. The Director of Health & Social Care advised that the Prevention and Early Intervention Strategy will feed into the Physically Activity Strategy and that work is progressing well. The Director of Public Health added that there will be opportunities to work with partners on physical activity.

A Haston, Non-Executive Member, requested an update on where the Breast Cancer Nurse, who has been recruited, has been utilised. The Medical Director agreed to take this forward outwith the meeting.

Action: Medical Director

Following a question from A Haston, Non-Executive Member, regarding oral cancer therapies, the Director of Pharmacy & Medicines advised that there are rapid numbers of approvals of oral cancer therapies, noting that they work in slightly different ways to traditional chemotherapies and require less monitoring. An explanation was provided on the issues of contracting.

The Committee took **assurance** from the Cancer Framework and related Delivery Plan.

8. QUALITY/PERFORMANCE

8.1 Integrated Performance & Quality Report

The Director of Nursing spoke to the report. It was noted that the Director of Nursing and Chief Executive from Health Improvement Scotland (HIS) visited Ward 53 in Victoria Hospital last month, and they were impressed with the data display.

S Braiden, Non-Executive Member, noted she would discuss performance in in-patient falls in more detail with the Director of Nursing and other colleagues outwith the meeting.

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

8.2 Healthcare Associated Infection Report (HAIRT)

The Director of Nursing outlined the report. It was advised there was an announced inspection on mental health in February 2023 and an update on the inspection will be included in the next iteration of the HAIRT. It was noted that the feedback from the inspection was positive.

Following a question from A Haston, Non-Executive Member, the Director of Nursing advised that a date is still awaited for restarting the monitoring of surgical site infections, which was paused due to the Covid pandemic. For surgical site infections and caesarean sections, it was advised that these are being closely monitored by local teams.

Following a question in relation to hand hygiene monitoring, it was advised that this detail was captured on a system that is not now being used. It was reported that teams are carrying out hand hygiene audits, and work is ongoing to capture this detail in the dashboard.

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

8.3 NHS Fife Response to the Ockenden Report

The Director of Nursing advised that the paper provides a review of learning from the Ockenden Report and identifies recommendations to be considered for NHS Fife's maternity services. Background information to the report was provided.

It was reported that 15 broad immediate actions were required, and staff within NHS Fife's maternity services carried out a review on the immediate actions. The summary of key findings was highlighted, as detailed in the paper.

The Director of Nursing advised that an open day was held for student midwives in their final year, which was attended by 40 people across Scotland. It was noted this is a testament to the positive reputation of the team in maternity services. The Director of Nursing highlighted that there is a concern nationally around the 28% drop in the number of applicants for midwifery.

K MacDonald, Non-Executive Member, questioned mandatory training and why the inclusion of human factors training is not mandated. The Director of Nursing agreed to provide more detail outwith the meeting.

Action: Director of Nursing

The Chair highlighted that it was difficult to identify green statuses, as the narrative and the outcome section did not match up. It was also noted that there is no key to describe each status. The responses to some of the actions of green status was also queried. The Director of Nursing agreed to ask the team to provide more granular detail on the RAG statuses.

Action: Director of Nursing

S Braiden, Non-Executive Member, praised the NHS Fife maternity services team, given her personal experience with the service.

K MacDonald, Non-Executive Member, praised the team for producing a detailed report in response to the Ockenden Report, which provides assurance for where there are issues and the learning that is being taken to address these.

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

8.4 National Treatment Centre - Fife Orthopaedics

The Director of Nursing highlighted the key points in the paper and advised that there is a high level of confidence that the centre will open to its first patients on 20 March 2023. The Director of Property & Asset Management advised that the NHS Assure team are going through the review findings thoroughly and an action plan will be developed for the lower category areas. Assurance was provided that NHS Assure team are ensuring there is evidence to support all aspects of the centre.

A Wood, Non-Executive Member, questioned if it would be straight forward to step up elective procedures in the old theatres if required. The Director of Nursing advised that systems are in place as a contingency should the centre not open as planned on 20 March 2023.

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

9. DIGITAL / INFORMATION

9.1 Information Governance & Security Steering Group Update

The Associate Director of Digital & Information advised that this is the second of the planned assurance reports from the Information Governance & Security Steering Group for the workplan and that it outlines the activities from the last report in September 2022. It was advised that the main focus for the group is aligning to the

risk profile, which demonstrates some improvement in terms of the number of risks and risk ratings.

The Associate Director of Digital & Information highlighted the priority areas the Group is focusing its attention on.

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

10. PERSON CENTRED CARE / PARTICIPATION / ENGAGEMENT

10.1 Patient Experience & Feedback Report - Quarter 3

The Director of Nursing reported on an improving position for complaints and highlighted a reduction in the number of open complaints. It was also advised that a large amount of work has been carried out around data collection, and a database is being explored. An update on progress of improvements being made within the complaints team was provided, and the additional posts in place within the team. The Director of Nursing outlined the main points from the report.

Following a question from the Chair, the Director of Nursing advised that discussions are ongoing between the Head of Patient Experience and services to look at what can be done to support services with complaints. It was advised a new post specifically to focus on supporting services with complaints is being explored.

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

11. ANNUAL REPORTS

11.1 Organisational Duty of Candour Annual Report

The Medical Director advised that the report is presented to the Committee on an annual basis and is thereafter required to be published. It was noted the report being published is for 2021/22, due to the timings of collating the data required. The Medical Director advised that the report provides assurance on our compliance around regulations.

The Medical Director noted that the report presented to the Committee is in its final format and an overview on the contents was provided.

Following a query from A Haston, Non-Executive Member, the Medical Director advised that there is an Adverse Events policy, and an explanation was provided on the process for adverse events.

Following a question from the Chair, the Medical Director clarified that the report is our direct response to the requirements of the legislation.

The Committee took **assurance** on the content of the report and noted it will be presented to the Board at their meeting on 28 March 2023.

11.2 Annual Review of Deaths of Children & Young People

The Director of Nursing spoke to the paper and advised that there is a requirement for the annual report to be published on a yearly basis.

The Director of Nursing clarified that non-expected deaths include road traffic accidents, rather than a clinical incident, and expected deaths would include children who are terminally ill.

The Associate Director of Quality & Clinical Governance noted that, as the numbers are very small, it is difficult to describe in depth the circumstances of each within the report, without risking making people identifiable.

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

12. FOR ASSURANCE

12.1 Delivery of Annual Workplan

The Associate Director of Quality & Clinical Governance advised that deferred items have been carried over to the 2023/24 workplan.

The Chair highlighted that there are seven annual reports scheduled to be presented to the Committee at the next meeting, which might mean an overly heavy agenda, and agreed to discuss this further at the next agenda planning meeting.

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

12.2 Proposed Annual Workplan 2023/24

The Associate Director of Quality & Clinical Governance presented the proposed workplan for 2023/24 and advised that it reflects the establishment of the new Medical Devices Group. The Associate Director of Quality & Clinical Governance confirmed that any further suggestions for inclusion / amendment can be sent directly to her via email.

The Committee:

- **considered** and **approved** the proposed workplan for 2023/2024; and
- **approved** the approach to ensure that the workplan remains current

13. LINKED COMMITTEE MINUTES

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

13.1 Area Clinical Forum held on 2 February 2023 (unconfirmed)

- The Director of Nursing advised that pressures in General Practitioners in relation to hate crime was discussed at the Equality & Human Rights Group recently.

13.2 Area Medical Committee held on 13 December 2023 (unconfirmed)

13.3 Cancer Governance & Strategy Group held on 13 January 2023 (unconfirmed)

13.4 Clinical Governance Oversight Group held on 20 December 2022 (confirmed)

13.5 Digital & Information Board held on 24 January 2023 (unconfirmed)

13.6 Fife Drugs & Therapeutic Committee held on 8 February 2023 (unconfirmed)

13.7 Fife IJB Quality & Communities Committee held on 8 November 2022 (confirmed) & 18 January 2023 (unconfirmed)

13.8 Health & Safety Subcommittee held on 20 January 2023 (unconfirmed)

13.9 Information Governance & Security Steering Group held on 31 January 2023 (unconfirmed)

13.10 Resilience Forum held on 1 December 2022 (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 NHS Fife Board.

15. ANY OTHER BUSINESS

There was no other business.

Date of Next Meeting – Friday 5 May 2023 at 10am via MS Teams

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

CLINICAL GOVERNANCE COMMITTEE – ACTION LIST

Meeting Date: Friday 5 May 2023

NO.	DATE OF MEETING	AGENDA ITEM / TOPIC	ACTION	LEAD	TIMESCALE	COMMENTS / PROGRESS	RAG
1.	01/07/22	**IPQR**	To take forward as an action whether the data within our existing statistics could be analysed further to give a better understanding of inequalities and adverse events and if there are any patterns.	**JK**	Extended to May 2023	In progress. The Lead for Adverse Events is taking this action forward and has arranged a meeting with the Equality & Human Rights Lead Officer. 15/02/23 - The current data collected within the Adverse Events reporting system does not cover a wide range of inequalities. Meeting will explore potential for further analysis of existing data and potential for capturing additional information.	In progress
2.	03/03/23	**Strategic Planning & Resource Allocation 2023/24**	To take forward putting actions in place in relation to the statement about ensuring links between financial sustainability and the Integrated Performance & Quality Report, which are detailed in the internal audit report 2021/22.	**MM**	May 2023		
3.	12/01/23	**Development Session**	A Development Session to be arranged on the relationship between NHS Fife and the University of St Andrews.	**HT**	October 2023 – exact date tbc.	Dates being explored with internal colleagues.	In progress / deadline not reached
4.	03/03/23	**Deep Dives**	To add specific levels of assurance, through discussions with the Executive Directors Group. Once the levels of assurance are agreed, these should be applied to the deep dives carried out to date.	**MM**	July 2023	The Risks and Opportunities Group will make a recommendation to the Executive Directors' Group on Thursday 4 May 2023	In progress / deadline not reached

NO.	DATE OF MEETING	AGENDA ITEM / TOPIC	ACTION	LEAD	TIMESCALE	COMMENTS / PROGRESS	RAG
5.	03/03/23		To apply a recommendation on the assurance level to the Covid-19 Pandemic deep dive for further discussion.	**JT/PC**	July 2023	An update on the Covid-19 risk will be provided to the Committee once the assurance level element has been through the Executive Directors' Group.	In progress / deadline not reached
6.	03/03/23	**Cancer Framework and Delivery Plan**	To provide an update on where the Breast Cancer Nurse, who has been recruited, has been utilised.	**CM**	May 2023	Complete.	Closed
7.	03/03/23	**NHS Fife Response to the Ockenden Report**	To provide more detail on mandatory training and why the inclusion of human factors training is not mandated.	**JK**	May 2023	Complete.	Closed
8.	03/03/23		To provide more granular detail on the RAG statuses.	**JK**	May 2023	Complete.	Closed
9.	03/03/23	**Corporate Risks Aligned to Clinical Governance Committee**	To clearly define the clinical, safety & quality issues around the digital and information quality risk.	**AG**	May 2023	Complete - wording of risk has been defined.	Closed
10.	03/03/23	**Resilience Annual Report**	A mid-year progress report to be provided to the Committee, for assurance.	**JT**	September 2023	Added to workplan.	Closed
11.	03/03/23	**Healthcare Improvement Scotland (HIS) Safe Delivery of Care Inspections**	To provide further detail, for assurance, around compliance with fire training.	**NM**	May 2023	Further information was provided to C Grieve.	Closed

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**5 May 2023**
Title:	**Annual Assurance Statements & Reports from Clinical Governance Sub-Committees & Groups**
Responsible Executive:	**Dr Chris McKenna, Medical Director**
Report Author:	**Gillian MacIntosh, Board Secretary**

1 Purpose

This is presented for:

- Assurance

This report relates to a:

- Legal requirement
- Local policy

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

- Effective

2 Report summary

2.1 Situation

All formal Committees of the NHS Board are required to provide an Annual Statement of Assurance for the NHS Board, which is consider initially by the Audit & Risk Committee. The requirement for these statements is set out in the Code of Corporate Governance. In order for the Clinical Governance Committee to finalise its own report, it first requires to consider the annual statements of assurance from its formal sub-groups, including the Quality & Communities Committee of the Integration Joint Board (now enclosed with this version of the paper, following their meeting on 3 May).

2.2 Background

The Clinical Governance Committee's sub-groups are the Digital & Information Board; Health & Safety Sub-Committee; and the Information Governance & Security Steering Group. For assurance purposes, the minutes and an annual report of both the NHS Fife Resilience Forum and the Quality & Communities Committee of the IJB are also part of the Committee's workplan of business.

2.3 Assessment

The five separate reports are given as annexes to this paper. Each report should indicate the span of business considered by each group over the course of the last financial year and draw out any areas of concern to be highlighted to the Committee. These are then covered within the Clinical Governance Committee's own annual report.

2.3.1 Quality/ Patient Care

Delivering robust governance across the organisation is supportive of enhanced patient care and quality standards.

2.3.2 Workforce

N/A.

2.3.3 Financial

The production and review of year-end assurance statements are a key part of the financial year-end process.

2.3.4 Risk Assessment/Management

The identification and management of risk is an important factor in providing appropriate assurance to the NHS Board.

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

No direct impact from this paper, but a number of the assurance statements detail how the respective groups are working to achieve this in their own areas of work.

2.3.7 Communication, involvement, engagement and consultation

Each of the Committee's sub-groups have considered and commented on their annual statements of assurance at recent meetings. Some of the reports still require formal sign-off by the respective Chair, though the content of each is not expected to change.

2.3.8 Route to the Meeting

Each of the Committee's sub-groups have considered their annual statements of assurance at recent meetings.

2.4 Recommendation

The paper is provided for:

- **Assurance** – For Members to take assurance that each group has delivered on its remit in the reporting year.

3 List of appendices

The following appendices are included with this report:

- Digital & Information Assurance Statement
- Health & Safety Sub-Committee Assurance Statement
- Information Governance & Security Steering Group Assurance Statement
- Resilience Forum Assurance Statement
- IJB Quality & Communities Committee Assurance Statement

Report Contact
Dr Gillian MacIntosh
Head of Corporate Governance & Board Secretary
gillian.macintosh@nhs.scot

ANNUAL STATEMENT OF ASSURANCE, 2022-23, FOR NHS FIFE DIGITAL & INFORMATION BOARD

1. Purpose

1.1 To provide the Clinical Governance Committee with an assurance statement, for the financial year 2022-23, that relates to the effectiveness of the Digital & Information Board and its development and monitoring of the Digital & Information Strategy and resulting delivery plan in line with the National Digital Health & Care Strategy and to support the delivery of the NHS Fife Annual Operational Plan, strategies and policies.

2. Membership

2.1 During the financial year to 31 March 2023, membership of the Digital and Information Board comprised: -

Names	*Roles / Designations*
Dr Chris McKenna	Medical Director (Chair) (Caldicott Guardian)
Dr John Chalmers	Digital Clinical Lead
Nicky Connor	Director of Health and Social Care
Claire Dobson	Director of Acute Services
Philip Duthie	GP Sub Committee Representative (Till July 2022)
Sharon Mullan	GP Sub Committee Representative (From July 2022)
Benjamin Hannan	Director of Pharmacy and Medicines
Alistair Graham	Associate Director Digital & Information
Linda Douglas	Director of Workforce (Till January 2023)
David Miller	Director of Workforce (From January 2023)
Margo McGurk	Director of Finance and Strategy (Co-Chair) (SIRO)
Janette Keenan	Director of Nursing
Dr Joy Tomlinson	Director of Public Health (From July 2022)
Caroline Somerville	Partnership Representative (From July 2022)

2.2 The Digital and Information Board may invite individuals to attend meetings for agenda items, but the list of attendees detailed in 2.1 will normally be in attendance at meetings. Other attendees, deputies and guests are recorded in the individual minutes of each meeting and their attendance is included in Appendix 1.

2.3 The membership and attendance of the group was sufficient enough to support the work and oversight necessary. The membership and attendance will be reviewed as part of the group's annual workplan at the April 2023 meeting and remains under annual review.

3. Meetings

3.1 The Digital and Information Board met on four occasions during the financial year to 31 March 2023, on the undernoted dates:

- 19th April 2022
- 28th July 2022

- 18th October 2022
- 24th January 2023

3.2 The attendance schedule is attached at Appendix 1.

4. Business

4.1 The Digital and Information (D&I) Board reviewed and commented on the Annual Delivery Plan. The Board recognised their responsibilities to ensure progress is made with delivering the strategic ambition, relating to year four of NHS Fife's Digital and Information Strategy (2019-2024) and ensuring the maintenance and improvement in performance across D&I technical and operational teams.

4.2 The Board reflected on the continued demand for the implementation of new or existing technologies being made through the digital health and care request process. Additional consideration was given to the revised resource model across Digital teams and how they continue to deal with the demand, while matching the responsibilities to operate the additional digital capabilities. The Board also heard about improvements being made through the recruitment of a more permanent workforce and reduced reliance on temporary and fixed term resources.

4.3 Throughout the year, the Board was updated on progress in relation to the Cyber Security Action Plan associated with the improved outcomes from the Network and Information Security Directive (NISD) audits. With a current compliance rating of 79%, the expectations from the plan would ensure NHS Fife moved ahead of the 80% target at the next audit cycle (delayed to July 2023). In considering the improvement plan the Board also considered the password policy and agreed to the recommendations made that significantly reduce the risk from a brute force attacks on any passwords. The Board took assurance from the action plan and associated measures.

4.4 The Board also heard, at their July 2022 and October 2022 meetings, of several system failure issues, one of which was cyber in nature, being handled within NHS Fife. A prolonged period of unavailability was reported on the Picture Achieving and Communication System (PACS), used in Radiology, the Docman system used in GP system to receive documents electronically and the disconnecting of the Out of Hours and Flow Navigation Centre system Adastra for a prolonged period due to a cyber event with the supplier. While concerning to the Board, assurance was taken from the incident response process, including reporting to Information Commissioners Office (ICO) and Scottish Government Competent Authority, active supplier management and the learning taken from these events. The Board also noted the resilience of the Business Continuity plans during this period.

4.5 Supplier Management continued to be a feature of the Board's work as they supported the reprioritisation of the Annual Workplan. Delays in the ability to deliver the improved TrakCare User Interface were noted and delays in several significant National Programmes (CHI replacement, Child Health Systems and GP IT Re-provisioning) resulted in a reprofiling of plans. eRostering initiation was more straightforward and the project is progressing through its Programme Board.

4.6 Two key items emerged during the year in the shape of the Hospital Electronic Prescribing and Medicines Administration (HEPMA) re-procurement and the rapid development of the Laboratory Information Management System (LIMS) risk assessment and associated Business Cases. Both matters proceeded at pace with the LIMS situation being significant to NHS Fife, the Business Case being agreed with the Finance, Performance and Resources Committee in October 2022

4.7 While supporting these key items, progress was noted with the approach to extending the Electronic Patient Record (EPR) capability for NHS Fife. With the National Treatment Centre Fife Orthopaedics (NTC) commissioning, the digital solutions allowed for the implementation of an early adoption of digital forms solutions, including a revised Operation Note, a preassessment tool (Elsie) that allows our patients to input directly to the system, avoiding unnecessary attendance, and the implementation of digital scanning solution allowing for the first stage of Paperlite to be achieved for NTC.

4.8 The governance of the EPR programme was a matter for discussion and consideration by the Board. The agreement to a programme being established was given and discussion requested with SLTs to support key membership and leadership to the EPR programme. It was recognised, as being key, that the clinical teams are required to design the approach. The scope of the programme agreed to consider: the scanning approach to existing records, the development of digital forms and workflow to reduce a reliance on scanning in the future and the development and availability for patient services to be available through digital means, via the Digital Front Door. The Board recognised the financial limitations and impact, while hearing the approach to ensure priorities are aligned to NHS Fife Population Health and Wellbeing Strategy.

4.9 The implementation of Elsie was one initiative in the year that has extended our ability to work with our patients digitally, where appropriate to do so. Our "Digital Front Door" capability was further extended by adoption of the Piota application with services, the introduction of the Chat Health within the Health & Social Care Partnership School Nursing Service, the implementation of Queuebuster to allow patient to request a call back and the further development of Near Me into Community Hub locations.

4.10 The Board was updated on the progress of the implementation of the Architecture and Resilience team within Digital and Information, with key links to NHS Fife's Resilience Forum and the development of standards for digital solutions implementation to ensure compliance with the Safe and Secure requirements.

4.11 The Board were regularly updated on financial matters, with presentation on budgetary performance for delegated budgets, capital allocation and Scottish Government Strategic Funding. Assurance was taken by the Board from these reports.

4.12 The Board were updated on Digital and Information Performance through the provision of the performance summary report, with the Board noting the breadth of activities undertaken and the maintenance of operational performance and improvement.

5. Risk Management

5.1 Throughout the year the Board were presented with a consistent summary risk profile by risk rating and information relating to the improvement or deterioration of risk during the period. Visualisation of the risk profile, that averaged 40 in number in the year, supported the critique and assurance the group were able to offer.

5.2 In addition, the report provided a reporting format that presented additional analysis on the highest ranked risks. This summary detailed the root cause analysis, management actions, impact on the risk rating and timeline for delivery. This provided the Board with additional understanding of the risk and allowed them to consider if the management actions would mitigate the risk within a suitable timescale. To date the Board has been able to provide that assurance for the highest ranked risks.

5.3 During the period the Board noted that 15 risks improved their rating, 5 moved to the target risk rating and moved to a status of monitoring and 4 risk were closed.

6. Other Highlights

6.1 The Board noted additional effort and prioritisation was required on the Digital Information Policy and Procedure review and compliance. A number of key policies were being progressed to ensure improvement in this position was achieved.

6.2 The group noted the delay in this year's NISD audit, with the planned date for this audit now being July 2023, rather than the expected March 2023 date.

7. Conclusion

7.1 As Chair of the Digital and Information Board, during financial year 2022-23, I am satisfied that the integrated approach, the frequency of meetings, the breadth of the business undertaken and the range of attendees at meetings of the Digital and Information Board has allowed us to fulfil our remit. As a result of the work undertaken during the year, I can confirm that adequate and effective governance arrangements were in place in the areas under our remit during the year.

7.2 I can confirm that that there were no significant control weaknesses or issues at the year-end which the Digital and Information Board considers should be disclosed in the Governance Statement, as they may have impacted financially or otherwise in the year or thereafter.

7.3 I would pay tribute to the dedication and commitment of fellow members of the Digital and Information Board and to all attendees. I would thank all those members of staff who have prepared reports and attended meetings.

Signed: Date: 19 April 2023

Dr Chris McKenna, Chair
Executive Medical Director
On behalf of the Digital and Information Board

Appendix 1 – Attendance Schedule

APPENDIX 1

NHS Fife Digital & Information Board Attendance Record
1st April 2022 to 31st March 2023

	25/01/22	19/04/22	28/07/22	18/10/22
Members				
Dr Chris McKenna (Chair)	ü	ü	ü	ü
John Chalmers	ü	ü	x	x
Nicky Connor	X	Eileen Duncan Deputising	Audrey Valente Deputising	Rachel Heagney Deputising
Claire Dobson	ü	x	Miriam Watts Deputising	x
Philip Duthie	ü	ü	x	
Sharon Mullan				x
Scott Garden	Sally Tyson Deputising			
Benjamin Hannan		Duncan Wilson Deputising	ü	Duncan Wilson Deputising
Alistair Graham	ü	ü	ü	ü
Margo McGurk	x	ü	ü	ü
Janette Keenan	ü	ü	x	x
Caroline Somerville			ü	x
Dr Joy Tomlinson			x	ü
Jillian Torrens	x	x	x	x

In attendance

	25/01/22	19/04/22	28/07/22	18/10/22
Lynn Barker	x	ü	Sally O'Brien Deputising	ü
Andy Brown	ü	ü	ü	ü
Eileen Duncan	x	ü	ü	ü
Margaret Guthrie	Craig McKinnon Deputising	ü	Michelle Campbell Deputising	x
Helen Hellewell	x	x	x	x
Marie Richmond	ü	ü	Sarah Callaghan Deputising	ü

	25/01/22	19/04/22	28/07/22	18/10/22
Torfinn Thorbjornsen	ü	x	ü	x
Miriam Watts	ü	ü	ü	x
Amanda Wong	ü	ü	x	ü
Allan Young	ü	ü	ü	ü

ANNUAL STATEMENT OF ASSURANCE 2022-23
HEALTH & SAFETY SUB-COMMITTEE

1. Purpose

The purpose of the Health & Safety Sub-Committee is to ensure that the NHS Fife Board provides a safe and secure environment for patients, members of the public and its staff whilst meeting all of its statutory obligations in relation to Health & Safety.

2. Membership

During the financial year to 31 March 2023, membership of the Health & Safety Sub-Committee comprised:

Names	Roles / Designations
Neil McCormick	Director of Property and Asset Management (Chair)
Linda Douglas	Director of Workforce (Vice-Chair until Dec 22)
Conn Gillespie	Staff Side H&S Representative
Janette Keenan	Director of Nursing (from March 23)
Rona Laskowski	Head of Complex & Clinical Services, H&SCP (from Sept 22)
Dr Christopher McKenna	Medical Director
David Miller	Director of Workforce (Vice-Chair from Jan 23)

The Health & Safety Sub-Committee may invite individuals to attend meetings for particular agenda items. Mr David Young (Health & Safety administration support) was in attendance at the 10 June 2022 meeting for purposes of minute taking. Andrea Barker replaced David Young with effect from 2 September 2022. Other attendees, deputies and guests are recorded in the individual minutes of each meeting.

Following approval by the group on 20 January 2023, an invitation was extended to Janette Keenan, Director of Nursing, to attend H&S Sub-Committee meetings so that issues within nursing are being considered.

3. Meetings

3.1 The Health & Safety Sub-Committee met on four occasions via Teams during the financial year to 31 March 2023, on the following dates:

- 10 June 2022
- 2 September 2022
- 9 December 2022 (re-scheduled to 20 January 2023)
- 10 March 2023

3.2 The attendance schedule is attached at Appendix 1.

4. Business

4.1 <u>Health & Safety Manager</u>

The Health & Safety Sub-Committee welcomed Billy Nixon as Health & Safety Manager at its meeting on 2 September 2022.

4.2 Staffing Proposals

Health & Safety staffing proposals were agreed and approved within existing budgets:

- Health & Safety Manager
- Health & Safety Assistant Advisor (full-time)
- Health & Safety Assistant Advisor (part-time)
- Manual Handling Team Lead/H&S Advisor
- Manual Handling Co-ordinator
- Manual Handling Trainer
- Manual Handling Trainer
- Violence & Aggression Advisor
- Violence & Aggression Assistant
- Administration Support

4.3 Health & Safety Manager (Projects)

Craig Webster returned to Health & Safety from his secondment post in the Infection Prevention & Control Team on 12 September 2022 as Health & Safety Manager (Projects).

4.4 Manual Handling

Manual Handling restructuring plans are underway for a sustainable evidence based service. A Training Plan has been developed to reflect the needs of the service over 5 days (with built in contingencies).

After successful interviews, two Manual Handling Trainers have been offered full-time posts and are expected to start in April 2023.

The post of Manual Handling Co-ordinator post has been advertised and a good response was received. Interviews will take place in early March 2023.

4.5 Link Worker Role

The role of the Link Worker has been defined in Training Plans moving forward and training courses have been set up with appropriate aims and learning outcomes defined.

4.6 Violence & Aggression

A Violence & Aggression Advisor has been in post since February 2023 and has identified training needs within Acute. Several of the techniques used will be refreshed to suit the requirements of the service.

Consideration is being given to techniques used with certain patient groups within other Boards. This will ensure that a consistent approach is achieved. Assistance has been extended to the Mental Health Service, for an interim period, to help with training until the post of Violence & Aggression Advisor within the H&SCP is filled.

The timescale for the post going live has to be determined.

4.7 Face Fit Testing

Face Fit Testing has been reduced to a one monthly clinic which is run by the Health & Safety Team using the quantitative method. This method is often utilised by staff who have failed the Bitrex Hood testing method or staff who have no Face Fit Testers in their location.

Additional ad-hoc sessions can be organised, where required.

Staff are aware that a Face Fit Testing refresher will be required after 2 years to ensure that masks still fit correctly; however, the number of staff within NHS Fife who wear masks has significantly dropped so we are not seeing a high number of returns for testing. Other Boards have pushed their re-testing out to 3 years to aid compliance.

We offer a Face Fit Trainer Training Course for teams to carry out their own face fit testing.

4.8 Ligature Works

Ligature Works are currently being planned in several wards within NHS Fife, with Craig Webster representing Health & Safety on the Ligature Mitigation Project Group.

The Programme of Ligature Risk Assessments, which are separate to the Ligature Mitigation Group, is due to start in March 2023 with 22 Risk Assessment reviews required over several sites within NHS Fife.

5. Risk Management

5.1 Health & Safety Enforcement Activity

There was no Health & Safety enforcement activity during the year for NHS Fife.

5.2 Sharps Strategy Group

It proved difficult to re-start the Sharps Strategy Group after two unsuccessful attempts. This was due to work pressures and staffing issues.

Discussions took place at ASD&CD LPF meetings where Claire Dobson, Director of Acute Services and Andrew Verrecchia, Branch Secretary, Unison agreed to take forward and encourage and promote clinical and nursing staff attendance at future meetings or to make Sharps a standing agenda item to be discussed at future ASD&CD LPF meetings.

The introduction of an Acute Health & Safety Committee has now also been agreed.

6. Conclusion

6.1 This annual report has been agreed by Mr Neil McCormick as Chair of the H&S Sub-Committee in discussion with Health & Safety Sub-Committee members.

6.2 As Chair of the Health & Safety Sub-Committee, during financial year 2022-2023 I am satisfied that the integrated approach, the frequency of meetings, the breadth of the business undertaken and the range of attendees at meetings has allowed us to fulfil our remit. As a result of the work undertaken during the year, I can confirm that adequate and effective governance arrangements were in place in the areas under our remit.

6.3 I can confirm that that there were no significant control weaknesses or issues at the year-end which the Health & Safety Sub-Committee considers should be escalated to the Clinical Governance Committee or disclosed in the Governance Statement, as they may have impacted financially or otherwise in the year or thereafter.

6.4 I would pay tribute to the dedication and commitment of fellow members of the Health & Safety Sub-Committee and to all attendees. I would thank all those members of staff who have prepared reports and attended meetings.

Signed:  Date: 30.03.23

Neil McCormick, Chair
On behalf of the Health & Safety Sub-Committee

APPENDIX 1

NHS Fife Health & Safety Sub-Committee Attendance Schedule
1 April 2022 to 31 March 2023

	10 June 22	2 Sept 22	~~9 Dec 22~~ 20 Jan 23	10 Mar 23

Members

Name				
Neil McCormick	ü	ü	ü	ü
Linda Douglas	ü	x		
Conn Gillespie	ü	ü	x	ü
Rona Laskowski		ü	ü	x
Dr Christopher McKenna	x	ü	x	x
David Miller			x	ü
Janette Keenan				x

In attendance

Name				
Andrea Barker		ü	ü	x
Paul Bishop	ü	ü	ü	x
Anne-Marie Marshall	ü	ü	ü	ü
Billy Nixon		ü	ü	ü
Kevin Reith		ü	ü	
David Young	ü			
Nicola Robertson (for Janette Keenan)				ü

ANNUAL STATEMENT OF ASSURANCE, 2022-23, FOR NHS FIFE INFORMATION GOVERNANCE & SECURITY STEERING GROUP

1. Purpose

1.1 To provide the Clinical Governance Committee with an assurance statement, for the financial year 2022-23, that relates to the effectiveness of the structures, policies and practice in place to ensure the confidentiality, availability and integrity of the information processed by or on behalf of NHS Fife, including patient records and all corporate records which are pertinent to regulations, and to enable the ethical and safe use of them for the benefit of individual patients and the public good.

2. Membership

2.1 During the financial year to 31 March 2023, membership of the Information Governance and Security Steering Group comprised: -

Names	***Roles / Designations***
Members	
Margo McGurk	**Chair/Senior Information Risk Owner** (SIRO) - Director of Finance and Strategy/Deputy Chief Executive
Dr Chris McKenna	**Vice Chair** - Medical Director and Caldicott Guardian
Nicky Connor	Director of Health & Social Care
Claire Dobson	Director of Acute Services
Linda Douglas	Director of Workforce (till November 2022)
David Miller	Director of Workforce (from January 2023
Philip Duthie	General Practitioner (till August 2022)
Sharon Mullan	General Practitioner (from October 2022)
Susan Fraser	Associate Director of Planning & Performance
Alistair Graham	Associate Director of Digital & Information
Benjamin Hannan	Director of Pharmacy & Medicines
Helen Hellewell	Associate Medical Director, Health & Social Care Partnership
Janette Keenan	Director of Nursing
Frances Quirk	Associate Director, Research, Innovation and Knowledge
Dr Joy Tomlinson	Director of Public Health
In Attendance	
Andy Brown	Principal Auditor, Internal Audit
Brian McKenna	HR Manager
Margaret Guthrie	Head of Information Governance & Security / Data Protection Officer
Elizabeth Gray	Patient Experience Team Lead
Gillian MacIntosh	Head of Corporate Governance & Board Secretary
Kirsty MacGregor	Associate Director of Communications
Allan Young	Head of Digital Operations
Claire Neal	Personal Assistant to Associate Director of Digital & Information

2.2 The Information Governance & Security (IG&S) Steering Group invited individuals to attend meetings for agenda items and the list of attendees detailed in 2.1 have been in regular attendance at meetings. Other attendees, deputies and guests have been recorded in the individual minutes of each meeting.

2.3 The membership and attendance of the Group was sufficient to support the work and oversight necessary. The membership and attendance will be reviewed as part of the Group's Terms of Reference review at the April 2023 meeting and remains under annual review.

3. Meetings

3.1 The Information Governance & Security Steering Group met on three occasions during the financial year to 31 March 2023, on the undernoted dates:

- 6th June 2022
- 11th October 2022
- 31st January 2023

A planned meeting due to be held on 8th April 2022 was postponed due to the pressures within NHS Fife at the time. Reports were provided to the Group by circulation at that time for comment.

3.2 The attendance schedule is attached at Appendix 1.

4. Business

4.1 The Information Governance and Security Steering Group reviewed and commented on the annual activity plan that was presented to the Group. The Group recognised the responsibilities across the four domains of Data Protection, Freedom of Information (FOI), Public Records and Network and Information Security Directive (NISD). The Group discussed and considered the priorities outlined and had an informed view, being able to review these alongside associated risks for the four domains. Priorities were amended where necessary.

4.2 The Group noted the inclusion of Key Performance Indicators and measurements associated with the activity plan, and also discussed and recognised some limitations where reporting or data was not yet available. The key measures made available throughout the year included, monthly Subject Access Request data, point in time Information Asset Register figures, Information Governance training compliance as of September 2022, monthly FOI performance, current policy and procedure review information, NISD compliance at time of audit, monthly adverse event reporting and summary information on reportable incidents to Information Commissioners Office/Competent Authority. Some key measures are included in Appendix 2 to this report, the IG&S Performance Summary.

4.3 The Group considered and discussed the data sharing arrangements established during the pandemic response, where Scottish Government (SG) had provided a directive that the Emergency Care Summary (ECS) should be made available to extended contractor groups including Optometrists and Community Pharmacists. SG had asked Boards to update the current position on their sharing arrangements and a questionnaire had been returned on behalf of NHS Fife. A discussion considered the controls around this sharing of the ECS data including a process for handling leavers. The Group were assured with the arrangements in place.

4.4 The Group's consideration of data sharing arrangements continued with discussion and debate on the planned approach to GP Data Sharing. The Group had commissioned further consideration to the approach and controls required to implement safe and appropriate sharing of GP data in support of clinical activities. The Group, in January 2023, heard an update on the progress being made following

presentation from the Primary Care Data Protection Officer and the Senior Project Manager. Hearing of the controls and gaining additional understanding of the specifics of Role Based Access, Audit and Fairwarning, the initial adoption of Breakglass functions and a phased implementation, the Group supported the recommendation to proceed with a phased implementation of GP data sharing via the Clinical Portal.

4.5 The Subject Access Request (SAR) process has been a focus of improvement for the Steering Group during the period and a Short Life Working Group (SLWG) was established to revise supporting processes. SARs should be responded to within one month of the request. The variability in data from those handling SARs and the requirement to support those receiving requests to process appropriately, led the SLWG to recommend a single point of contact be established, to provide support, but also ensure the monitoring of our compliance in this area. The Steering Group has received regular updates through the year and the improvement work is due to conclude in May 2023. Availability of compliance data is being seen as evidence of improvement as shown in Appendix 2.

4.6 The Network Information Security Directive (NISD) Audit is an annual component of the Steering Group's work and the drive for improvement across the domains of Identify, Protect, Detect, and Respond and Recover. A written report was presented to the July 2022 meeting of the Group outlining the audit results from May 2022. The Group noted the improvement to a 76% compliance status, an uplift of 7% from the previous year's report. Along with the audit result, the action plan for 2022-23 was presented and discussed by the Group. The Group took assurance from the result and future action plan, but also discussed areas of improvement to support the education opportunities for our workforce and in the area of Supplier Management. The Steering Group supported the presentation on Cyber Security at the September 2022 Board Development Session.

4.7 At the October 2022 meeting the Steering Group were able to review the response from the Keeper of the Records for Scotland relating to NHS Fife's Records Management Plan (RMP) that had been submitted in February 2021. The Keeper confirmed that the RMP set our proper arrangements and noted the improvement activities necessary in Business Classification and Audit Trail. In considering this matter the Group supported the recommendation to establish a Records Management Steering Group to oversee the work, give its breadth of impact to NHS Fife. The Group agreed the RMP outcome should be reported to the Clinical Governance Committee (CGC) via the Executive Directors Group. (The matter was reported at the January 2023 meeting of the CGC).

4.8 A mapping between the Information Commissioners Office Accountability Framework (10 categories and 338 controls) and the NISD Framework (17 categories and 434 controls) were undertaken, and summary provide to the Steering Group. The mapping identified seven areas of commonality allowing a more unified approach to reporting and assurance to take place. The Group noted that this would demonstrate additional maturity and assurance to the organisation as we develop our approach to Information Governance and Assurance. The revised mechanism continues to be in development and will be presented to the April 2023 meeting for consideration. The Group recognised additional compliance information will be required in support of this including Performance Indicators for Subject Access Requests, Records Management and staff training compliance and adoption figures, including new starters induction uptake.

4.9 The Group considered, at its October 2022 meeting, an incident report following an extended cyber event that affected a Third-Party Supplier and the availability of the Out of Hours system Adastra. The report detailed the rapid response initiated to protect NHS Fife and the associated reporting to the ICO and other authorities. The incident was managed nationally, through the establishment of a National Incident Management Team. No evidence of loss of data for NHS Fife subjects was known. At the time of this report the incident is still active, with national lessons learnt outstanding and the ICO requesting additional information locally. The incident was considered a moderate categorisation.

4.10 The Group was also updated on the ICO Audit that was originally planned for October 2022 but was cancelled until March 2023, the outcome of the audit being expect in April 2023.

4.11 The Group undertook, as scheduled, its annual review of Terms of Reference and update to annual workplan.

5. Risk Management

5.1 Throughout the year the Group were presented with a consistent summary risk profile by risk rating and information relating to the improvement or deterioration of risk during the period. Visualisation of the risk profile, which averaged 26 in number over the year, supported the critique and assurance the Group were able to offer.

5.2 In addition, the report provided a reporting format that presented additional analysis on the highest ranked risks. This summary detailed the root cause analysis, management actions, impact on the risk rating and timeline for delivery. This provided the Group with additional understanding of the risk and allowed them to consider if the management actions would mitigate the risk within a suitable timescale. During the period, the highest risk considered in this manner has seen a reduction in risk rating for Risk 2109 – Unauthorised use of Applications and Risk 1338 – Ability to respond, recognising the increased threat of a cyber event. Risk 1500 – the overarching Cyber Resilience Risk - continues to be monitored by the Group.

5.3 During the period, the Group noted that 9 risks improved their rating, 1 risk deteriorated during the period, 3 equalled their target risk rating and moved to a status of monitoring and 5 risks were closed.

5.4 During January 2023, a risk appetite and tolerance matrix was presented to the Group for discussion. Further actions were requested to expand the assessment framework and category descriptors, to ensure the Group could provide discussion and support at its next meeting.

6. Other Highlights

6.1 Through the year, 14 incidents were reported to the ICO, the same number as the previous year. Of the 14, 8 (71%) were reported within the 72-hour requirement. Of the 14 incidents, 10 have been confirmed not to require any further follow up and 4 remain to be confirmed.

6.2 The Group await the final report from the ICO Audit of March 2023.

6.3 The Group continues to monitor progress with the recommendations contained in the Internal Audit Internal Control Evaluation 2022/23 and the two assigned actions.

Action Point Reference 9 – IG&S Assurance Reporting and Action Point Reference 10 – IG Incident reporting.

7. Conclusion

7.1 As Chair of the Information Governance & Security Steering Group during Financial Year 2022-23, I am satisfied that the integrated approach, the frequency of meetings, the breadth of the business undertaken and the range of attendees at meetings of the Information Governance & Security Steering Group has allowed us to fulfil our remit. As a result of the work undertaken during the year, I can confirm that adequate and effective governance arrangements were in place in the areas under our remit during the year.

7.2 I can confirm that that there were no significant control weaknesses or issues at the year-end which the Information Governance & Security Steering Group considers should be disclosed in the Governance Statement, as they may have impacted financially or otherwise in the year or thereafter.

7.3 I would pay tribute to the dedication and commitment of fellow members of the Information Governance & Security Steering Group and to all attendees. I would thank all those members of staff who have prepared reports and attended meetings.

Signed: Date: xx April 2023

Margo McGurk, Chair
Director of Finance and Strategy/Deputy Chief Executive
On behalf of the Information Governance & Security Steering Group

Appendix 1 – Attendance Schedule
Appendix 2 – IG&S Performance Summary

Appendix 1

NHS Fife Information Governance & Steering Group Attendance Record 1st April 2022 to 31st March 2023

	06/07/22	11/10/22	31/01/23
Members			
Margo McGurk	ü	ü	ü
Nicky Connor	x	Fiona McKay Deputising	x
Claire Dobson	x	ü	ü
Linda Douglas	ü	x	
David Miller			ü
Philip Duthie	x		
Sharon Mullan		ü	x
Susan Fraser	ü	ü	ü
Alistair Graham	ü	x	ü
Benjamin Hannan	Duncan Wilson Deputising	Duncan Wilson Deputising	Duncan Wilson Deputising
Helen Hellewell	x	ü	x
Dr Chris McKenna	x	ü	x
Janette Keenan	x	ü	x
Frances Quirk	ü	x	x
Dr Joy Tomlinson	ü	ü	x
In Attendance			
Andy Brown	ü	ü	ü
Margaret Guthrie	ü	ü	ü
Elizabeth Gray	x	x	x
Kirsty MacGregor	ü	ü	ü
Gillian MacIntosh	ü	ü	ü
Brian McKenna	x	ü	x
Allan Young	ü	ü	x

Appendix 2 - IG&S Performance Summary

	Information Governance & Security Performance Summary	Target	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Operational Performance	Cyber Security - Exposure Score*	25%	25	23	30	26	24	23	22	29	25	30	25	
	FOI's - Responses within target	85%	97.6%	96.0%	90.5%	80.0%	83.1%	86.3%	93.8%	95.0%	89.9%	90.7%	90.1%	
	SARs Received (% responded to timeously)	100%	67.0%	87.0%	84.0%	100.0%	100.0%	97.7%	98.0%	98.9%	99.0%	98.9%	97.4%	
	Information Governance Incidents	Avg 87	97	117	98	95	102	90	78	82	62	60	80	
	Incidents Reported to ICO or CA		0	2	1	1	3	2	1	0	0	1	2	
	Incidents Reported within 72 Hours		0	1	1	1	3	2	1	0	0	0	1	
	Follow up required by ICO		0	1 x TBC	0	0	o	0	0	0	0	1	2	
	Annual Measures		**2020**	**2021**	**2022**									
	NISD Compliance Status		53%	69%	76%									
	NISD Risk Exposure		13%	8%	3%									
	NISD Controls Completed		53%	58%	64%									

* Scored out of 100; Low 0-29, Med 30-69, High 70-100

ANNUAL STATEMENT OF ASSURANCE FOR NHS FIFE RESILIENCE FORUM

1. Purpose

1.1 To provide the Clinical Governance Committee with an assurance statement for the financial year 2022-23, that relates to the effectiveness of NHS Fife in meeting its statutory emergency planning duties & planning in preparedness as outlined within the Civil Contingencies Act 2004 and the NHS Scotland Standards for Resilience. NHS Scotland Standards require NHS Fife to ensure it can respond to any emergency situation while maintaining core service delivery.

1.2 NHS Fife has duties as a Category 1 organisation to support an effective response as a receiving hospital (working alongside multi-agency partners in regional/national emergency situations). As a Category 1 responder, NHS Fife is subject to the full set of civil protection duties where the Board are required to:

- Assess the risk of emergencies occurring and use this to inform contingency planning
- Put in place emergency and business continuity plans and arrangements and a resilience training and exercising programme
- Maintain arrangements to warn, inform and advise staff and the public in the event of an emergency and/or business continuity incident
- Share information with other local responders to enhance co-ordination; and
- Co-operate with other local responders, supporting the local and regional resilience partnerships

1.3 The Civil Contingencies Act and supporting regulations require NHS Fife to have an established and clear set of roles and responsibilities for those involved in emergency preparation and response at the local level.

2. Membership

2.1 During the financial year to 31 March 2023, membership of the NHS Resilience Forum comprised: -

Names	*Roles / Designations*
Dr Joy Tomlinson	Director of Public Health (Chair)
Margo McGurk	Director of Finance and Strategy/Deputy Chief Executive (Vice Chair)
Susan Cameron	Head of Resilience
Susan Fraser	Associate Director of Planning and Performance
Claire Dobson	Director of Acute Services
David Miller	Director of Workforce
Nicky Connor	Director of Health and Social Care
Neil McCormick	Director of Property and Asset Management
Janette Keenan	Director of Nursing

Hazel Close	Head of Pharmacy
Dr Christopher McKenna	Medical Director
George Brown	Emergency Planning Officer
Paula Lee	Head of Procurement
Nicola Taylor	Primary Care Representative
Alistair Graham	Associate Director, Digital and Information
Kirsty Macgregor	Associate Director of Communications
Wilma Brown	Employee Director
Craig Burns	Emergency Planning Officer
Donna Baile	Scottish Ambulance Service Resilience
Steven Rutherford	Personal Assistant to Head of Resilience

2.2 The Resilience Forum may invite individuals to attend meetings for particular agenda items, but the list of routine members in 2.1 will normally be in attendance at meetings. Other attendees, deputies and guests are recorded in the individual minutes of each meeting.

2.3 The Resilience Forum is the group responsible for strategic oversight of the resilience function for NHS Fife in line with the Civil Contingencies Act 2004 and relevant national guidance; it is chaired by the Director of Public Health and its membership is drawn from key NHS Fife stakeholders. The group is quorate when 50% of the membership are present, one of which should be an NHS Fife senior executive (i.e. the Director of Public Health or the Vice Chair, the Director of Acute Services, Director of Nursing or the Director of Property and Asset Management).

2.4 The Assurance of Resilience Capabilities requires directorates and operational areas of NHS Fife to annually report on their ability to prevent disruption to services, manage disruptive incidents and respond to internal & external emergencies (including major incidents). Ongoing operational pressures have impacted this process, in consequence of which Executive Directors have agreed to extend the reporting timescales during 2022-23.

3. Meetings

3.1 The NHS Resilience Forum met on four occasions during the financial year to 31 March 2023, on the undernoted dates:

- 15 June 2022
- 25 August 2022
- 1 December 2022
- 1 March 2023

3.2 The attendance schedule is attached at **Appendix 1.**

4. Business

4.1 An assurance process has been established by means of a quarterly report, reviewed and commented on by the Resilience Forum and considered by the Executive Directors' Group. The report provides a quarterly overview of internal and external resilience activities supported by the resilience team and assurance metrics for Business Continuity planning. The Resilience Forum provides a key link regionally with membership including partner agencies covering Category 1 joint emergency response planning, testing & exercising. The Terms of Reference for the Resilience Forum were updated and ratified in November 2022.

Emergency Planning

4.2 A draft Major Incident Plan has been available as a working document in NHS Fife since 2019. The Resilience Forum received the draft Major Incident Plan for consideration and comment at their meetings in June and August 2022. Over the course of 2022/23 the Action Cards were updated and the supporting Framework documents (see below) are under review. On the 26th August 2022 the respond section of Major Incident emergency planning was tested within the emergency department at the Victoria Hospital Kirkcaldy by means of a live play of HAZMAT scenario involving multiple casualty decontamination.

4.3 Learning following this event was shared with the Resilience Forum and has been taken forward with appropriate Chemical, Biological, Radiation & Nuclear (CBRN) kit and development of local guidance. The Radiation Protection Advisor provided post event training for radiation decontamination response, equipment & exposure hazards/limits. Powered Respirator Protective Suits (PRPS), train the trainer session was provided by Scottish Government CBRN lead in October 2022.

Major incident Framework

4.4 The Major Incident Framework plan is currently in the process of being reworked following additional Executive Directors' Group feedback received from their meeting of 19 January 2023. Revisions include a standardised communications strategy and a streamlined approach, with internal incident escalation notification and level 4 major incident level triggers. This will ensure a clear relationship with the Operational Pressures Escalation Levels (OPEL) framework.

4.5 The incident management planning for NHS Fife includes a set of associated local framework guidance documents, which sit alongside the management plan. These include:

- A Severe Weather Framework Plan
- A Suspicious Package & Bomb Threat Framework Plan
- A Lockdown Framework Plan
- CBRN/HASMAT Standard Operating Procedure (SOP)
- East of Scotland Regional Resilience Scientific & Technical Advice Cell (STAC) - *this document has been published to Resilience Direct following local resilience joint agency partnership stakeholder review*

4.6 The East of Scotland Regional Resilience Scientific & Technical Advice Cell (STAC) guidance, Severe Weather Framework, Bomb Threat and Lockdown Plans were considered by Forum members at their meeting in December 2022.

4.7 All of the Plans and Frameworks are considered by the Forum and internal and external stakeholder engagement is fully captured by the implementation of consultation timescales. The agreed consultation period is 4 weeks for document review and an editorial checklist is presented to support final document ratification. This process was agreed by the Resilience Forum at their meeting on 1 December 2022. During 2022/23 the Forum considered and updated the leads for the NHS Scotland Organisational Resilience Standards to ensure that these were correctly aligned.

Business Continuity

4.8 The most recent Business Continuity Assurance statement and overarching Corporate Business Continuity Plan were presented to the Resilience Forum and

EDG in December 2020. The Templates used within the Corporate Business Continuity Plan were included in the update to the Resilience Forum in June 2022 and members have provided advice and support on the timescales and approach to completion of the assurance statement. The timescale to prepare the assurance statement for 2021/22 was delayed because of a combination of pandemic pressures and key vacancies within the resilience team. The Forum recognises there have been challenges in carrying out the baseline process in light of ongoing system pressures; the preferred option is to complete the assurance of Business Continuity plans over a longer time period.

4.9 Areas where Business Continuity plans are identified as requiring to be annually updated are being monitored, with support to aid completion offered.

4.10 In March 2021 resilience data sets for Business Continuity planning were re-evaluated to ensure that a consistent approach was taken and assurance metrics across Acute & H&SCP service areas were aligned. Currently NHS Fife (including H&SCP service areas) has 133 areas identified that require Business Continuity plans.

4.11 Where NHS Fife currently has received partial assurance that Business Continuity plans are in progress, the resilience team are providing *step by step* business continuity guidance, highlighting templates and business continuity training support that is available.

Division	*BC Plan Confirmed*	*BC Plan advised to be in Progress*	*No BC Plan Received*	***Total***
Acute	38	24	1	63
Corporate	9	5	0	14
H&SCP	48	8	0	56

4.12 A central repository of all plans received is now in place where these documents are available to access if required in response to any incident requiring business continuity actions to be taken. Each service area's Business Continuity plan provides an in-depth business impact analysis & plan specific to the activities undertaken in the department/service area.

Business Continuity Training

4.13 The Resilience Forum receive regular updates about the delivery of training. Training is provided to promote confidence in business continuity planning and the resilience team continue to support regular business continuity training update sessions. To date 34 training sessions have been provided, supporting 169 staff.

4.14 Digital resilience partners are also promoting awareness of digital systems impact by means of monthly digital resilience presentations.

Business Continuity Plan Testing & Exercising

4.15 NHS Fife's Business Continuity Plans include arrangements for testing and for ensuring arrangements for the provision of training to those involved in implementing the plan. The testing and exercising programme is reviewed by the Resilience Forum and any lessons learned are considered further by the group. Annual testing and exercising ensures Business Continuity Plans are kept up to

date and continue to be appropriate. Integral to that is the practising and testing of all the elements of emergency plans.

4.16 Planning for business continuity emergencies cannot be considered reliable until it is exercised and proven to be workable, especially since false confidence may undermine effectiveness of any written plan.

5. PREVENT

5.1 In Quarter 2 (2022) there was a change in oversight for the PREVENT programme and this now sits within the Resilience team. Reporting to the Forum is incorporated within the established quarterly updates and the summary of training completed is set out in the table below. Advice is available from NHS Fife's Resilience team and information about raising concerns is provided via the Emergency Preparedness Resilience Response (EPRR) staff link intranet pages. The Fife PREVENT resilience leads work with local partners to put in place a tailored support package to protect the vulnerable person.

PREVENT Training TURAS 2022-23

Quarter	H&SCP	Acute
1	131	234
2	131	138
3	172	159
4	224	143

6. Risk Management

6.1 The Resilience Forum is responsible for strategic oversight of the resilience function for NHS Fife. The Forum receives assurance on local planning and arrangements through regular review and exercising of plans and consideration of any escalated issues from NHS Fife Acute Services Division and NHS Fife Health and Social Care Partnership Resilience Group. The Forum reports directly to the Executive Directors' Group and minutes from the Forum are presented to both the NHS Fife Board's Clinical Governance Committee and the Health & Social Care Partnership Resilience Group of the Integration Joint Board.

6.2 The Public Health Assurance Committee reviews overarching strategic resilience risks to ensure that appropriate management actions are in place. The Public Health Assurance Committee meets four times annually, where a review of Public Health risks (including resilience) is undertaken. The minutes are submitted to the NHS Fife Board's Public Health and Wellbeing Committee. The Public Health risk register is discussed and updated and frequency of the review period is in line with organisational requirements.

6.3 Datix Risk 518 currently reflects a moderate risk level within Resilience Emergency planning & Business Continuity.

7. Other Highlights

7.1 NHS Fife established dedicated pages on StaffLink in March 2022 and this was supported by the Forum as an opportunity to raise awareness more widely with staff about the importance of organisational resilience. This site allows resilience training to be booked and templates and guidance are readily accessible to the workforce.

7.2 The Resilience team have developed a quarterly workforce resilience brief to facilitate a “shared situational awareness” within emerging resilience themes, which is communicated across StaffLink.

7.3 The Forum have supported developments to strengthen the HAZMAT/CBRN response in NHS Fife through an agreement to train 10 non-clinical HAZMAT responders; the purpose of this non-clinical group is to support clinical staff in any HAZMAT/CBRN response situation, supporting the emergency department with the management of presenting casualties.

8. Conclusion

8.1 As Chair of the Resilience Forum during financial year 2022-23, I am satisfied that the developing internal reporting & monitoring systems provides an integrated partnership approach.

8.2 The frequency of Resilience Forum meetings and the range of attendees at meetings of the NHS Resilience Forum provides a platform for partnership consultation to facilitate policy and frameworks planning to fulfil our civil contingencies remit.

8.3 As a result of the work undertaken during the year, I can confirm that governance procedures and assurance metrics are developing across Emergency planning, Business Continuity and PREVENT portfolios, so that NHS Fife can evidence assurance from emergency planning arrangements.

8.4 The Head of Resilience has worked throughout the year to support the Forum and has progressed the key areas highlighted within the Interim Internal Audit report on resilience planning. Strong progress has been made, with some areas requiring ongoing support. The Forum noted that partial assurance can be reported to the Clinical Governance Committee for the reporting year 2022/23, reflecting the work-in-progress underway to strengthen arrangements for resilience planning as detailed further in this report. A further full system review is being undertaken in the 2022/23 Internal Audit Plan.

8.5 I would pay tribute to the dedication and commitment of fellow members of the NHS Resilience Forum and to all attendees. I would thank all those members of staff (internal & external multiagency partners) who have prepared reports and attended the Resilience Forum meetings.

Signed:

Joy Tomlinson, Chair
Director of Public Health
On behalf of the Resilience Forum

Susan Cameron
Head of Resilience

Date: 17/4/2023

NHS Fife RESILIENCE FORUM Attendance Record

1st April 2022 to 31st March 2023

Meeting Date	15/06/2022	25/08/2022	01/12/2022	01/03/2023
Members				
Joy Tomlinson	✓	✓	✓	✓
Margo McGurk	x	x	x	x
Susan Cameron	✓	✓	✓	✓
Susan Fraser	✓	x	✓	✓
Claire Dobson	x	Andrew Mackay Deputising	Donna Galloway Deputising	Donna Galloway Deputising
David Miller				
Linda Douglas	✓			
Brian McKenna		✓	Kevin Reith Deputising	x
Nicky Connor	Avril Sweeny Deputising	Lorraine King Deputising	Lynne Garvey Deputising	Lorraine King Deputising
Neil McCormick	x	Paul Bishop Deputising	Paul Bishop Deputising	x
Janette Keenan	x	Nicola Robertson Deputising	x	x
Hazel Close	Ewan Reid Deputising	✓	x	x
Christopher McKenna	x	x	x	x
George Brown	✓	✓	✓	✓
Paula Lee	x	x	x	x
Nicola Taylor	Joy Kelly Deputising	x	x	x
Alistair Graham	x	Allan Young Deputising	Allan Young Deputising	x
Kirsty MacGregor	✓	x	✓	✓
Wilma Brown	x	x	x	x
Jason Inglis	✓			
Craig Burns				✓
Donna Baillie	✓	✓	x	Samantha McLaughlin Deputising
In attendance				
Jimmy Ramsay	✓			

Meeting Date	15/06/2022	25/08/2022	01/12/2022	01/03/2023
Members				
Andrew Lam	✓			
Maggie Currer	✓	✓	x	x
Kathleen Bolton		✓		
Siobhan McIllroy	x	x	x	✓
Kevin Irving		✓		

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

ANNUAL STATEMENT OF ASSURANCE FOR
CLINICAL & CARE GOVERNANCE/QUALITY & COMMUNITIES COMMITTEE

1. Purpose

1.1 To provide assurance to the Integration Joint Board (IJB) that it is fulfilling all its statutory requirements and, on the adequacy, and effectiveness of systems of internal control and assurance, with appropriate and consistent escalation and action in accordance with the scope of services as defined in the Integration Scheme.

1.2 Enable the IJB to deliver its statutory functions in line with the Health and Wellbeing Outcomes, National and Local policy directions, statutory principles of Integration and the vision, mission and values within Fife's Strategic Plan.

2. Membership

2.1 During the financial year to 31 March 2023, membership of the Clinical & Care Governance/Quality & Communities Committee comprised:

Name	Role / Designation
Cllr Tim Brett	Chair (to April 2022)
Sinead Braiden	Chair (from July 2022)
Cllr Liewald	Vice Chair (from July 2022)
Martin Black	Member (to April 2022)
Cllr David J. Ross	Member (to April 2022)
Cllr Jan Wincott	Member (to April 2022)
Cllr Graeme Downie	Member (from July 2022)
Cllr Margaret Kennedy	Member (from July 2022)
Lynn Mowatt	Member (from July 2022)
Cllr Sam Steele	Member (from July 2022)
Ian Dall	Member (from July 2022)
Kenny Murphy	Member (from July 2022)
Morna Fleming	Member (from July 2022)
Paul Dundas	Member (from July 2022)

2.2 The Quality & Communities Committee may invite individuals to attend meetings for particular agenda items, but the Deputy Medical Director (Exec Lead), Director of Fife Health & Social Care Partnership, Director of Nursing HSCP, Head of Education and Children's Services, Director of Allied Health Professionals, Director of Pharmacy & Medicines, Head of Strategic Planning, Performance & Commissioning, Head of Community Care Services, Head of Complex and Critical Care Services, Head of Community Care Services, Head of Primary & Preventative Care Services, Staff Side Representative and Quality Clinical & Care Governance Lead will normally be in attendance at meetings.

Other attendees, deputies and guests are recorded in the individual minutes of each meeting.

3. Meetings

3.1 The Clinical & Care Governance/Quality & Communities Committee met on six occasions during the financial year to 31 March 2023, on the undernoted dates:

1. Wednesday 20 April 2022
2. Tuesday 5 July 2022
3. Friday 9 September 2022
4. Tuesday 8 November 2022
5. Tuesday 18 January 2023
6. Friday 10 March 2023

3.2 The attendance schedule is attached at Appendix 1.

4. Business

4.1 Following the elections of May 2022 and the redesign of IJB governance structures, the Quality & Communities Committee was created, and revisions to the membership became effective. In July, Sinead Braiden, NHS Board Member was confirmed as the Chair of the Quality & Communities Committee, with Vice Chair confirmed as Cllr Rosemary Liewald.

4.2 The Qualities and Communities Terms of Reference were reviewed at the July 2022 meeting with the revised document approved at the November 2022 meeting.

4.3 This terms of reference confirms that the key purpose of this Committee is to provide assurance to the IJB in relation to its statutory duty, policy requirement and strategic approach

- Safe, effective, person-centred care in accordance with the scope of services as defined in the Integration Scheme.
- Locality capacity building, locality planning, community development, participation and engagement and support to carers.
- Help the people of Fife to live independent and healthier lives by transforming health and care, supporting early intervention and prevention and working closely with delegated, third and independent services to reduce health inequalities.
- Clinical and care governance and that quality of care is being led professionally and clinically.
- Health and Wellbeing Outcomes, the Clinical and Care Governance Framework, the Governance for Quality Social Care in Scotland Report, National and Local policy directions, and statutory principles of Integration and the vision, mission and values within Fife's Strategic Plan

4.4 Assurance can be provided that the committee is working towards its full terms of reference, recognising the significant change in membership and function. Progress has been made in 2022/23 with plans for further development of the agenda against all areas of the committees remit in 2023/24:

- A key driver for reviewing and changing this committee's focus was to broaden the remit from clinical and care governance and to recognise and value the Integration Joint Board's role and duties in relation to matters such as localities, carers and beyond managed services. It was also important to reduce duplication of reporting and ensure that matters of governance are reporting as appropriate to either the quality and communities committee, NHS Fife Clinical Governance Oversight Group and Fife Council Scrutiny Committee recognising the statutory roles of NHS Fife and Fife Council. This is underpinned by robust operational governance within the Health and Social Care Partnership through the Quality Matters Assurance Group and The Senior Leadership Assurance Meeting. The Deputy Medical Director, Director of Nursing – HSCP and Professional Social Work lead jointly lead the operational clinical and care assurance work in the Health and Social Care Partnership and attend the relevant committees of NHS Fife and Fife Council with direct professional reporting lines to the Medical Director, Director of Nursing and Chief Social Work Officer.
- A key strength of the new committee structure is the inclusion of non-voting members of the IJB on the Quality and Communities Committee which assures that there is Patient Representative, Carers Representative and the Third and Independent Sector Leads representation. This enables the committee to have representation across the full scope of services within the Health and Social Care Partnership beyond statutory services.
- There is strong clinical and professional leadership in place to support the committee with the Deputy Medical Director being the named Senior Leadership Team Lead to support the chair of this committee. The work of this committee is supported by the Director of Nursing for the Health and Social Care Partnership and the Professional Social Work Lead. The committee has considered professionally led reports for example the Nursing and Midwifery Professional Assurance Framework and the Chief Social Work Officers Annual report.
- In 2022/23 the committee covered business that represented a range of services in the Health and Social Care Partnership for example: palliative care, primary care, Macmillan cancer support, pharmaceutical care services, and mental health. The committee has also received reports on key matters of governance for example duty of candour, risk register review, reducing harms and public protection.
- The committee has also been instrumental in the scrutiny of key strategies including the Participation and Engagement Strategy, workforce strategy as well as performance reports and the impact of care including the annual performance report, annual care inspectorate grades report, alcohol and drugs partnership annual report and performance of delivery of the equalities duties.
- This will be supported by a robust work plan to assure forward planning of agenda items and reports that will cover the full scope of the committee in 2023/24; this proposed refreshed work plan will report to Committee within the first quarter of 2023/24.

5. Governance

5.1 Items are raised under Governance at every meeting, reports presented include:

5.2 Reducing Harms Presentation was presented which discussed harm in its various forms such as fall, Pressure Ulcers and Catheter Associated Urinary Tract Infections (CAUTI). It was noted that the aim was to achieve a 25% reduction in occurrences experienced and a further 25% reduction in 2023.

5.3 Delayed Discharge Update was provided in April 2022 to give assurance to the Committee following the last paper discussed in October 2021. It was noted that the proportions of delays presented in October 2021 had significantly improved with care homes now being used as interim placements rather than patient remaining in hospitals. The update noted that the 2021/22 winter period had been very challenging with significant outbreaks of Covid/Omicron, increased presentations in the emergency department and staff absence rates.

5.4 Fife Macmillan Improving the Cancer Journey progress was reported on in April 2022 which outlined the significant enquiries received by the service despite the covid restrictions.

5.5 The Duty of Candour Reports for the NHS and Fife Council were reported at the April 2022 committee. It was noted that for General Practice only the practices which are 2C are included within the report as the other practices have their own duty of candour reports. The committee noted the learning being taken forward and the changes implemented from the reports.

5.6 An update was provided on Corporate Parenting where the three improvement activities which the Corporate Parenting Board had committed to were outlined.

5.7 The Mental Health Strategy Progress Report was reported to the July 2022 meeting. The report provided examples of progress against the 7 strategic commitments within Mental Health. A further Strategy Progress Update was provided in January 2023 where it was highlighted that the Action 15 monies had been confirmed and are to be awarded on a recurring basis.

5.8 The Participation and Engagement Strategy was reported at the July 2022 meeting. There was discussion around the requirement for clear values around objectivity, transparency and accountability but it was felt that the strategy took significant steps to achieving the improvements required and the committee supported recommending approval to the Integration Joint Board.

5.9 The Workforce Strategy Plan 2022-25 was reported at the July 2022 committee where approval was requested prior to the plan being submitted to Scottish Government prior to the deadline of 31 August 2022. There was discussion relating to skills development and staff wellbeing and the committee were content to recommend the workforce strategy plan to the IJB.

5.10 The Winter Lessons and Reflections report was reported at the July 2022. The committee recognised collaboration and leadership demonstrated over the winter 2021/22 period and also noted that the challenges and pressures on the system were now constant beyond the winter period. Winter planning was also reviewed within the November 2022 Committee meeting which provided an overview of

actions being taken by the Partnership in preparation for winter and the committee confirmed that they had taken assurance of the plans outlined within the report.

5.11 An update on Home First was reported at the July 2022 committee where it was highlighted that the overarching principle of assisting people within Fife to live longer and healthier lives at home or within a homely setting aligned itself to the Scottish Government policies and the governance around Home First.

5.12 Business Cases for the Lochgelly and Kincardine Health and Wellbeing Hubs were presented at the July 2022 committee.

5.13 The 5th HSCP Annual Performance Report 2021/22 was reported at the September 2022 committee. The report outlined the ongoing impact of the pandemic, cost of living crisis and workforce challenges faced by the Partnership. The report outlined the 5 Strategic Priorities with a case-study demonstrating progress in these areas. There was discussion around percentages versus numbers being used in the report and it was noted that comments will be taken on board for future reports to provide additional context. The committee recommended this report for approval to the Integration Joint Board.

5.14 The Fife HSCP Year 1 Workforce Action Plan 2022/23 was reported at the September 2022 meeting. The key points of the action plan were discussed and confirmation that there had been engagement with staff side representation in the development of the plan. The Strategy and Action Plan was also reported at the November Committee Meeting seeking the committee's approval prior to submission to IJB before being placed on the Partnership website by the end of November 2022. The committee confirmed that they were content to recommend approval to the IJB.

5.15 The Child Protection Annual Report was presented by the Independent Chair of the Fife Child Protection Committee who noted that the report covered the period April 2020-July 2021 which was a critical and difficult time due to the pandemic. The Revised Child Protection Guidelines were also reviewed to provide assurance that the structure was in place to implement the new guidance within Fife HSCP.

5.16 The Primary Care Implementation Plan with a Memorandum of Understanding 2 Progress Update was provided to the November 2022 committee where it outlined the background to the Plan and the reasons behind it. It was acknowledged that the Vaccination Transformation Programme had fully transferred to the NHS Board responsibility in March 2022 but the Pharmacotherapy and Community Care and Treatment Centre are unlikely to be transferred by the original aim of April 2023. A summary of the 6 workstreams and their remits were given. Assurance was given that the implementation of the Primary Care Improvement Plan has been thoroughly planned with plans in place and also considered workforce challenges within Multi-disciplinary Team Groups.

5.17 The Pharmaceutical Care Services Report for 2021/22 was reported to the November 2022 committee. It was noted that Pharmacy are legally obligated to submit the report in line with Pharmacy Regulations which sits within the complexity of both Primary Care and Independent Contractors. It was noted that

the provision for community pharmacy is delegated to the IJB however the regulations and pharmacy regulations are enacted by the Health Board.

5.18 The Professional Assurance Framework Report (NMAHP) was tabled at the November 2022 committee for assurance. It was noted that it was very comprehensive and recognised there were was only a few substantive changes to the previous framework which kept it contemporary taking into account new strategies.

5.19 The Quality & Communities Strategic Risk Register was reviewed where it was noted that the risks had been reviewed and updated.

5.20 The Fife Specialist Palliative Care Services Service Model was presented and discussed at the November 2022 meeting where assurance was provided that Fife was in alignment with the National direction and that work was ongoing to develop a proposal on this model to be reported back to committee in 2023.

5.21 The Strategic Plan 2022-25 was tabled at the November committee. It was noted that the plan had been developed by the Strategic Planning Working Group, Heads of Service and Senior Managers across the HSCP. A discussion took place in relation to the outcomes, participation and engagement and reference to the clinical and care governance arrangements. The committee discussed and supported recommendation to the IJB for approval.

5.22 The annual Care Inspectorate Grades for Social Services report was reported at the November 2022 committee which outlined the care and support services which the HSCP provide or commission. The committee confirmed that they took assurance from the report.

5.23 Health and Social Care Day Services for Older People Report was reported at the November committee which provided an update on the day care services provided for older people within Fife which outlined the programme of redesign of the service following the pandemic.

5.24 The 2021/22 Fife Alcohol and Drug Partnership Annual Report was reported at the November Committee. It was noted that the report is submitted to the Government on an annual basis outlining the work taken forward around the MAT Standards.

5.25 The Violence against Women Annual Report 2021/22 was reported in January 2023 to inform and assure the committee of the work being undertaken within NHS Fife, Fife HSCP and Fife Violence against Women Partnership. The report contained 3 detailed annual reports from April 2021-March 2022 underpinning the Safe Scotland Strategy which is designed to prevent/eradicate violence against women and girls.

5.26 The Joint Inspection of Adult Services Improvement Plan was reported at the March 2023 Committee which advised between June-November 2022 the Care Inspectorate and Health Improvement Scotland carried out a joint inspection of services provided to adults with complex needs. It was acknowledged that staff were commended for their great efforts to enable the Partnership to continue to deliver good outcomes. The recommendations and improvement plan were supported for onward reporting to the Integration Joint Board.

5.27 The Mainstreaming the Equality Duty and Equality Outcomes Progress Report was reported at the March 2023 Committee. It was noted that strengthening the voice of the carer within the report would be beneficial. The report was supported for onward reporting to the Integration Joint Board.

5.28 The Fife Adult Support and Protection Committee Biennial Report 2020-22 which covered the majority of the covid pandemic lockdown was presented; it was noted that the report was assuring and very robust.

5.29 The Chief Social Work Officer's Report 2021/22 was reported at the March 2023 meeting which focussed on children and families work, children, adult and older people's health and social work and social care services. There was discussion on the report including looked after children before, during and after the pandemic.

5.30 The Review of the IJB Risk Management was discussed at the March 2023 Committee. It was highlighted that the review supports the delivery of the strategic plan and considers the development of risk appetite, the distinction between processes for IJB Strategic Risks and Partner Operational Risks and the removal of the "corporate risk" category and aligns with the new governance committees. The committee recommended this to the Integration Joint Board for approval.

5.31 The committee has also introduced development sessions in 2022/23. The first session was held in November 2023 focused on the services users lived experience and Health and Social Care Partnership Services assisted people recovery relation to drugs and alcohol. The committee found this a very powerful description of people's journeys and supported a deeper understanding of the Drugs and Alcohol Committee report. Further development sessions will be planned in 2023/24.

6. Other Highlights

6.1 Throughout the period of this annual assurance report there were no issues taken to the committee which required escalation to the IJB. The committee did however have a very active role in scrutinising reports and strategies ahead of submission to the Integration Joint Board.

6.2 The committee chair provides an update to the Integration Joint Board on all reports that are presented to the Integration Joint Board that have been considered by this committee. The committee chair also provides an update to the Integration Joint Board on the minutes of the Quality and Communities Committee.

6.3 The review of the work plan will further support the development of this committee and recognises the statutory responsibilities also held by NHS Fife and Fife Council and that there are also reports presented to the Clinical Governance Oversight Board in NHS Fife and Scrutiny Committees of Fife Council

7. Conclusion

7.1 As Chair of the Qualities & Communities Committee during financial year 2022-23, I am satisfied that the integrated approach, the frequency of meetings, the breadth of the business undertaken and the range of attendees at meetings of the Qualities & Communities Committee has allowed us to fulfil our remit. As a result of the work undertaken during the year, I can confirm that adequate and effective governance arrangements were in place in the areas under our remit.

7.2 I can confirm that that there were no significant control weaknesses or issues at the year-end which the Qualities & Communities Committee considers should be disclosed in the Governance Statement, as they may have impacted financially or otherwise in the year or thereafter.

7.3 I would pay tribute to the dedication and commitment of fellow members of the Qualities & Communities Committee and to all attendees. I would thank all those members of staff who have prepared reports and attended meetings.

Signed: Date:

Sinead Braiden
On behalf of the Qualities & Communities Committee

QUALITIES & COMMUNITIES COMMITTEE – ATTENDANCE RECORD 1st April 2021 to 31st March 2022

Members	20 April 2022	5 July 2022	9 September 2022	8 November 2022	18 January 2023	10 March 2023
Cllr Tim Brett (Chair to April 22)	√					
Sinead Braiden (Chair from July 22)	x	√	√	√	√	x
Rosemary Liewald (Vice-Chair from July 22)	√	√	√	√	√	√
Cllr David J. Ross	√					
Cllr Jan Wincott	√					
Wilma Brown	x					
Christina Cooper	√					
Martin Black (to Nov. 22)	√	x	√	√		
Graham Downie		√	√	√	√	√
Margaret Kennedy		√	√	√	X	√
Lynn Mowatt		√	√	√	√	√
Sam Steele		√	√	√	√	√
Amanda Wong		√	x	√	X	x
Kenny Murphy		√	√	√	X	x
Morna Fleming			√	√	√	√
Paul Dundas		x	x	√	√	√
Ian Dall		√	√	√	√	√

Members	**20 April 2022**	**5 July 2022**	**9 September 2022**	**8 November 2022**	**18 January 2023**	**10 March 2023**
In Attendance						
Name						
Dr Helen Hellewell (Exec Lead)	√	√	x	√	√	√
Lynn Barker	√	x	√	X	X	x
Nicky Connor	x	√	x	√	X	√
Chris McKenna	X	x	x	X	X	x
Ben Hannan	x	√	√	X	X	x
Kathy Henwood	√	√	√	X	X	√
Rona Laskowski	x	√	√	√	√	√
Fiona McKay	√	√	x	√	x	x
Lynne Garvey	√	√	√	√	√	x
Bryan Davies	x	√	x			
Lisa Cooper				√	√	√
Catherine Gilvear	√	x	√	√	√	√
Simon Fevre		√	√	√	√	√

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**5 May 2023**
Title:	**Draft Clinical Governance Committee Annual Statement of Assurance 2022-23**
Responsible Executive:	**Dr Chris McKenna, Medical Director**
Report Author:	**Gillian MacIntosh, Board Secretary**

1 Purpose

This is presented to the Committee for:

- Assurance

This report relates to a:

- Legal requirement
- Local policy

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

- Effective

2 Report summary

2.1 Situation

All formal Committees of the NHS Board are required to provide an Annual Statement of Assurance for the NHS Board, which is consider initially by the Audit & Risk Committee. The requirement for these statements is set out in the Code of Corporate Governance. The Clinical Governance Committee is invited to review a draft of this year's report and comment on its content, with a view to approving the report in a final version for onward submission.

2.2 Background

Each Committee must consider its proposed Annual Statement at the first Committee meeting of the new financial year. The current draft takes account of initial comments received from the Committee Chair.

2.3 Assessment

In addition to recording practical details such as membership and rates of attendance, the format of the report includes a more reflective and detailed section (Section 4) on agenda

business covered in the course of 2022-23, with a view to improving the level of assurance given to the NHS Board.

2.3.1 Quality/ Patient Care

Delivering robust governance across the organisation is supportive of enhanced patient care and quality standards.

2.3.2 Workforce

N/A.

2.3.3 Financial

The production and review of year-end assurance statements are a key part of the financial year-end process.

2.3.4 Risk Assessment/Management

The identification and management of risk is an important factor in providing appropriate assurance to the NHS Board.

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. Details on the Committee's review of business concerning equality and diversity is captured within the report.

2.3.6 Climate Emergency & Sustainability Impact

No direct impact, though the Committee has reviewed in reference to its recent input into the organisational strategy.

2.3.7 Communication, involvement, engagement and consultation

N/A.

2.3.8 Route to the Meeting

This paper has been considered in draft by the Committee Chair.

2.4 Recommendation

The paper is provided for:

- **Approval** – subject to members' comments regarding any amendments necessary, for final sign-off by the Chair and submission to the Audit & Risk Committee.

Report Contact
Dr Gillian MacIntosh
Head of Corporate Governance & Board Secretary
gillian.macintosh@nhs.scot

ANNUAL STATEMENT OF ASSURANCE FOR NHS FIFE CLINICAL GOVERNANCE COMMITTEE 2022/23

1. Purpose

1.1 To provide the Board with the assurance that appropriate clinical governance mechanisms and structures are in place for clinical governance to be supported effectively throughout the whole of Fife NHS Board's responsibilities.

2. Membership

2.1 During the financial year to 31 March 2023, membership of the Clinical Governance Committee comprised: -

Christina Cooper	Chair / Non-Executive Member (to November 2022)
Arlene Wood	Chair (from December 2022) / Non-Executive Member
Martin Black	Non-Executive Member (to November 2022)
Sinead Braiden	Non-Executive Member
Simon Fevre	Area Partnership Forum Representative
Cllr David Graham	Non-Executive Member (to May 2022; reappointed June 2022)
Colin Grieve	Non-Executive Member (from December 2022)
Anne Haston	Non-Executive Member (from September 2022)
Rona Laing	Non-Executive Member (to May 2022)
Aileen Lawrie	Area Clinical Forum Representative
Kirstie MacDonald	Non-Executive Member & Whistleblowing Champion
Dr Christopher McKenna	Medical Director
Dr Joy Tomlinson	Director of Public Health
Janette Keenan	Director of Nursing
Carol Potter	Chief Executive

2.2 The Committee may invite individuals to attend the Committee meetings for particular agenda items, but the Director of Acute Services, Director of Finance & Strategy, Director of Health & Social Care, Director of Pharmacy & Medicines, Deputy Medical Director (Acute Services Division), Deputy Medical Director (Fife Health & Social Care Partnership), Associate Director, Digital & Information, Associate Director of Quality & Clinical Governance and Board Secretary will normally be in attendance at Committee meetings. Other attendees, deputies and guests are recorded in the individual minutes of each Committee meeting.

2.3 As part of the recent Committee's Terms of Reference annual review, further discussion has taken place on the potential means of capturing the patient voice across the Committee's full areas of responsibility, following the decision taken not to fill the historical patient representative vacancy on the Committee. This will assist in complementing members' existing input into the review of the adequacy of patient participation and engagement measures, at both locality and service levels. This work is expected to develop over the next year, as the Committee trials new means of ensuring that the patient voice is central to its annual cycle of business.

3. Meetings

3.1 The Committee met on eight occasions during the financial year to 31 March 2023, on the undernoted dates:

- 29 April 2022
- 10 June 2022 (Development Session)
- 1 July 2022
- 2 September 2022
- 1 November 2022 (Development Session)
- 4 November 2022
- 13 January 2023
- 3 March 2023

3.2 The attendance schedule is attached at Appendix 1.

4. Business

4.1 In October 2021, the Board established a new Public Health & Wellbeing Committee, which has taken under its remit some public health-related areas previously covered by the Clinical Governance Committee. A comprehensive review of workplans and terms of reference of each committee has taken place, to limit the potential for any unnecessary duplication of effort and help clarify each committee's responsibilities over agenda items that might be tabled to more than one standing committee, as part of reporting through the governance structure. After completing its first full annual cycle of business during 2022-23, the Public Health & Wellbeing Committee has settled on a comprehensive workplan to ensure appropriate coverage of business throughout the year. This, in turn, has given the Clinical Governance Committee an opportunity for more focused agendas and enhanced scrutiny on the key aspects of business aligned to its specific remit.

4.2 The Clinical Governance Committee's first meeting of the 2022-23 reporting year took place in April 2022, with updates given to members on the high levels of activity then being experienced due to a further wave of Omicron variant Covid cases, which were particularly impacting upon staffing and general activity levels. Assurance was provided on the measures put in place to ensure the safe and effective delivery of care. The impact of the pandemic, including the effect of seasonal waves of infection, has remained a regular part of the Committee's agendas over the year, as significant pressures on the overall health and social care system continued. The Committee has kept a dedicated section on its agenda for 'active or emerging issues' not otherwise contained in its regular workplan, so members can be apprised of any areas of activity experiencing pressure due to levels of demand. In July 2022, given the background of a rapid increase in Covid cases in Fife due to two new Omicron variants then circulating, the Committee received details on the impact on staffing, limitations of visitor numbers within the inpatient estate footprint, the Covid booster vaccination programme and the enduring impact of long Covid symptoms on individuals. Members have thus been provided with the most up-to-date information on what has continued to be a rapidly changing situation with regard to the continuing impact of the pandemic on health and care services within Fife.

4.3 In April 2022, members considered a report on the governance of advanced practice roles in NHS Fife and Fife Health & Social Care Partnership, with a particular focus on Advanced Nurse Practitioners. The clinical governance aspects of the roll-out of these roles were considered, particularly the clinical supervision of these roles and the need for postholders to have adequate Continuing Personal Development processes and non-clinical time to ensure their learning is developed, in order to ensure high-quality care is delivered to patients. A briefing paper on the development of Assistant Practitioner roles was considered in detail by

the Committee at its November 2022 meeting, focusing on the possible skills mix and enhancements to clinical delivery of service via these roles, as well as the processes for accountability and delegation and the career development pathways that could be best supported by this initiative. The Committee took broad assurance from the development of the roles and the training to be put in place to support staff, welcoming the proposal in an effort to make further enhancements to the workforce.

4.4 A detailed report on the work of the Early Cancer Diagnostic Centre (ECDC) pathway was also considered by the Committee in April 2022, as we continued to see recovery in performance following the impact of the pandemic and have dedicated funding to support this trajectory for 2022/23. Around 40% of patients in Scotland are not currently diagnosed through the existing urgent suspicion of cancer pathway, with an ambition for the ECDC to capture more of these patients and support swift diagnosis and treatment. Dedicated patient navigators aid speedy progress from referral to diagnostic testing, with excellent patient feedback thus far on the effectiveness of the pathway. The Committee welcomed the greatly positive impact of the ECDC, noting that ongoing governance is provided through the Cancer Strategy Group. A dedicated Cancer Framework, and related delivery plan, has also been created, which was presented to the Committee for scrutiny in January 2023 (with a related update tabled to the following meeting in March 2023). This will support aspects of the overall organisational Population Health & Wellbeing Strategy, whilst also setting key priorities around workforce and medicines in this area. A review of progress against the delivery plan is due to come forward annually to the Committee, for assurance on the effectiveness of actions and milestone targets.

4.5 A Joint Remobilisation Plan (RMP4), outlining the planning for addressing the backlog of planned care activity following the initial phase of the Covid pandemic, was endorsed by the Committee in 2021. The Plan detailed the adopted methodology around the planning for resumption of normal services, based around a 'Respond, Recover and Renew' approach, building on earlier iterations of the Plan approved by Scottish Government. A progress update on deliverables was previously considered by the Committee at its January 2022 meeting, with a further update on achieving the RMP targets reviewed in April 2022. Assurance was provided that the majority of targets had been achieved or remained on track to be achieved. A lessons learned review of the Winter period 2021-22 activity was also encompassed in the update to the Committee, reflecting on a challenging period of extreme pressure on health and social care services. The supporting role of the Strategic Planning & Resource Allocation (SPRA) process has been recognised. The Committee considered updates on the SPRA methodology and winter actions detailed in the 2022-23 Annual Delivery Plan at its November 2022 meeting, taking assurance from the preparations being made for what would prove to be a challenging period of intense front-door activity. At the January 2023 meeting, members noted the considerable pressures on the system over the Christmas period, indicating a peak of Covid infections and respiratory illness circulating more generally. Assurance was however taken from the positive uptake of both the Covid and Seasonal Flu vaccinations across Fife, with the Board exceeding national targets for delivery of vaccinations.

4.6 The Committee's input into the development of the Board's recently approved Population Health & Wellbeing Strategy has been a regular part of this year's agendas. A report on the outcomes delivered from the previous Clinical Strategy was scrutinised by members in November 2022, following initial discussion at a full Board Development Session in October 2022. Whilst the report recognised that significant progress had been made in achieving the aims of the 2016-21Clinical Strategy, the impact of the Covid pandemic (particularly in the way the Board now operates) had been significant. The new Population Health & Wellbeing Strategy therefore aims to continue work around key priority areas begun in the Clinical Strategy, revising these to ensure these reflect new ways of working post-Covid. In January 2023, members received detail on the engagement work that has been undertaken to inform the content of the strategy, noting the importance of the ambitions being bold and ambitious, in

order to deliver the recovery of the local healthcare system after the challenges experienced during the pandemic period.

4.7 Following detailed discussion at a number of full Board Development Sessions over the reporting year, in March 2023 the Committee considered the most recent update to the Population Health & Wellbeing Strategy document, before a final version was tabled for Board approval at its meeting on 28 March 2023. Strengthening the commitments around addressing health inequalities, in addition to improving the linkages to the Fife Integration Joint Board's strategic priorities for 2023-26, were some of the issues supported by members as the strategy moved towards its final stage of drafting. Following formal Board approval of the new Population Health & Wellbeing Strategy, the Committee expects to have a significant role in the year ahead in helping shape the delivery actions and gaining assurance on progress with the various implementation actions detailed within.

4.8 Some programme workstreams to be encompassed within the new strategy are already underway, and the Committee received an update on the Year One activities of the High Risk Pain Medicines Patient Safety Programme in January 2023, taking a high level of assurance from the work undertaken thus far to prevent patient harm, address addiction and tackle linkages to involvement of prescribed medicines in drug deaths. Initial work has been undertaken to gather data, to fully understand the pertinent issues, and the production of a Stage 1 Equality Impact Assessment, to ensure equality issues are appropriately addressed, has been completed. Regular reporting of this programme will continue to the Committee in the year ahead. Related to equality issues, members have also considered the interim progress report on the Board's Equality Outcomes & Mainstreaming Plan for 2021 to 2025, reviewing the mainstreaming activity completed thus far and taking assurance from the progress made in delivering the full ambitions of the Plan.

4.9 As part of the strategy development work, a Clinical Governance Strategic Framework and Delivery Plan has been created, which is fundamental to the Board's aim to be an organisation that listens, learns and improves on a continuous basis. The Framework outlines the key clinical governance activities linked to the attainment of the Board's strategic ambitions and the enablers put in place to ensure effective delivery. The supporting governance structures underneath the Clinical Governance Committee, to ensure operationally effective scrutiny of performance with meaningful measures in place to assess quality and safety of services, is detailed fully in the new Framework, and the Committee has had input to ensure that routes of escalation to itself as the key governance body are clear and unambiguous. Approval of the Framework will also address a number of outstanding Internal Audit recommendations made across a number of reports published in the last few years, principally around the reporting line of assurance reporting to the Clinical Governance Committee. In formally endorsing the Framework at its January 2023 meeting, members noted the importance of clear and ongoing communication with staff around the priorities of the Framework, in order for its priorities to be achieved.

4.10 The draft Corporate Objectives 2022/23 were presented to the Committee in April 2022. The report described what NHS Fife aims to achieve in-year, in tandem with a looking-back review of Directors' Objectives for 2021/22. Each objective has been carefully refined, with details on what Directors are leading on or supporting more generally. Assurance was provided that there was appropriate linkage to the Health & Social Care Partnership's strategic priorities and that those objectives for Acute will require strong collaborative working to be achievable. The objectives are framed under the four key strategic priorities of the Board, as aligned to national programmes, and reference the ongoing strategy development work undertaken in this reporting year. Each Board Committee has had a role in reviewing the objective from their own specific perspective. Following review, the Committee were pleased to endorse the Corporative Objectives for onward submission to the Board for formal approval. In March 2023, as part of

the update on the Strategic Planning & Resource Allocation process for the year ahead, an initial proposal for a suite of Corporate Objectives for 2023/24 were discussed at the Committee, with members' feedback helping shape these further prior to further consideration at the May 2023 meeting and formal approval by the Board later in spring 2023.

4.11 The Committee received a presentation at its January 2023 on the service model for Fife Specialist Palliative Care Service, outlining changes made to the delivery of end-of-life care during the pandemic and the lessons learned from the patient experience since those changes were made. Challenges around the growing levels of demand for community-based services, aligned with the staffing required to deliver such care, were discussed by members. Whilst the decision-making route for approval of any service changes is via the Integration Joint Board, the clinical governance, quality and safety aspects of any proposal will come back to the Committee for consideration early in 2023/24. The Committee look forward to inputting into discussions on the best service model to be established to meet patient demand.

4.12 The Committee carefully scrutinises at each meeting key indicators in areas such as performance in relation to falls, pressure ulcers, complaints and the number of Adverse Events, via the Integrated Performance & Quality Report (IPQR). A dedicated report on Healthcare Associated Infection (HAIs) is also provided on a quarterly basis, to give assurance around the effectiveness of infection prevention, control and surveillance. Following a Board-wide review of the IPQR, reflecting the establishment of the Public Health & Wellbeing Committee, a set of performance-related metrics specific to the Committee has now been refined, to allow for appropriate, regular scrutiny of these at each meeting. Further enhancements have also been made to provide information on corporate risks within the IPQR, aligned to the various improvement outcomes. The Committee considered a report on the outcome of the IPQR review process at its July 2022 meeting and supported its recommendations on the enhancement of metrics and targets to be scrutinised by the Clinical Governance Committee.

4.13 During the pandemic and in the recovery period following thereon, strategic decisions have been made in relation to both the configuration of services and on which services could reasonably be provided. Changes to service provision have been risk assessed and the Committee has recognised that some patients may be affected by these decisions. As such, any consequences that resulted would not be considered avoidable, given that this was based on the strategic decision to prioritise services to address the pandemic. Importantly, actions to mitigate identified risks were implemented at all opportunity. The Committee considers that the local response to the pandemic, and the following recovery period into the reporting year, was appropriate, considered and aligned to Scottish Government direction. Throughout, urgent services such as cancer services and urgent care have been prioritised. Data on Hospital Standardised Mortality Ratios (HSMR) has been considered in regular reporting via the IPQR and via a standalone update given to the Committee at its November 2022 meeting (with members noting that NHS Fife's performance is in keeping with the national average). Members have noted the data and taken assurance, following discussion about the significance and interpretation of the data within the pandemic period. Also during the year, the Committee has considered data around instances of avoidable harm as detailed within the IPQR. The Committee is aware of the increase in cardiac arrest and linkages to patient deterioration, and specific assurance has been sought via the Clinical Governance Oversight Group that improvement actions are underway, with a further report anticipated at a future meeting regarding the impact and effectiveness of the improvement work. In-patient falls and hospital-acquired pressure ulcer performance has also been carefully scrutinised. Whilst assurance has been provided around the improvement work underway, the Committee is aware that the performance across both measures has not yet shifted in terms of reducing avoidable harm. Ongoing review of performance across both measures will continue to be undertaken by the Committee.

4.14 The governance route for changing or stopping services has been carefully scrutinised through the pandemic response structures of Bronze, Silver and Gold Command groups, which have again stepped up in this reporting year to manage periods of high levels of activity. Critically, clinical teams and leaders have been central to decision-making, to ensure that any potential harm resulting from cessation or service change was appropriately mitigated. Examples of mitigation include the nationally agreed surgical prioritisation framework, use of 'Near Me' for the continuance of remote appointments, and outpatient prioritisation. The dynamic nature of the pandemic and the evolving understanding of the virus has necessitated a continual review of changes, which have been considered through the command structures described and also discussed by the Committee during the year. As services continue to recover to pre-pandemic levels, the Clinical Governance Committee will continue to offer oversight, to provide assurance in relation to the recovery of services and planning for tackling increased waiting lists.

4.15 Stand-alone updates on complaints performance / patient experience and feedback have also been discussed at the Committee, noting the backdrop of a backlog of cases built up during the pandemic and a related increase in complaints as treatment delays have multiplied due to pauses in outpatient and elective surgery appointments. Recovery performance has been variable, with the need to pause some complaint activity during the year at times of extreme pressure on staff, exacerbated also by the issue of staff shortage within the Patient Experience team. Enhancements in reporting to the Committee have been introduced, to provide more meaningful data around patient feedback and experience and analysis / learning from themes and trends, progressed by a new Organisational Learning Group. The Committee heard detail on the Recovery & Improvement Plan at its meeting in April 2022, to be supported by more nuanced quarterly reporting to the Committee that will give a broader view of the types of feedback submitted. In September 2022, focus was given to the feedback left by patients and families on Care Opinion, 80% of which was positive about the service respondents had received. Further investment has been made into the Patient Experience team, via the secondment of staff who had previously been part of the Test & Protect Covid response. Benchmarking against other territorial boards has also been undertaken, to explore new ways of working and to enhance process mapping understanding. In November 2022, the Committee received a further update on performance, noting the planned improvement activities being undertaken by a new Head of Patient Experience, particularly around processes aimed at meeting the 20 day target for complaint responses. Whilst NHS Fife continues to struggle to achieve this target, despite the initiatives cited above, it has been noted that the position is broadly similar across all other NHS Boards, reflecting the system-wide pressures on staff and services as the effects of the pandemic continue to be felt.

4.16 In relation to the Organisational Duty of Candour 2021/22 report, delays to its publication (related to the pandemic impacting upon timeliness of the adverse events process) were highlighted in the Internal Audit Annual Report 2021/22, considered by the Committee at its meeting in July 2022, where it was noted that there had been limited reporting to the Committee on cases occurring during the 2020/21 reporting year. Members agreed that backlog in reporting was unsatisfactory and requested an update as soon as information allowed. The final report, outlining the Board's compliance with the relevant legislation and detailing the number of cases that had triggered Duty of Candour processes, was tabled to the Committee at its March 2023 meeting, prior to its formal approval by the Board at their meeting on 28 March 2023. There were 36 adverse events detailed within the report, with the most common outcome (for 20 patients) being an increase in their treatment. A number of areas of strength have been identified, including notifying the person and providing details of the incident, provision of an apology, reviewing all cases and offering support and assistance.

4.17 Further detail on a national spike in neonatal adverse events was considered in private session at the Committee's July 2022 meeting, with information given on the local position. Assurance

was taken that the forthcoming national review being undertaken by Healthcare Improvement Scotland (HIS), to better understand any potential linkages between a clusters of cases of neonatal mortality occurring in 2020/21 (detail of which was presented to the September and November 2022 meetings), would have NHS Fife's full participation, and that local significant adverse event reviews of relevant cases (assisted by external reviewers from Greater Glasgow & Clyde Health Board) would still be undertaken to provide the required assurance around the quality of our own processes and importantly to capture any areas of learning. The Committee has also considered (in November 2022 and March 2023) a report reviewing the deaths of Children and Young People in Fife, this being produced to address national guidance introduced in 2021 to learn from and prevent unnecessary deaths. A multi-disciplinary and multi-agency review group was established to take forward the review, and the full implementation of the national guidance is on track to be completed. Members took assurance from the first year of reporting, noting the governance arrangements and the robust implementation of the national review guidance within Fife.

4.18 In January and March 2023, members considered the issues raised by a letter to all NHSScotland Boards from Healthcare Improvement Scotland's Director of Quality Assurance, highlighting general concerns raised via a number of recent Safe Delivery of Care Inspections of acute hospitals across Scotland. The issues cited within reflected the exceptional winter pressures experienced by Scottish hospitals, including potential overcrowding in emergency departments and admission units, heavy use of supplementary staffing, pressures on staff health and wellbeing, the criticality of appropriate medicines governance, and the need for visible and active leadership on-site in clinical areas. Although focused on the results of acute inspections, members recognised that addressing all the action points required nothing less than a whole-system approach, to be achieved through close working with Fife Health & Social Care Partnership colleagues. An action plan has been developed to address the issues raised by HIS, to be supported by a series of 'mock inspections', to provide assurance that lessons learned from the HIS inspections would be carefully reviewed against practice within the Victoria Hospital.

4.19 In January 2023, members reviewed the learning from a Breast Screening Programme adverse event linked to nationally provided equipment, with assurance taken from Fife's local response to the issues raised by this incident. In March 2023, members considered a detailed paper benchmarking Fife against the learning from the Ockenden Report, an independent review of maternity services delivered at the Shrewsbury & Telford Hospital NHS Trust. This report outlined a number of essential actions to be taken in response to new-born, infant and maternal harm at the Trust. Whilst some actions were specific to the Trust alone, a number of more general recommendations for maternity care were made in the report, which offers an opportunity to implement learning within Fife. The paper gave important assurance that NHS Fife's maternity service had carefully benchmarked its activities against the system-wide recommendations made in the Ockenden Report and had identified areas where action was needed, to help improve the quality and safety of maternity care available to mothers and babies born within the service.

4.20 Annual reports were received on the subjects of: Radiation Protection; the work of the Clinical Advisory Panel; the Director of Public Health Annual Report 2020-21; Nursing, Midwifery & Allied Health Professionals' Assurance Framework; Occupational Health & Wellbeing Service 2021-22; Integrated Screening; Medical Education; Medical Appraisal & Revalidation; Prevention & Control of Infection; Management of Controlled Drugs; Volunteering; Research & Development Strategy & the Research, Innovation & Knowledge Annual Review; and any relevant Internal Audit reports that fall under the Committee's remit, such as those on Resilience Planning.

4.21 The Committee has received minutes and assurance reports from its three sub-groups, namely the Digital & Information Board, Health & Safety Sub-Committee, and the Information Governance & Security Steering Group, detailing their business during the reporting year. As agreed previously, guidance and a template for the format of sub-groups annual assurance statements has been created for the groups to follow, to improve the consistency and content of information provided, and the annual reports of each of the groups have been reviewed at the Committee's May 2023 meeting. An additional assurance statement has also been submitted from the Clinical Governance Oversight Group, considered by the Committee at its meeting in September 2022, outlining the range of activities being taken forward by the group, in support of the clinical effectiveness agenda. It is hoped that the timing of this in future will be able to be aligned to the other formal assurance reports submitted to the Committee at financial year end.

4.22 In reference to the Health & Safety Sub-Committee, the annual assurance statement from the group outlines the additional staffing changes made in year to strengthen the team. These include the appointment of a new Health & Safety Manager, a managerial post dedicated to Health & Safety projects, and a number of new posts to enhance Manual Handling and Violence & Aggression compliance and training. Workstreams undertaken during the year include Face Fit refresher training for staff and ligature risk assessments across several NHS Fife sites. In relation to enhancing safety around usage and disposal of sharps, whilst the reestablishment of the Sharps Strategy Group has stalled due to continuing pressures on clinical staff, sharps has been added as a standing item to the Acute Services & Corporate Directorates Local Partnership Forum meetings, to enhance scrutiny in this area. The introduction of an Acute Services Health & Safety Committee has also recently been approved. There was no Health & Safety Executive enforcement undertaken during the year within NHS Fife. Noting the detail of the Health & Safety Sub-Committee's activities, the Clinical Governance Committee can take broad assurance from the work undertaken on its behalf during the reporting year.

4.23 The Digital & Information Board has continued to develop the governance, process and controls necessary to assure the organisation about the consideration and delivery of the Digital & Information Strategy and associated delivery plan. Specifically, this relates to ensuring progress is made with delivering the strategic ambition, relating to year four of NHS Fife's Digital and Information Strategy (2019-2024), and ensuring the maintenance and improvement in performance across Digital & Information technical and operational teams. This work has included consideration of a number of significant and outstanding Internal Audit findings given in previous reports, as well as the action points from previous NIS audits. The Committee considered an update report at its meeting in July 2022, noting the progress across a number of key areas, including Phase 2 of the 'Near Me' virtual appointments programme, approval of the Board's Record Management Plan, and further digital enhancements to support the operation of the National Treatment Centre Fife Orthopaedics. Members noted delays to the implementation of Hospital Electronic Prescribing and Medicines Automation (HEPMA). Contractual negotiations did not proceed as planned, which has delayed the project considerably from its original due date. However, the Committee has received assurance that the positive clinical impact and transformational benefits of the introduction of HEPMA remain undiminished and a new procurement process (as detailed in a report to the Committee in private session in July 2022) has begun to move this work forward. The impact of the pandemic on initiatives such as Paperlite electronic patient record has also slowed planned roll-out, however progress in these areas will continue to be closely monitored by the Committee. A further update on the progress of delivery of the Digital Strategy, and a stand-alone report on the Keeper of the Registers of Scotland's Report assessing the Board's Records Management Plan, was considered by members in January 2023, with members taking considerable assurance from the progress made in delivery of the related programmes of work.

4.24 During the pandemic period, there has been unprecedented change in the areas of digital adoption, for staff, patients and the public in general. There has been continued demand for the implementation of new or existing technologies through the digital health and care request process. Additional consideration has been given to the revised resource model across Digital teams, as they continue to deal with the demand, whilst matching the responsibilities to operate the additional digital capabilities. Improvements to the recruitment of a more permanent workforce and reduced reliance on temporary and fixed term resources is being progressed. Via the number of updates throughout the year, the Committee were assured that Digital & Information colleagues will take due account of such demand as the Board continues to deliver the key ambitions of the Digital & Information Strategy, noting that these will be scrutinised and prioritised in accordance with the individual programmes and workstreams of the new organisational strategy. A revised engagement model has been established, which ensures the correct level of clinical and leadership engagement with digital developments, including the prioritisation of projects reflecting clinical effectiveness and safety issues, to help manage excess demand. The annual Assurance Statement of the Digital & Information Board provides further detail on the Group's activities, as considered by the Committee at its May 2023 meeting. During the year, 15 risks aligned to the Digital & Information Board improved their rating, 5 moved to the target risk rating (and thus moved to the status of monitoring) and 4 risks were closed. No significant issues have been escalated for disclosure in the Governance Statement and the Clinical Governance Committee can take broad assurance from the work undertaken by the Digital & Information Board over 2022-23.

4.25 The Clinical Governance Committee has also considered updates from the Information Governance & Security Steering Group. The Group has reviewed reports (in September 2022 and March 2023) detailing the current baseline of performance and controls within the remit of Information Governance & Security activities, recognising that whilst compliance and assurance in some areas is effective, in others improvement in data availability and reporting is necessary to ensure the confidentiality, availability and integrity of patient, corporate and staff information. The Group have adopted a set of performance measures and a defined workplan, with projects and deliverables associated across outcomes per quarter. This, in turn, brings assurance to support a strong baseline of performance in the area of Information Governance & Security, with improvement against key controls to better measure performance. Key measures reviewed throughout the year included: monthly Subject Access Request data; point-in-time Information Asset Register figures; Information Governance training compliance; monthly Freedom of Information performance; current policy and procedure review information; Network and Information Security Directive (NISD) compliance at time of audit; monthly adverse event reporting; and summary information on reportable incidents to the Information Commissioner's Office / Competent Authority.

4.26 Throughout the year, the Group were presented with a consistent summary risk profile by risk rating and information relating to the improvement or deterioration of risk during the period. Key areas under the Group's scrutiny include Data Protection and GDPR; Freedom of Information; Public Records; and the National Information Security Directive (NISD), including audit against this framework. Visualisation of the risk profile, which amounted to 26 in number over the year, supported the critique and assurance the Group were able to offer after consideration of individual workstream reports and overall activity tracker. In year, focus has been on data sharing agreements with GPs and external contractors; the processes around addressing Subject Access Requests (SARs) to improve timeliness of response; actions required following the Keeper of the Records of Scotland's approval of NHS Fife's Records Management Plan; and compliance activities mapped against the Information Commissioner's Office Accountability Framework and NISD Framework. For the most recently reported NIS audit, NHS Fife achieved a compliance score of 76%, indicating steady improvement from the 69% achieved in the 2021 audit. During the period, nine risks aligned to the Steering Group

improved their rating, one risk deteriorated during the period, three equalled their target risk rating (and thus moved to a status of monitoring) and five risks were closed. There are no issues identified that require disclosure within the Governance Statement, which is continuing testament to improvements made across the domain of Information Governance & Security in the reporting year.

4.27 New for this year to the Committee's workplan has been enhanced reporting around resilience and emergency planning, culminating in a new annual assurance statement being submitted from the Resilience Forum to provide members with greater detail around the further development of business continuity plans within NHS Fife. An Internal Audit report (tabled to the Committee in April 2022) indicated a lack of effectiveness around resilience arrangements, notwithstanding the emergency response swiftly enacted during the pandemic, signifying a potentially high risk to the Board in this area. A new Head of Resilience appointed in spring 2022 is progressing areas of focussed work around emergency planning, resilience guidance documents and Business Continuity Planning across the organisation, thereby addressing the audit points raised in the report. An update outlining the workstreams being taken forward to make improvements in this area was considered by the Committee in April 2022, to be supported by a number of workshops and real-life scenarios to be run for key operational groups to help identify where resilience planning needed to be strengthened. A further paper was considered by members in July 2022, focused on progress in implementing the various internal audit recommendations and clarifying future reporting arrangements, including regular updates to the Executive Directors' Group, particularly around testing and exercising, business continuity and Major Incident Plan development. In March 2023, the Resilience Annual Report was considered by members, containing details of activity across the full range of major incident planning and business continuity work, and this has been supported by a formal annual statement of assurance from the Resilience Forum, considered at the Committee's May 2023 meeting. The statement of assurance concludes that partial assurance can be taken from the developing and maturing process around emergency planning, noting that the Major Incident Plan framework remains under revision, following initial consideration by EDG. The completion of Business Continuity Plans for all relevant service areas is being progressed to completion over a longer timescale than previously intended. The majority of plans (95) have now been approved, with the remainder (38) in progress of being drafted. The Corporate Risk Register currently records a moderate level of risk within Emergency Planning & Business Continuity, reflecting the developing status of processes within this area as the team continues to work towards full compliance with statutory requirements and best practice guidance detailed in the Civil Contingencies Act 2004 and the NHS Scotland standards for Resilience.

4.28 An annual statement of assurance has also been received and considered from the Quality & Communities Committee of the Integration Joint Board, detailing how clinical & care governance mechanisms are in place within all Divisions of the Fife Health & Social Care Partnership and that systems exist to make these effective throughout their areas of responsibility. The Committee has gone major restructuring during the reporting year and is working towards implementing its full Terms of Reference, recognising the significant change in membership and function over 2022-23. Progress has been made, as detailed further in the Committee's annual assurance statement, with plans for further development of agendas and workplan to reflect all areas of the Committee's remit in the year ahead.

4.29 The Committee has held a series of dedicated Development Sessions throughout the year, allowing members to gain a greater understanding and to receive detailed briefings on a number of topics. In June 2022, a session with the Committee discussed the Edinburgh Cancer Centre reprovision and the proposed regional service model, with a particular focus on the potential impact on NHS Fife regarding the optimisation of pathways. The briefing helped assist members in their understanding of the programme of work, prior to the Committee's formal consideration of the relevant Initial Agreement at its July 2022 meeting, aided by a presentation

from colleagues from NHS Lothian. The June 2022 Development Session also received a presentation from the Research, Innovation & Knowledge team (RIK), complementing their formal route of reporting into the Committee across the year. At the following Committee meeting in July 2022, members considered in detail the Data Sharing Agreement for a use case demonstration project with DataLoch, to support the evaluation of NHS Fife business needs and strategies as informed by real-life data. Given the complexity around this, the earlier Development Session from the RIK team helped aid members' understanding of the formal proposal brought subsequently to the Committee.

4.30 The November 2022 Development Session saw presentations from clinical teams on E-Coli Bacteraemia, to support the Committee's knowledge around HAI surveillance and performance, and detail on the cancer services provided in Fife in relation to the draft Cancer Framework which was then presented for endorsement to the Committee in January 2023. Members welcomed the assurance given by the clinical specialists and appreciated the opportunity to ask questions directly of the relevant specialists in these areas.

4.31 Minutes of Clinical Governance Committee meetings have been subsequently approved by the Committee and presented to Fife NHS Board. The Board also receives a verbal update at each meeting from the Chair, highlighting any key issues discussed by the Committee at its preceding meeting. The Committee maintains a rolling action log to record and manage actions agreed from each meeting, and reviews progress against deadline dates at subsequent meetings. The format of the action log has been enhanced, to provide greater clarity on priority actions and their due dates.

5. Best Value

5.1 Since 2013/14 the Board has been required to provide overt assurance on Best Value. A revised Best Value Framework was considered and agreed by the NHS Board in January 2018. Appendix 2 provides evidence of where and when the Committee considered the relevant characteristics during 2022/23.

6. Risk Management

6.1 In line with the Board's agreed risk management arrangements, NHS Fife Clinical Governance Committee, as a governance committee of the Board, has considered risk through a range of reports and scrutiny, including oversight on the detail of the Board Assurance Framework (BAF) in the areas of Quality & Safety and Digital & Information, and via its aligned risks assigned to it under the new Corporate Risk Register introduced in this reporting year. Progress and appropriate actions were noted. In addition, many of the Committee's requested reports in relation to active and emerging issues have been commissioned on a risk-based approach, to focus members' attention on areas that were central to the Board's priorities around care and service delivery, particularly during challenging periods of activity.

6.2 From May 2022, the Public Health & Wellbeing Committee took over detailed scrutiny of the Strategic Planning Board Assurance Framework (BAF). Improvement to the risk level has been seen in-year, due to the detailed work undertaken to creating the required structures, engagement activities and governance to support the development of the Board's new Population Health & Wellbeing Strategy and full resourcing of the Corporate Programme Management Office. As part of the move to a refreshed Corporate Risk Register during 2022/23, a new risk has been drafted around the effectiveness of strategy and its delivery, which will be monitored closely by the Public Health & Wellbeing Committee in the year ahead.

6.3 The replacement of the BAF by the Corporate Risk Register has allowed for revision of the key strategic risks reported to the Board, along with presentation improvements to aid clarity of

members' understanding. The Committee considered the full set of draft Corporate Strategic Risks at its meeting in September 2022, noting the proposed 18 risks, their mapping against the Board's strategic priorities, and the proposed visual presentation of these in report form. Linkages to the Board's overall risk appetite have been discussed with members, noting that for those individual metrics currently facing a risk profile in excess of the Board's agreed appetite, a degree of tolerance has been agreed, given the scale of external challenges at this time.

6.4 During the year, in relation to Quality & Safety, the Committee has specifically considered the overall component of this BAF, along with its linked operational risks. In April 2022, the potential impact on quality of care and safety of services from reduced nursing and midwifery staffing levels was carefully considered by members, this also being linked to Staff Governance Committee's own scrutiny of the dedicated Workforce BAF. Given the likely negative impact upon patient safety through reduced staffing levels, the linkage of the risk to both BAFs was supported by members. Additional discussions on this BAF have focused on Cancer Waiting Times Access Standards and Covid-related risks, including Public Health oversight of care homes. The Quality & Safety BAF remained unchanged for the Committee's July and September 2022 meeting, prior to its replacement by the Corporate Risk Register.

6.5 In relation to Digital & Information risks, the alignment of risks to the two subordinate governance groups (the Digital & Information Board and the Information & Security Steering Group) has been completed, to reflect core operational, strategic and information security risks critical to the organisation and enhanced framing within the overall Digital Strategy. A number of risks have heightened during the year, including those related to the overall cyber threat landscape, given the conflict in Ukraine. In July 2022, this risk was reduced to moderate, to reflect the introduction of new mitigating actions to limit the potential for a cyber-attack on NHS Fife. Also reduced during the year was the risk of additional financial costs from the Office365 national licensing agreement, and the Digital & Information financial position more generally, given the conclusion of prioritisation activity as part of the annual SPRA process. It has been agreed that the move from the BAF to the new presentation of the Corporate Risk Register will allow for a reassessment of the visibility of operational risks, such as those linked to the replacement Laboratory Information Management System (LIMS), which has been the subject of Board-level discussions in-year. A stand-alone paper detailing the mitigation of risks in reference to the LIMS project has also been considered by the Committee at its November 2022 meeting.

6.6 The replacement of the BAF by the Corporate Risk Register has allowed for revision of the key strategic risks reported to the Board, along with presentation improvements to aid clarity of members' understanding. The Committee considered the full set of draft Corporate Strategic Risks at its meeting in September 2022, noting the proposed 18 risks, their mapping against the Board's strategic priorities, and the proposed visual presentation of these in report form. Linkages to the Board's overall risk appetite have been discussed with members, noting that for those individual metrics currently facing a risk profile in excess of the Board's agreed appetite, a degree of tolerance has been agreed, given the scale of external challenges at this time.

6.7 In November 2022, members considered in detail the six individual risks aligned to the Clinical Governance Committee, presented in the new Corporate Risk Register format. It is noted that refinement of these will continue over the coming year, as the new risk presentation beds in. The risks aligned specifically to the Clinical Governance Committee cover the areas of optimal clinical outcomes; quality of care provided; the ongoing impact of Covid, particularly on those most at risk from severe outcomes; and delivery of the Digital & Information strategy and cyber resilience measures, against a difficult backdrop of financial challenges. In addition to the summary presentation of the aligned risks at all meetings since November 2022, members

have received deep-dive information on the Digital & Information risk (November 2022) and the Covid-19 pandemic risk (March 2023), with in-depth review of Optimal Clinical Outcomes corporate risk scheduled for May 2023. Deep dives allow for greater scrutiny of the root causes of risks and discussion on the effectiveness of management actions in place to reduce risk levels. This area of the new risk management approach is expected to mature in the year ahead, to provide members with the necessary levels of assurance on the effectiveness of mitigating actions.

7. Self-Assessment

7.1 The Committee has undertaken a self-assessment of its own effectiveness, utilising a revised questionnaire considered and approved by the Committee Chair. Attendees were also invited to participate in this exercise, which was carried out via an easily accessible online portal. A report summarising the findings of the survey was considered and approved by the Committee at its March 2023 meeting, and action points are being taken forward at both Committee and Board level.

8. Conclusion

8.1 As Chair of the Clinical Governance Committee, I am satisfied that the integrated approach, the frequency of meetings, the breadth of the business undertaken and the range of attendees at meetings of the Committee has allowed us to fulfil our remit as detailed in the Code of Corporate Governance. As a result of the work undertaken during the year, I can confirm that adequate and effective governance arrangements were in place throughout NHS Fife during the year.

8.2 I can confirm that that there were no significant control weaknesses or issues at the year-end which the Committee considers should be disclosed in the Governance Statement, as they may have impacted financially or otherwise in the year or thereafter.

8.3 I would pay tribute to the dedication and commitment of fellow members of the Committee and to all attendees. I would thank all those members of staff who have prepared reports and attended meetings of the Committee.

Signed: Date: ** May 2023

Arlene Wood, Chair
On behalf of the Clinical Governance Committee

Appendix 1 – Attendance Schedule
Appendix 2 – Best Value

NHS Fife Clinical Governance Committee Attendance Record
1 April 2022 to 31 March 2023

	29.04.22	10.06.22	01.07.22	02.09.22	04.11.22	13.01.23	03.03.23
Members							
C Cooper, Non-Executive Member **(Chair)**	P	P	P	P	P		
A Wood, Non-Executive Member **(Chair)**	P	P	P	P	x	P	P
M Black, Non-Executive Member	P	x	P	P	P		
S Braiden, Non-Executive Member	P	P	x	P	x	P	P
S Fevre, Area Partnership Forum Representative	P	P	P	P	P	P	P
Cllr D Graham, Stakeholder Member, Fife Council	x						
C Grieve, Non-Executive Member					P Observing	P	P
A Haston, Non-Executive Member				P	P	P	P
R Laing, Non-Executive Member	x						
A Lawrie, Area Clinical Forum Representative	x	x	P	x	P	P	x
K MacDonald, Non-Executive Whistleblowing Champion		P	x	P	P	P	P
C McKenna, Medical Director **(Exec Lead)**	P	P	x	P	P	P	P
J Keenan (Previously Owens), Director of Nursing	P	P	P	P	P	P	P
C Potter, Chief Executive	x	P	x	P	P Part	P Part	x
J Tomlinson, Director of Public Health	x	P	P	x	x	P	P
In Attendance							
A Akhtar, Orthopaedics Consultant		P Item 4					
L Barker, Associate Director of Nursing				P	P		
N Beveridge, Head of Nursing						P	
J Bowden, Palliative Care Consultant		P Item 4				P	
J Brown, Head of Pharmacy			P				
L Campbell, Associate Director of Nursing				P			
N Connor, Director of H&SC	P	P	P Part	x	P	P	P

APPENDIX 1

	29.04.22	10.06.22	01.07.22	02.09.22	04.11.22	13.01.23	03.03.23
G Couser, Associate Director of Quality & Clinical Governance	x	x	x	x			
S Cosens, NHS Lothian			P Item 7.1				
P Cumming, Risk Manager	P Item 5.5			P Item 7			
D Dhasmana, Respiratory Medicine Consultant		P					
C Dobson, Director of Acute Services	P	P	P	P	P	P	P
S Fraser, Associate Director of Planning & Performance			P Part			P	P
A Graham, Associate Director of Digital & Information	P	P	P	P	P	P	P
K Gray, Research & Development Lead Nurse		P Item 4					
B Hannan, Director of Pharmacy & Medicines	P	x	x	P	P	P	P
S Harrow, NHS Lothian			P Item 7.1				
H Hellewell, Associate Medical Director, H&SCP	P	x	P	x	P	P	P
G MacIntosh, Head of Corporate Governance & Board Secretary	P	x	P	P	P	P	P
A MacKay, Speech & Language Therapy Operational Lead	P Observing						
S McCormack, Associate Medical Director for Emergency Care and Planned Care							P Observing
N McCormick, Director of Property & Asset Management							P
M McGurk, Director of Finance & Strategy	P Part	P	P	P	P	P	P
D Miller, Director of Workforce						P	
J Morrice, AMD, Women & Children Services	x	P	x	x	x	x	x
E Muir, Clinical Effectiveness Manager	P	P	P	x	P	P	P
K Nicoll, Cancer Transformation Manager		P Item 4					
G Ogden, Head of Nursing					P		P
E O'Keefe, Consultant in Dental Public Health	P Item 6.2			P	P		
M Paterson, Head of Nursing	P	P					
F Quirk, Assistant Research & Development Director		P Item 4	P Item 7.2				
C Reid, NHS Lothian			P Item 7.1				

APPENDIX 1

	29.04.22	10.06.22	01.07.22	02.09.22	04.11.22	13.01.23	03.03.23
S A Savage, Interim Associated Director of Quality & Clinical Governance					P Observing	P	P
M Wood, Interim Associate Medical Director for Surgery, Medicines & Diagnostics	x	x	x	x			
K Wright, Clinical Services Manager						P Item 8.5	

Best Value Framework

Vision and Leadership

A Best Value organisation will have in place a clear vision and strategic direction for what it will do to contribute to the delivery of improved outcomes for Scotland's people, making Scotland a better place to live and a more prosperous and successful country. The strategy will display a clear sense of purpose and place and be effectively communicated to all staff and stakeholders. The strategy will show a clear direction of travel and will be led by Senior Staff in an open and inclusive leadership approach, underpinned by clear plans and strategies (aligned to resources) which reflect a commitment to continuous improvement.

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
The strategic plan is translated into annual operational plans with meaningful, achievable actions and outcomes and clear responsibility for action.	Winter Plan Capacity Plan	**FINANCE, PERFORMANCE & RESOURCES COMMITTEE** **CLINICAL GOVERNANCE COMMITTEE** **BOARD**	Annual Bi-monthly Bi-monthly	Winter Plan review NHS Fife Clinical Governance Workplan is approved annually and kept up to date on a rolling basis Minutes from Linked Committees e.g. · NHS Fife Area Drugs & Therapeutics Committee · Acute Services Division, Clinical Governance Committee · NHS Fife Infection Control Committee · NHS Fife H&SCP Quality & Communities Committee NHS Fife Integrated Performance & Quality Report is considered at every meeting

Governance and Accountability

The "Governance and Accountability" theme focuses on how a Best Value organisation achieves effective governance arrangements, which help support Executive and Non-Executive leadership decision-making, provide suitable assurances to stakeholders on how all available resources are being used in delivering outcomes and give accessible explanation of the activities of the organisation and the outcomes delivered.

A Best Value organisation will be able to demonstrate structures, policies and leadership behaviours which support the application of good standards of governance and accountability in how the organisation is improving efficiency, focusing on priorities and achieving value for money in delivering its outcomes. These good standards will be reflected in clear roles, responsibilities and relationships within the organisation. Good governance arrangements will provide the supporting framework for the overall delivery of Best Value and will ensure openness and transparency. Public reporting should show the impact of the organisations activities, with clear links between the activities and what outcomes are being delivered to customers and stakeholders. Good governance provides an assurance that the organisation has a suitable focus on continuous improvement and quality. Out with the organisation, good governance will show itself through an organisational commitment to public performance reporting about the quality of activities being delivered and commitments for future delivery.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
Board and Committee decision-making processes are open and transparent.	Board meetings are held in open session and minutes are publicly available. Committee papers and minutes are publicly available	**BOARD** **COMMITTEES**	Ongoing	Strategy updates considered regularly Via the NHS Fife website
Board and Committee decision-making processes are based on evidence that can show clear links between activities and outcomes	Reports for decision to be considered by Board and Committees should clearly describe the evidence underpinning the proposed decision.	**BOARD** **COMMITTEES**	Ongoing	SBAR reports EQIA section on all reports

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
NHS Fife has developed and implemented an effective and accessible complaints system in line with Scottish Public Services Ombudsman guidance.	Complaints system in place and regular complaints monitoring.	**CLINICAL GOVERNANCE COMMTTEE**	Ongoing Bi-monthly	Single complaints process across Fife health & social care system NHS Fife Integrated Performance & Quality Report is discussed at every meeting. Complaints are monitored through the report.
NHS Fife can demonstrate that it has clear mechanisms for receiving feedback from service users and responds positively to issues raised.	Annual feedback Individual feedback	**CLINICAL GOVERNANCE COMMITTEE**	Ongoing Bi-monthly	Update on Participation & Engagement processes and groups undertaken during the reporting year. NHS Fife Integrated Performance & Quality Report is discussed at every meeting. Complaints are monitored through the report.

Use of Resources

The “Use of Resources” theme focuses on how a Best Value organisation ensures that it makes effective, risk-aware and evidence-based decisions on the use of all of its resources.

A Best Value organisation will show that it is conscious of being publicly funded in everything it does. The organisation will be able to show how its effective management of all resources (including staff, assets, information and communications technology (ICT), procurement and knowledge) is contributing to delivery of specific outcomes.

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
There is a robust information governance framework in place that ensures proper recording and transparency of all NHS Fife’s activities.	Information & Security Governance Steering Group Annual Report Digital & Information Board Annual Report Digital & Information Board minutes	**CLINICAL GOVERNANCE COMMITTEE**	Annual	Minutes and Annual Report considered, in addition to related Internal Audit reports. Reporting format and content has been enhanced in current year.
NHS Fife understands and exploits the value of the data and information it holds.	Remobilisation Plan Integrated Performance & Quality Report	**BOARD** **COMMITTEES**	Annual Bi-monthly	Integrated Performance & Quality Report considered at every meeting Particular review of performance in relation to pressure ulcers, falls, catheter infections and E Coli undertaken in current year

Performance Management

The "Performance Management" theme focuses on how a Best Value organisation embeds a culture and supporting processes which ensures that it has a clear and accurate understanding of how all parts of the organisation are performing and that, based on this knowledge, it takes action that leads to demonstrable continuous improvement in performance and outcomes.

A Best Value organisation will ensure that robust arrangements are in place to monitor the achievement of outcomes (possibly delivered across multiple partnerships) as well as reporting on specific activities and projects. It will use intelligence to make open and transparent decisions within a culture which is action and improvement oriented and manages risk. The organisation will provide a clear line of sight from individual actions through to the National Outcomes and the National Performance Framework. The measures used to manage and report on performance will also enable the organisation to provide assurances on quality and link this to continuous improvement and the delivery of efficient and effective outcomes.

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
Performance is systematically measured across all key areas of activity and associated reporting provides an understanding of whether the organisation is on track to achieve its short and long-term strategic, operational and quality objectives	Integrated Performance & Quality Report encompassing all aspects of operational performance, Annual Operational Plan targets / measures, and financial, clinical and staff governance metrics. The Board delegates to Committees the scrutiny of performance Board receives full Integrated Performance & Quality Report and notification of any issues for escalation from Committees.	**COMMITTEES** **BOARD**	Every meeting	Integrated Performance & Quality Report considered at every meeting Minutes from Linked Committees e.g. · Area Drugs & Therapeutics Committee · Acute Services Division, Clinical Governance Committee · Digital & Information Board · Infection Control Committee · Information Governance & Security Steering Group
The Board and its Committees approve the format and content of the performance reports they receive	The Board / Committees review the Integrated Performance & Quality Report and agree the measures.	**COMMITTEES** **BOARD**	Annual	Integrated Performance & Quality Report considered at every meetings. Review of format and content is being undertaken in reporting year.
Reports are honest and balanced and subject to	Committee Minutes show scrutiny and challenge when performance	**COMMITTEES**	Every meeting	Integrated Performance & Quality Report considered at

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
proportionate and appropriate scrutiny and challenge from the Board and its Committees.	is poor as well as good; with escalation of issues to the Board as required	**BOARD**		every meetings Minutes of Linked Committees are reported at every meeting, with improved process for escalation of issues.
The Board has received assurance on the accuracy of data used for performance monitoring.	Performance reporting information uses validated data.	**COMMITTEES** **BOARD**	Every meeting Annual	Integrated Performance & Quality Report considered at every meeting The Committee commissions further reports on any areas of concern, e.g. as with complaints, adverse events.
NHS Fife's performance management system is effective in addressing areas of underperformance, identifying the scope for improvement, agreeing remedial action, sharing good practice and monitoring implementation.	Encompassed within the Integrated Performance & Quality Report	**COMMITTEES** **BOARD**	Every meeting	Integrated Performance & Quality Report considered at every meeting Minutes of Linked Committees · Area Clinical Forum · Acute Services Division, Clinical Governance Committee · Area Drugs & Therapeutics Committee

Cross-Cutting Theme – Equality

The "Equality" theme is one of the two cross-cutting themes and focuses on how a Best Value organisation has embedded an equalities focus which will secure continuous improvement in delivering equality.

Equality is integral to all our work as demonstrated by its positioning as a cross-cutting theme. Public Bodies have a range of legal duties and responsibilities with regard to equality. A Best Value organisation will demonstrate that consideration of equality issues is embedded in its vision and strategic direction and throughout all of its work.

The equality impact of policies and practices delivered through partnerships should always be considered. A focus on setting equality outcomes at the individual Public Body level will also encourage equality to be considered at the partnership level.

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE:
NHS Fife meets the requirements of equality legislation.		**BOARD** **COMMITTEES**	Ongoing	Strategy updates regularly considered, along with People with Planning updates in current year All strategies have a completed EQIA
The Board and senior managers understand the diversity of their customers and stakeholders.	Equality Impact Assessments are reported to the Board and Committees as required and identify the diverse range of stakeholders.	**BOARD** **COMMITTEES**	Ongoing	Strategy updates regularly considered All strategies have a completed EQIA
NHS Fife's policies, functions and service planning overtly consider the different current and future needs and access requirements of groups within the community.	In accordance with the Equality and Impact Assessment Policy, Impact Assessments consider the current and future needs and access requirements of the groups within the community.	**BOARD** **COMMITTEES**	Ongoing	All NHS Fife policies have a EQIA completed and approved. The EQIA is published alongside the policy when uploaded onto the website
Wherever relevant, NHS	In accordance with the Equality	**BOARD**	Ongoing	Update on Participation &

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE:
Fife collects information and data on the impact of policies, services and functions on different equality groups to help inform future decisions.	and Impact Assessment Policy, Impact Assessments will collect this information to inform future decisions.	**COMMITTEES**		Engagement processes and groups undertaken during the reporting year, which encompassed effectiveness of engagement with key groups of users

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**5 May 2023**
Title:	**Corporate Risks Aligned to the Clinical Governance Committee**
Responsible Executive:	**Dr Chris McKenna, Medical Director, NHS Fife**
Report Author:	**Pauline Cumming, Risk Manager, NHS Fife**

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Annual Delivery Plan
- Emerging issue
- 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 is brought as part of the fourth cycle of reporting on the corporate risks to the governance committees. It provides an update on the current status of the risks aligned to this Committee since the last report on 3 March 2023.

The Committee is invited to:

- Note the Corporate Risk detail as at 25 April 2023 at Appendix 1;
- Consider the Deep Dive Review at Appendix 2;
- Review all information provided against the Assurance Principles at Appendix 3;
- Consider and be assured of the mitigating actions to improve the risk levels;
- Conclude and comment on the assurance derived from the report.

2.2 Background

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

- relevance
- proportionality
- reliability
- sufficiency

2.3 Assessment

NHS Fife Strategic Risk Profile

The overall Strategic Risk Profile contains 18 risks as previously reported.

- No risks have been closed.
- No new risks have been identified.
- Increased risk - 1 high level risk aligned to the Finance, Performance, & Resources Committee has increased its current rating - *Access to outpatient, diagnostic and treatment services*. Likelihood (L) x Consequence (C) from 16 {likely (4) x major (4)} to 20 {almost certain- (5) x major (4)}
- 1 moderate level risk aligned to the Population Health & Wellbeing Committee has increased its risk target rating - *Population Health & Wellbeing Strategy* from Moderate 8 to Moderate 12.

The Committee is asked to note, that as previously reported, the majority of the risks remain outwith risk appetite; this reflects the current organisational context and the ongoing challenges across all areas of service delivery.

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

Strategic Risk Profile
Table 1

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

Summary Statement on Risk Profile

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

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

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

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		

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

Risks aligned to the Clinical Governance Committee
Table 2

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
To improve the quality of health and care services	1	-	-	-	◀▶	• 9 - Quality and Safety	
To deliver value and sustainability	2	1	-	-	◀▶	• 16 - Off Site Area Sterilisation and Disinfection Unit Service • 17 - Cyber Resilience • 18 - Digital and Information	Risk 17 - Mitigations updated Risk 18 - Description revised

Key Updates

Risk 3 - COVID -19 Pandemic- It is noted that the risk has reached its target and is below appetite. Following discussion at the Risks and Opportunities Group and subsequent engagement with the risk owner, it is recognised that the risk management actions are now established. There will be a recommendation to the Executive Directors' Group (EDG) in the first instance, to consider closing this risk on the Corporate Risk Register. There is likely to be a need for a corporate risk related to future pandemic preparedness, and so what is being considered, is the transition point between closing this risk and then deliberately looking ahead and critically appraising the future risk. That decision will be guided by both Public Health Scotland Surveillance and the WHO decision on when the pandemic can be officially considered at an end. The Committee will be appraised of developments as they emerge.

Risk 16- Off-Site Area Sterilisation & Disinfection Unit Service - Our service is provided by NHS Tayside. The risk owner advises members that there was a significant issue with the service provided over the Easter Bank Holiday weekend due to damage to NHS Tayside's central decontamination unit. Contingency arrangements meant that only a small number of elective procedures had to be cancelled locally. This is the 3rd such incident in the last 3 years which resulted in a loss of service for 5 or more days. This event received national media coverage which reinforced recently expressed concerns about 'capacity challenges' within decontamination services across NHS Scotland.

Risk Description

Risk 18 - Digital & Information at the request of the Committee Chair, to define the clinical, safety & quality issues around the risk, the description has been amended *from:*

"There is a risk that the organisation will fail to recognise and afford the financial investment necessary to deliver its D&I Strategy and current operational lifecycle commitment to enable transformation across Health and Social Care" ***to:***

"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."

Risk Target

The Committee is asked to note that the Risk Target component of the Register has been amended. Following a review by the Director of Finance and Strategy, the Associate Director of Digital and Information, and the Risk Manager, it was agreed that to be more meaningful, this should be modified to allow the target timescale to be set at the risk owner's discretion rather than fixed at year end.

Risk owners were asked to consider the current and target risk scores to ensure these realistically reflect the risks, and the extent to which these can be mitigated towards target in the current and foreseeable challenging climate. Details are reflected in Appendix 1.

Deep Dive Reviews

Deep dives will continue to be commissioned for specific risks via the following routes:

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

The review schedule is as follows:

Risk Title	Committee Meeting Date
Optimal Clinical Outcomes	5 May 2023
Quality and Safety	7 July 2023
Off Site Area Sterilisation and Disinfection Unit Service	8 September 2023
Cyber Resilience	3 November 2023
Digital & Information	12 January 2024

The Deep Dive Review of Optimal Clinical Outcomes is provided at Appendix 2.

Next Steps

Assurance

At the inception of reporting on the corporate risks to the governance committees, it was recognised that the Register and the associated 'assurance framework' would evolve and be subject to further refinement and development. It was agreed that it would be appropriate to take stock after three to four reporting cycles, allowing time for the new approach to gain traction, and to elicit and consider Committee feedback to inform further developments.

The feedback to date has been generally positive. There is consensus on the need to improve the mechanism for providing more specific information on which to base an assurance opinion i.e. supporting assurance evidence on the effectiveness of the controls and mitigating actions in place for risks.

As we enter the fourth cycle of reporting, the ROG has been asked to develop the assurance component around the corporate risks and to explore a model that allows provision of appropriate levels of assurance. The Group has also been asked to consider a mechanism for clearly defining specific levels of assurance, linked to the impact of risk mitigation, to be used in conjunction with the existing Assurance Principles (Appendix 3). This should enable an explicit conclusion to be reached on the overarching level of assurance provided by the risk owner and received by a committee.

Details of a proposed approach will be recommended to EDG in a Risks & Opportunities Group Progress Report on 4 May 2023.

The Corporate Risk Register will continue to be updated between each committee cycle, including through review at the ROG and recommendations to EDG. This process will take note of each Committee's feedback, and use this to enhance future reports.

Connecting to Key Strategic Workstreams
The ROG will continue to develop its role in considering emergent risks and opportunities arising in particular, from the Population Health and Wellbeing Strategy, the Strategic Planning and Resource Allocation process and the Annual Delivery Plan, in order to recommend changes or additions to the corporate risks.

2.3.1 Quality / Patient Care

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

2.3.2 Workforce

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

2.3.3 Financial

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

2.3.4 Risk Assessment / Management

Subject of the paper.

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 on Option 1: No further action required.

2.3.6 Climate Emergency & Sustainability Impact

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

2.3.7 Communication, involvement, engagement and consultation

This paper reflects a range of communication and engagement, including with the ROG on 4 April 2023, and specifically on the deep dive, with EDG on 20 April 2023.

2.3.8 Route to the Meeting

- Neil McCormick, Director of Property & Asset Management on 25 April 2023

- Dr Chris McKenna, Medical Director on 25 April 2023
- Dr Shirley- Anne Savage, Associate Director of Quality & Clinical Governance on 25 April 2023
- Dr Joy Tomlinson, Director of Public Health on 25 April 2023

2.4 Recommendation

This report is presented to the Committee for

- **Assurance**

3 List of appendices

The following appendices are included with this report:

- Appendix No. 1, Summary of Risks Aligned to the Clinical Governance Committee as at 25 April 2023
- Appendix No. 2, Deep Dive Review of Corporate Risk 5 - Optimal Clinical Outcomes
- Appendix No. 3, Assurance Principles

Report Contact
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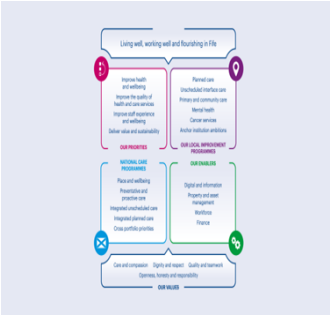
Appendix 1

Summary of Corporate Risks Aligned to the Clinical Governance Committee as at 25 April 2023

To improve health and wellbeing

	Risk	Mitigation	Current Risk Level / Rating	Target Risk level/ rating by 31/03/23	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.	The spring booster campaign is now underway. Implementation of new treatments for individuals at higher risk of adverse outcomes. Monitoring continues of possible new variants at national level. Tailored support continues to be provided to Care Homes with positive staff or resident cases. Public communications programme to raise awareness of infection prevention and control measures across the region	Mod 12	Mod 12	Mod 12 by 30/06/23	◄►	Below	Director of Public Health

		and across the population. Deep dive was presented to CGC in March 2023.						
5	**Optimal Clinical Outcomes** There is a risk that recovering from the legacy impact of the ongoing pandemic, combined with the impact of the cost-of-living crisis on citizens, will increase the level of challenge in meeting the health and care needs of the population both in the immediate and medium-term.	The Board has agreed a suite of local improvement programmes, as detailed in the diagram below to frame and plan our approach to meeting the challenges associated with this risk. The governance arrangements supporting this work will inform the level of risk associated with delivering against these key programmes and reduce the level of risk over time.  A deep dive of this risk will be presented to the CGC on 05/05/23.	High 15	Mod 10	Mod 10 by 31/03/24	◄►	Within	Medical Director

To improve the quality of health and care services

	Risk	Mitigation	Risk Level	Target Risk Level by 31/03/23	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.	High 15	Mod 10	Mod 10 by 31/03/24	◄►	Above	Medical Director

				To deliver value and sustainability				
	Risk	**Mitigation**	**Risk Level**	**Target Risk Level by 31/03/23**	**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 through Decontamination Group. Establishment of local SSD for robotics is progressing. Health Facilities Scotland (HFS) agreed the design, and the unit at St Andrews Community Hospital (SACH) should be operational by June 2023.	Mod 12	Low 6	**TBC**	◄►	Within	Director of Property & Asset Management
17	**Cyber Resilience** There is a risk that NHS Fife will be overcome by a targeted and sustained cyber attack that may impact the availability and / or integrity of digital and information required to operate a full health service.	Considerable focus continues in 2023 with heightened threat level to improve our resilience to attack and ability to recover quickly. The primary mechanism for prioritising items is the response to the Network Information Systems Directive (NISD) review	High 16	Mod 12	Mod12 (4x3) by Sept 2024	◄►	Above	Medical Director

		report May 2022. Next audit due July 2023.						
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 developing Health & Wellbeing Strategy. Digital & Information Board Governance established and supporting prioritisation with ongoing review.	High 15	High 15	Mod 8 (4x2) by April 2025	◄►	Above	Medical Director

Risk Movement Key

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

Appendix 2

Deep Dive Review of Corporate Risk 5 - Optimal Clinical Outcomes

Corporate Risk Title	**Optimal Clinical Outcomes**		
Strategic Priority	 To improve health and wellbeing		
Risk Appetite	HIGH		
Risk Description	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.		
Root Cause (s)	• COVID -19 related disruption • Demand exceeding capacity • Stepping down of some non-urgent services • Cost-of-living crisis 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.		
Current Risk Rating ([LxC] & Level (e.g. High Moderate, Low)	**Likelihood - 5**	**Consequence - 3**	**Level -** High
Target Risk Rating([LxC] & Level (e.g. High, Moderate, Low)	**Likelihood - 5**	**Consequence - 2**	**Level -** Moderate

Management Actions (current)

Action	Status	Impact on Likelihood/ Consequence
The Population Health & Well-being Strategy was published in April 2023. Delivering Care to the people of Fife while fully acknowledging the challenges and designing services to respond to these challenges. This strategy sets out to prioritise health inequalities and support improvement in the health and wellbeing of our citizens. Through annual delivery plans, the implementation of the strategy will be taken forward in the context of a range of drivers for change.	On Track – ongoing	Reduced Consequence
There are a number of boards working on various local improvement programmes. Integrated Planned Care Programme Board Chaired by the Director of Acute Services. • Focus on waiting times and support people, where appropriate, to wait well for their procedure • Further develop our day surgery service at Queen Margaret Hospital • Increase the level of ambulatory services across Fife • Continue to invest and develop in new technologies such as robot assisted surgery to provide high quality care • Provide a world class elective orthopaedic service through the National Treatment Centre – Fife Orthopaedics	Significant level of delivery challenge	Reduced Consequence

Integrated Unscheduled Care Project Board chaired by the Medical Director and reports to Clinical Governance Committee three times per year. Reduce attendances – Redesign of Urgent Care • Flow Navigation Centre improvements • Reduce Admissions – Alternatives to Inpatient Care • Development of new pathways • Reduce Length of Stay – Rapid Assessment and Streaming • Support early decision making • Optimise Flow to align discharges and admissions patterns Effective Discharge Planning	Significant level of delivery challenge	Reduced Consequence
Acute Cancer Services Delivery Group chaired by the Director of Acute Services and reports to the Cancer Governance and Strategy Group chaired by the Medical Director. The purpose of this group is to ensure the routine operation of Cancer Services in NHS Fife Acute Services Division is managed effectively. It provides assurance and highlights any exceptions to performance, waiting times, and quality standards and systems resilience. The Cancer Framework and delivery plan have been developed. Optimal pathways and integrated care are included in the framework along with viewing Cancer Waiting Times targets as a minimum standard. Effective Cancer Management Framework Action plan agreed both locally and by Scottish Government and actions identified. The Rapid Cancer Diagnosis Service (RCDS) was established in June 2021 and is now supporting a rapid diagnostic pathway for patients with vague or concerning symptoms. The implementation in September 2022 of a Single Point of Contact Hub (SPOCH) piloting centralised support for urological and bowel cancers. SPOCH aims to improve patient experience by providing a central contact point for contact for patients going through a cancer pathway. This supports patient experience and also helps with early identification of potential delays before they are picked up at the patient tracking meeting.	On Track – ongoing	Reduced Consequence
Primary Care Strategy Group reports into the Public Health and Wellbeing Committee chaired by the Medical Director and Director of Health & Social Care. It oversees the development of the strategy and delivery plan and provides assurance to the Clinical Governance Committee for oversight.	On Track – ongoing	Reduced Consequence
Mental Health Redesign Programme's aim is to ensure that there is access to the right level of care and treatment for mental health problems, which meet the needs of our communities. A priority has been to improve the current in-patient facilities and a business case is currently being developed.	Significant level of delivery challenge	Reduced Consequence
Fortnightly meetings of Scheduled Care Group to monitor and review waiting times for urgent and long waiting patients and agree actions to improve within current resources. Includes implementation of patient initiated review (PIR) toward increasing	On Track – ongoing	Reduced Consequence

clinic capacity for reviews and Active Clinical Referral Triage (ACRT) for reducing new appointment waiting lists. There is also work ongoing looking at Theatre Utilisation and maximisation of day surgery procedures.		
A workshop has been developed for Realistic Medicine and Value Based Care and will be run in May 2023. This will be a platform for NHS Fife members of staff to meet, learn about Realistic Medicine and provide a values-based vision/road map (holistic journey) for the governance arrangements for embedding Realistic Medicine in Fife. A streamlined approach will be undertaken with regards to internal and external communications to ensure flexibility and uniformity in communication of key messages.	On Track – ongoing	Nil
Management Actions (future)		
Action	**Status**	**Impact on Likelihood/ Consequence**
Continue escalation of issues through Senior Leadership Teams to Executive Director's Group then through to Clinical Governance Committee.	On Track - Ongoing	Nil
Review the Scottish Government (SG) Delivering Value Based Health & Care. A Vision for Scotland, December 2022 document against our local plans.	On Track – June 2023	Nil
The Cancer Framework and delivery plan for 2022/23 is complete. Work is underway on the 2023/24 delivery plan.	On Track – June 2023	Reduced Consequence

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

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 on Effectiveness of Risk Mitigation

- Relevance
- Proportionality
- Reliable
- Sufficient

Chairs Assurance Report

- Consider issues for disclosure
- Emergent risks or - Escalation / Recording
- Scrutiny of 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? Are 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 to 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 risk 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 they '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 are 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	Adequate Assurance	Limited Assurance
Controls are applied continuously with minor lapse	Controls are applied with some lapses	Significant breakdown in the application of controls

DRAFT CLINICAL GOVERNANCE COMMITTEE
PROPOSED 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**
TBC							
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)	**Board Secretary**	✓					
Annual Committee Assurance Statement (inc. best value report)	**Board Secretary**	✓					
Annual Internal Audit Report	**Director of Finance & Strategy**		✓				
Annual Statement of Assurance for Clinical Governance Oversight Group	**Medical Director / Associate Director of Quality & Clinical Governance**						✓
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**	✓ **Cyber Resilience**	✓ **Digital & Information**	✓

Governance Matters (cont.)							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Review of Terms of Reference	**Board Secretary**						✓ Approval
Strategy / Planning							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Advanced Practitioners Review	**Director of Nursing**	✓					
Annual Delivery Plan 2023/24	**Director of Finance & Strategy / Associate Director of Planning & Performance**	**Deferred to July**	✓		✓		✓
Cancer Strategic Framework	**Medical Director**				✓		
Clinical Governance Framework	**Medical Director / Associate Director of Quality & Clinical Governance**						✓
Clinical Governance Delivery Plan	**Medical Director / Associate Director of Quality & Clinical Governance**	**Deferred to July**	✓			✓	
Corporate Objectives	**Director of Finance & Strategy / Associate Director of Planning & Performance**	✓					
Data Loch	**Medical Director / Associate Director for Research, Development & Innovation**		✓				
Development Assistant Practitioner Role	**Director of Nursing**	✓					
Integrated Unscheduled Care	**Medical Director**		✓		✓		✓
Laboratory Information Management System Update	**Associate Director of Digital & Information**			✓			

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**		✓				
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**		✓				
Safer Management of Controlled Drugs	**Director of Pharmacy & Medicines**				✓		
Covid Mortality Report	**Medical Director**	**TBC**					
Digital / Information							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Digital and Information Strategy Update	**Medical Director / Associate Director of Digital & Information**		✓			✓	
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	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Equalities Outcome Report *(also goes to PHWC)*	**Director of Nursing**						✓
Patient Experience & Feedback	**Director of Nursing**	✓	✓	✓	✓	✓	✓
Volunteering Report	**Director of Nursing**				✓		

Annual Reports							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Adult Support & Protection Annual Report *(also goes to PHWC)*	**Director of Nursing**	✓					
Allied Health Professional Assurance Framework	**Director of Nursing**	**Deferred to July**	✓				
Annual Resilience Report	**Medical Director**	**Partial Assurance Statement**			✓ **Mid-year Assurance Report**		✓ **Annual Report**
Clinical Advisory Panel Annual Report	**Medical Director**		✓				
Controlled Drug Accountable Officer Annual Report	**Director of Pharmacy & Medicines**				✓		
Director of Public Health Annual Report *(also goes to PHWC)*	**Director of Public Health**		✓				
Equality Outcomes Progress Report	**Director of Nursing**					✓	
Fife Child Protection Annual Report	**Director of Nursing**	**Deferred to July**	✓				
Hospital Standardised Mortality Ratio (HSMR) Update Report	**Medical Director**				✓		
Integrated Screening Annual Report *(also goes to PHWC)*	**Director of Public Health**				✓		
Medical Education Report	**Medical Director**				✓		
Medical Appraisal and Revalidation Annual Report	**Medical Director**				✓		
Medical Devices Annual Report	**Medical Director**			✓			
Occupational Health Annual Report 2022/23	**Director of Workforce**			✓			
Organisational Duty of Candour Annual Report	**Medical Director**						✓

Annual Reports (cont.)							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Participation & Engagement Report and Quality Framework for Participation & Engagement Self-Evaluation *(also goes to PHWC)*	**Director of Nursing**				✓		
Prevention & Control of Infection Annual Report	**Director of Nursing**				✓		
Radiation Protection Annual Report	**Medical Director**	✓					
Research & Development Progress Report & Strategy Review	**Medical Director**					✓	
Research, Innovation and Knowledge Annual Report	**Medical Director**					✓	
Review of Deaths of Children & Young People	**Director of Nursing**						✓
For Assurance							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Review of Annual Workplan	**Associate Director of Quality & Clinical Governance**	✓	✓	✓	✓	✓	✓ Approval
Integrated Unscheduled Care Report	**Medical Director**	✓		✓		✓	
Nursing & Midwifery Professional Assurance Framework	**Director of Nursing**	**Deferred to July**	✓				✓
Linked Committee Minutes							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Area Clinical Forum	**Chair of Forum**	06/04 **Mtg Cancelled**	✓ 08/06	✓ 03/08	✓ 05/10	✓ 07/12	✓ 08/02
Area Medical Committee	**Medical Director**	✓ 14/02	✓ 11/04	✓ 13/06	✓ 08/08	✓ 10/10	✓ 12/12
Area Radiation Protection Committee	**Medical Director**	✓ 31/08	TBC	TBC	TBC	TBC	TBC
Cancer Governance & Strategy Group	**Medical Director**	✓ 30/03	✓ 31/05		✓ 17/08	✓ 02/11	

Linked Committee Minutes (cont.)							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Clinical Governance Oversight Group	**Medical Director**	✓ 14/02	✓ 18/04	✓ 20/06	✓ 22/08	✓ 24/10	✓ 12/12
Digital & Information Board	**Medical Director**	✓ 19/04		✓ 19/07		✓ 18/10	
Fife Area Drugs & Therapeutic Committee	**Medical Director**		✓ 26/04	✓ 21/06	✓ 16/08	✓ 21/10	✓ 20/12
Fife IJB Quality & Communities Committee	**Associate Medical Director**	✓ 10/03	✓ 03/05	✓ 30/06	✓ 07/09	✓ 02/11	
Health & Safety Subcommittee	**Chair of Subcommittee**	✓ 10/03	✓ 09/06		✓ 08/09	✓ 08/12	
Infection Control Committee	**Director of Nursing**	✓ 05/04	✓ 07/06	✓ 09/08	✓ 04/10	✓ 06/12	
Ionising Radiation Medical Examination Regulations Board (IRMER)	**Medical Director**		TBC	TBC	TBC	TBC	TBC
Information Governance & Security Steering Group	**Director of Finance & Strategy**	✓ 11/04		✓ 13/07	✓ 10/10		
Medical Devices Group	**Medical Director**	✓ 08/03	✓ 14/06		✓ 13/09		✓ 13/12
Research, Innovation & Knowledge Oversight Group	**Medical Director**	✓ 27/03		✓ 21/06	✓ 19/09	✓ 11/12	
Resilience Forum	**Director of Public Health**	✓ 01/03		✓ 08/06	✓ 07/09	✓ 07/12	
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 *(also goes to PHWC)*	**Medical Director**	**Deferred to July**	✓				
Medical Devices	**Director of Property & Asset Management**	✓					
Public Protection, Accountability & Assurance Framework	**Director of Nursing**	✓					

Ad Hoc Items (cont.)							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Fatal Accident Enquiry	**Medical Director**	✓					
Development Sessions							
	Lead						
Development Session 1 • Medical Education • Addiction Services	**Medical Director**	**12/04/23**					
Development Session 2 • Research relationship between NHS Fife and the University of St Andrews.	**Medical Director**	**TBC – End of October 2023**					

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**5 May 2023**
Title:	**Corporate Objectives 2023/24**
Responsible Executive:	**Carol Potter, Chief Executive**
Report Authors:	**Margo McGurk, Director of Finance & Strategy**

1 Purpose

This paper sets out the proposed corporate objectives for 2023/24.

This is presented for:

- Assurance

This report relates to:

- NHS Fife Population Health and Wellbeing Strategy
- Annual Delivery Plan
- Government policy/directive

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The committee requires to consider and propose the key corporate objectives for 2023/24, these objectives align the recently approved NHS Fife Population Health and Wellbeing Strategy and SPRA process.

2.3 Assessment

The corporate objectives of any organisation normally reflect the in-year, highest level actions which will create the objectives of the Chief Executive. In that context, this paper proposes a refinement of the SPRA generated objectives to reflect those at that corporate level. The corporate objectives proposed have been mapped to one of the 4 NHS Fife agreed strategic priorities or to the new "Cross Cutting Actions" category and are set out in Annex 1.

2.3.1 Quality/ Patient Care

NHS Fife corporate objectives underpin the delivery of high Quality of Health and Care Services.

2.3.2 Workforce

NHS Fife corporate objectives link directly to the strategic priority to “Improve Staff Experience and Wellbeing”.

2.3.3 Financial

NHS Fife corporate objectives link directly to the strategic priority to “Deliver Value and Sustainability”.

2.3.4 Risk Assessment/Management

Each corporate objective has an appropriate risk and opportunities assessment as detailed through the SPRA process.

2.3.5 Equality and Diversity, including health inequalities

Each corporate objective either has a completed Impact Assessment or is in the process of completing one.

2.3.6 Other impact

N/A

2.3.7 Communication, involvement, engagement and consultation

Circulated to Executive Directors for comment by Chief Executive on 24 April 2023.

2.3.8 Route to the Meeting

EDG 4 May 2023

2.4 Recommendation

The committee is asked to **take assurance** from the corporate objectives.

3 List of appendices

The following appendices are included with this report:

- Annex 1, Draft Corporate Objectives.

Report Contacts

Margo McGurk
Director of Finance & Strategy
Email margo.mcgurk@nhs.scot

Annex 1 : Proposed Corporate Objectives

Draft Corporate Objectives 2023/24

Our vision
Living well, working well and flourishing in Fife

Our values

- Care and compassion
- Dignity and respect
- Openness, honesty and responsibility
- Quality and teamwork

Our principles

- Listening and involving
- Supporting communities
- Empowering people
- Prevention and early intervention
- Creating wellbeing
- Being kind

NHS Fife

Improve health and wellbeing

1. Progress the business case for the mental health services programme
2. Support the ADP in the delivery of MAT standards
3. Develop a prevention and early intervention strategy, and delivery plan, to support health improvement
4. Develop a primary care strategy and supporting delivery plan
5. Develop and deliver a system wide medicines safety programme

Improve quality of health and care services

1. Implement redesign and quality improvement to support mental health services
2. Review and redesign the Front Door model of care to support improvements in performance
3. Deliver an ambulatory care model supporting admission avoidance and early appropriate discharge
4. Further develop Queen Margaret Hospital as centre of excellence for ambulatory care and day surgery as part of a wider plan to deliver improvements in elective performance
5. Develop and deliver an improved patient experience response process to support a culture of person centred care

Improve staff health and wellbeing

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

Deliver value & sustainability

1. Deliver year one actions of the financial improvement and sustainability programme
2. Implement actions to support climate emergency
3. Develop the digital medicines programme

Cross-cutting actions

1. Develop a corporate communications and engagement plan
2. Develop the strategic plan to secure teaching health board status
3. Deliver Anchors ambitions working collaboratively with partners

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**5 May 2023**
Title:	**Advanced Nurse Practitioners Review**
Responsible Executive:	**Janette Owens, Director of Nursing**
Report Author:	**Mairi McKinley, Senior Practitioner (PPD) Advanced Practice**

1 Purpose

This is presented for:

- Assurance
- Discussion
- Decision

This report relates to a:

- Local Policy
- Workforce Update

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

Further to the report presented to the Executive Directors Group on 10 March 2022, an update on the progress of the development of Advanced Practice (AP) roles in NHS Fife and the HSCP, specifically Advanced Nurse Practitioners (ANPs) is provided for consideration. The anticipated publication of a Scottish Government Transforming Roles (TR) for Advancing Practice in the Allied Health Professions (AHPs) in 2022 has not materialised; therefore this paper focuses on ANPs whilst awaiting publication of the TR AHP paper.

A permanent post of Senior Practitioner (Practice and Professional Development (PPD)) Advanced Practice was established within the PPD team and appointed to in May 2022. In addition, a fixed term secondment post of 0.4 WTE Lead Facilitator (PPD) Advanced Practice has recently been established to assist in the ongoing implementation of the guidance published in CNOD Advanced nursing practice - transforming nursing roles: phase two paper[1], progress NMaHP AP governance and assurance across the organisation and facilitate the publication of the AP toolkit and the establishment of an AP forum.

2.2 Background

Significant progress continues to be made within Fife towards meeting the CNOD transforming nursing roles recommendations including the development of generic job descriptions/person specifications, competency frameworks, and the development of the AP toolkit and AP Forum.

The AP toolkit is designed for use by managers, trainee and qualified Advanced Practitioners and includes key documents for managers e.g. service needs analysis tool, business case and pre-recruitment checklists; key trainee ANP (tANP) documentation such as the competency frameworks, learning needs analysis tool, sign-off documentation; and annual appraisal, clinical supervision, ongoing professional development and appraisal tool documentation for qualified APs.

2.3 Assessment

Since the publication of the CNOD Advanced Nursing Practice - Transforming Nursing Roles: Phase two paper necessitated further work within Fife to standardise the implementation, governance, and assurance of ANP roles.

2.3.1 Quality/ Patient Care

The environment in which ANPs work remains complex and demanding. Within Fife, ANPs work in all Directorates and many services including Neonatal and paediatrics; Mental Health; Urgent Care; Community and GP practices; and Acute services. To meet the needs of these services, the ANP must work across all four pillars of advanced practice:

- Clinical Practice
- Facilitation of Learning
- Leadership
- Evidence, Research and Development.

To facilitate safe, effective and person-centred care by enabling ANPs to retain/further develop their level of practice across all pillars, the following are recommended:

[1] https://www.gov.scot/publications/transforming-nursing-roles-advanced-nursing-practice-phase-ii/

- **Non-Clinical Time (NCT) -** ANPs require dedicated non-clinical time to work across the remaining 3 pillars. Therefore, it is recommended that a minimum of **3.75 hours (pro rata) per calendar week** be allocated as non-clinical time on an ongoing basis.

- **Clinical Supervision -** All ANPs should have a named clinical supervisor and actively engage in supervision throughout the year.

- **Continuous Professional Development (CPD) -** All ANPs should have the opportunity to access high quality CPD to ensure that they continue to deliver robust, current, evidence-based care.

- **Supporting Professional Activities (SPA) -** Specific SPAs should be negotiated with the ANP's line manager and such activities should be resourced accordingly.

2.3.2 Workforce

A 100% data cleanse of ANP posts was undertaken in April 2023. Table 1 illustrates the number of ANPs across NHS Fife has increased by **48.75 WTE** with a further **31.95 WTE** trainee ANPs in post since 2016. The total number of WTE ANPs and trainees across NHS Fife is now over 100. Given that the Scottish Government pledged to increase the number of ANPs in Scotland by 500 over a period of 5 years (2016-2021), we exceeded our NRAC target of 35 WTE and continue to increase the size of the workforce to enhance service delivery.

Table 1

	Acute ANPs	HSCP ANPs	Total ANPs	Acute Trainees	HSCP Trainees	Total Trainees
2016	24.18	0	24.18	0	0	0
2021*	39.67	27.97	67.64	10.84	20.32	31.16
2022	40.24	20.85	61.09	11.84	12.6	24.44
2023**	38	34.93	**72.93**	15.67	16.28	**31.95**
Increase since 2016	**13.82**	**34.93**	**48.75**	**15.67**	**16.28**	**31.95**

*Inconsistencies in the recording of data may have resulted in incorrect results, therefore 100% data cleanse undertaken in 2022 and 2023.

**This data includes 0.64 WTE ANPs employed within General Practice. The ongoing governance, supervision and support offered to this post holder will require additional consideration.

As identified previously, ANP job plans should include a minimum of 3.75 hours per week (pro-rata) non-clinical time (NCT). This non-clinical time already features in some ANP job plans, but not in others, therefore a consistent approach is required.

Supported by their clinical leads and Senior Practitioner PPD, three Advanced Practice Teams within Acute (AU1, Frailty/RAD Ambulatory Team and the NTC) started a pilot to

embed NCT within their job plans in 2022. The creation of this non-clinical time is already having a positive impact on the ANPs, enabling them to pursue activity that is restorative and developmental for them as individuals, but also provides the opportunity to enhance service delivery through effective leadership, quality improvement/research and education activity.

This activity is already enhancing the service delivery of the wider healthcare team including clinical supervision and educational development of the nursing team and medical trainees as well as providing audit and QI activity and is being captured via a locally developed monitoring/recording tool.

Over the next 12 months, the aim is to ensure that all ANPs and their managers across Fife can be supported to embed NCT within job plans to support the development of the ANP and the service.

To support this activity, an ANP forum/network/council is being established, to create an environment to share best practice across all services in Fife. Overall, it is anticipated that this will have a positive impact on job satisfaction, and health and wellbeing. Activity undertaken as part of the non-clinical pillars is also likely to enhance an individual's professional development and help facilitate career progression.

A survey of Advanced Practitioners undertaken in November 2022 received 50 responses (AHP = 13, Nursing = 35 and Pharmacy = 2) and indicated high interest in the development of an AP forum, CPD and networking opportunities. The forum is currently being established and the first CPD event was held on 6th April 2022.

Across Fife, in the last 12 months, a further 3 ANPs now have the knowledge and skills to assess the capacity of people who may come under the protection of the Adults with Incapacity (Scotland) Act 2000 (Part 5 amendment) and issue section 47 certificates. It is anticipated that a further 3 ANPs will complete the training this year and achieve this competency.

2.3.3 Financial

Funding for ANP posts is secured following successful business cases or realignment of medical budgets. ANP posts are not funded from existing nursing establishment.

To accommodate the CNOD recommendations, there may be a small financial impact for some services due to the small reduction in clinical hours provided by ANPs on behalf of the service and the requirement to support CPD and SPA. As such, this should be considered when creating a business case for new ANP posts and considered during future workforce planning.

2.3.4 Risk Assessment/Management

Previously, tANPs have identified varying levels of clinical mentorship and supervision. There is currently no formal or standardised ongoing CPD or clinical supervision within NHS Fife for ANPs. ANPs have identified there is a tendency for mentorship and supervision to cease once they are no longer trainees.

Most ANPs state they receive no protected time for CPD or activities in the non-clinical pillar. The recommendations in section 2.3.1 established in policy and an ANP strategic framework, once implemented, will minimise the risk across the organisation.

2.3.5 Equality and Diversity, including health inequalities

An impact assessment will be included in the proposed Advancing Practice Policy document.

2.3.6 Other impact

Similar policies and procedures already exist in other Scottish Health Boards, therefore this work will align Fife with other Boards, ensuing that the highest standard of advanced care and treatment is delivered to patients and their families, whilst supporting ANPs' ongoing development requirements.

2.3.7 Communication, involvement, engagement and consultation

The report's author has engaged with NHS Greater Glasgow and Clyde, NHS Grampian, NHS Lothian and NHS Tayside ANP Leads to seek examples of best practice. NHS Fife is a member of the East of Scotland Advanced Practice Academy and continues to engage with regional and national AP discussions.

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 - 10 March 2022 and 20 April 2023
- Nursing and Midwifery Workforce Planning Group, 18 April 2023

2.4 Recommendation

For Discussion:

- To **acknowledge** the increase in ANPs and trainee ANPs across NHS Fife.
- To **approve** and support the **launch** of the AP toolkit and AP Forum.
- To **facilitate** the ability of ANPs to demonstrate their ability to practice across all 4 pillars of advanced practice.

- To **consider** the permanent establishment of a Lead Facilitator PPD for Advanced Practice role across NHS Fife to support ongoing CPD and development of the AP workforce.

Report Contact

Mairi McKinley, Senior Practitioner (PPD) Advanced Practice
mairi.mckinley@nhs.scot

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**5 May 2023**
Title:	**Update on the Role of Assistant Practitioner**
Responsible Executive:	**Janette Keenan, Executive Director of Nursing**
Report Authors:	**Tracy Hunter, Senior Nurse (PPD) Workforce**

1 Purpose

This is presented for:

- Assurance

This report relates to an:

- Government Directive
- Health & Social Care Support Worker Development Programme (NES / SG)

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

- Safe
- Effective
- Person-centred

2 Report summary

2.1 Situation

This report has been prepared to provide assurance to update the Clinical Governance Committee on the development and introduction of the Assistant Practitioner (AP) role in Fife.

Development of the AP role within NHS Fife and Health and Social Care Partnership (HSCP) will assist in developing the nursing workforce, by varying the skill mix and providing an alternative career pathway into the nursing profession for Health Care Support Workers.

2.2 Background

2.2.1 Nursing Workforce

Supply of Registered Nurse workforce

NHS Scotland Boards are facing significant challenges in the supply of Registered Nurses. These challenges are being faced across the UK, Europe and is a global issue. There are multiple recruitment activities, and whilst all our recruitment activities continue, we are focusing our effort, at present, on international recruitment, which commenced in February 2022, and the development of the Assistant Practitioner role to support a more sustainable nursing workforce.

The issue is compounded by the high level of existing vacancies, which has been adversely affected by changing service models, such as the development of National Treatment Centres (NTC) and the development of the Community Treatment and Care (CTAC) which require an increased number of registrants. Staff sickness absence rates, as well as turnover rates, remain significantly higher than previous years.

Wellbeing of staff remains a priority for NHS Fife, but the vacancy position and absence levels, combined with high patient demand, continues to cause additional pressures on the nursing and midwifery workforce. There is a growing reliance on supplementary staffing, which cannot fully meet demand, but brings additional cost pressures through increased agency nurse deployment.

Impact on quality of care remains a consequential concern.

As there can no longer be reliance on the number of newly qualified practitioners entering the profession, which traditionally balanced the number of 'leavers', and conventional recruitment methods to address the vacancy gap, alternative nursing and midwifery recruitment and staffing models are required to:

- reduce the risk to the quality of care and on patient safety
- maintain safe staffing levels
- establish a more sustainable workforce
- promote and support staff well-being
- respond to the increased staffing requirements of national drivers, new service models
- address escalating agency costs

2.2.2 Sustainable Workforce

Response to current system pressures

In response to current systems pressures within health and social care and the emergence of new service models, NHS Education for Scotland was commissioned by the Chief Nursing Officer Directorate (CNOD) in Scottish Government, in October 2021. The aim of the commission was to scope and recommend a nationally agreed framework to support definition of Healthcare Support Worker (HCSW) roles, career progression and development through education and training, with a focus on how HCSW's support registered staff.

Cognisant of the variation in role, education provision and development for HCSW in Nursing, Midwifery and Health Professions (NMAHP), including health care science, across NHS Scotland, the work aimed to propose a **national education and development framework** outlining the knowledge, skills and behaviours required to deliver safe, effective, person-centred care.

This would not only maximise the impact of the roles within each level but also maximise the support for registered health care professionals enabling them to practice to their full potential within their scope. The need to develop and enhance these roles at pace responds to pressures in the system and the emergence of new service models.

By undertaking further education and competency assessments, the AP can support registrants to provide high quality patient care, creating a sustainable workforce. Education and training are well established recruitment and retention strategies, in addition to supporting staff to feel valued and recognised for the work they do.

2.3 Assessment

2.3.1 National Development of the Assistant Practitioner role

2.3.1.1 NES Healthcare Support Worker Development and Education Framework for Levels 2 – 4 NMAHP Healthcare Support Workers

The finalised version of the Development and Education Framework for Levels 2-4 NMAHP Healthcare Support Workers has been available on the TURAS platform since October 2022.

The Framework supports the development of core knowledge, skills and behaviours in the four pillars of practice and enables profession specific and specialist knowledge, skills and behaviours to be added for all NMAHP HCSWs working at Level 2-4. HCSWs work with and under direct supervision of healthcare practitioners their learning and development is essential to support the delivery of safe, effective and person-centred care. The framework recognises how complex NMAHP HCSW roles have become and helps to explain the differences for Levels 2, 3 and 4 using the Four Pillars of Practice appendix 1.

2.3.1.2 Assistant Practitioner Role Definition

Assistant Practitioners work at a level above that of other Healthcare Support Workers and have more in-depth understanding about factors that influence health and ill health and have developed more specialised skills relevant to specific area of practice.

The role of Assistant Practitioner is defined in the NES Healthcare Support Worker Career Development and Education Framework for Levels 3 and 4 Nursing Healthcare Support Workers (October 2022) as:

Level of Practice	Role Title	Definition
Level 4	Assistant Practitioner	The Assistant Practitioner can evidence previous experience and consolidation of practice as a Senior HCSW and/or has the appropriate skills and knowledge and demonstrates the depth of understanding and ability required to participate in the planning and carrying out of holistic, protocol-based care under the direction and supervision of healthcare professionals. They will assist and support the multidisciplinary team in the delivery of high-quality care. The Assistant Practitioner will possess or have the opportunity to attain education at SCQF Level 8 within an agreed timeframe.

2.3.1.3 Next steps at national level - considerations

There is support for a 'Once for Scotland' approach as it is felt that a standardised and consistent approach to education, role development and governance will promote the adoption of professional values, ethical standards and engagement in continuous learning in all HCSW roles. It may also make the role more attractive to applicants considering a career in healthcare, aid transition for HCSWs moving posts within Boards and add value to the role with recognised accreditation supporting the progression to registered practitioner.

Work is being taken forward at national level to support this approach, with representatives from NHS Fife on the national steering group.

To provide standardisation in role titles across NHS Scotland:

- Level 2: Healthcare Support Worker
- Level 3: Senior Healthcare Support Worker
- Level 4: Assistant Practitioner

Future policy considerations include the potential to regulate HCSWs. This would include:

- setting national standards for education and practice
- accreditation of education programmes
- maintenance of a register and fitness to practise

2.3.2 Local Development of the Assistant Practitioner Role

Local development of the role is running in parallel with the national approach, bearing in mind the need to take the development forward at pace.

2.3.2.1 Governance and Leadership

The Clinical Assistant Practitioner Workforce Group drove forward the development of the clinical AP workforce across NHS Fife. This group has now evolved into 'Health Care Support Worker and Assistant Practitioner (Band 2-4) Career Development Framework Group' The scope of this group, which will continue to report into the Nursing and Midwifery Workforce Planning Group is to provide tactical and operational leadership to the HCSW and AP development programme across NHS Fife and Health and Social Care Partnership (HSCP), whilst ensuring connections to other relevant groups and work streams for example the 'Bank and Agency Programme Board'.

The Group's membership includes senior nurses, service managers, general managers, representatives from staff side, finance, workforce, communications, and Practice and Professional Development staff. The Group is currently meeting at fortnightly intervals.

2.3.2.2 Role description

The Job Description and Person Specification were developed and job evaluation processes followed to Band the post.

Whilst undertaking the educational programme, the staff member will be in a Trainee Assistant Practitioner role and the organisation will rely on the arrangements within the AfC Handbook regarding Annex 21.

2.3.2.3 Education programme and support

Fife College will deliver the educational component for Assistant Practitioner development.

Academic Requirement	Supplementary Information
Underpinning Knowledge	8 weeks accelerated underpinning knowledge (1 day per week college attendance)
SCQF Level 8	Professional Development Award (online and college attendance)

The Professional Development Award (PDA): Acute and Community Care has been developed in collaboration with Fife College.

The first cohort of 22 individuals from Acute Services commenced with Fife College in February 2023 successfully completing the 8 week Underpinning Knowledge module; the full cohort begins the PDA April 2023. The first cohort is anticipated to become qualified and 'signed off' APs by December 2023.

The second cohort consisting of 40 staff from across acute, mental health, learning disabilities and community services commence the programme with Fife College in April 2023.

A timetable for future cohorts has been agreed with Fife College, with 3 intakes per year: February; April and August.

The Trainee will be supported by a Practice Supervisor and Practice Assessor at ward/ team level, as well as support provided by Fife College.

2.3.2.4 NES Recognition of Prior Learning (RPL) Guiding Principles (Appendix 2)

Recognition of Prior Learning means that staff can get recognition for learning completed in a work-based environment and learning from life experience to support their career development. NHS Fife will, as part of the introduction of this programme, apply an RPL approach to the delivery of the programme in order that as many candidates as possible can complete the programme as soon as is reasonably practical, whilst ensuring a person-centric approach.

2.3.2.5 Service Needs Analysis Tool (SNAT) (Appendix 3)

A Service Needs Analysis Tool has been designed, based on the SNAT used in NHS Lothian and which is informing the 'Once for Scotland' approach, to assess the need for APs, ensuring service needs, workforce planning, accountability and governance arrangements are considered.

2.3.2.6 Safe Staffing - HSP workforce tools

The Professional Judgement Tool will be used as a planning tool to provide information on the design / shape / skill mix of nursing teams.

2.4 Quality/ Patient Care

Healthcare staffing levels are associated with the delivery of high quality, person-centred care. The development of the Assistant Practitioner role will assist in creating a more sustainable workforce, supporting the delivery of safe, quality care.

Following the Development and Education Framework will ensure that staff have the knowledge, skills and behaviours required to deliver safe, effective, person-centred care.

This will maximise the support for registered health care professionals enabling them to practice to their full potential within their level of practice. By undertaking further education and competency assessments, the AP can support registrants to provide high quality patient care, helping to create a sustainable workforce.

2.5 Workforce

The Staff Governance Standard applies to all staff employed by NHS Boards. The CAPWG will ensure that the strands of the Standard are addressed:

Well informed	A communications plan is being developed by the CAPWG. Drop-in sessions have been arranged, and discussion is taking place with staff side colleagues to enhance staff engagement and communication
Appropriately trained and developed	There are excellent, skilled, trained HCSWs already working in Fife at Band 3 level. The Development and Education Framework will provide consistency in describing the level of training, experience, and education for the role of Assistant Practitioner. The RPL process is being utilised.
Involved in decisions	Discussions have taken place with staff side colleagues to enhance staff engagement and communication
Treated fairly and consistently	Fair and equitable recruitment processes are in place
Provided with a continuously improving and safe working environment	Enhanced training and education will support staff development, promoting safe, person-centred care. A more sustainable workforce will provide a safer working environment.

2.6 Financial

The underpinning financial plans to support nursing will require to be considered over the medium-term to facilitate the delivery of this innovative approach to mitigating the ongoing shortfall in trained staff. There is currently a significant gap in the level of recruited Band 5 nurses against establishment which is anticipated will continue over the medium-term, the reasons for this are explained elsewhere in the paper. This leaves a vacancy balance which can be utilised to support the introduction of Band 4 and other HCSW supporting roles over the medium-term.

The following key principles will apply:

1. over the medium-term, the budget available for Band 5 staff will be maintained at a level which allows all possible recruitment to flow whilst recognising that it is unlikely that the full Band 5 budget will be utilised for this purpose

2. it is possible that the introduction of Band 4 staff will in itself have the potential to create part of that Band 5 recruitment over time where staff choose to enter the degree programme following successful completion of the Band 4 training process
3. in the event that Band 5 levels of recruitment increase over the medium-term beyond that which is nationally predicted, there may be a requirement to create a cost improvement programme to support the long-term sustainability of the Band 4 role
4. there will be recurring realignment of a level of Band 5 vacancy to Band 4 to cover the agreed level of Band 4 recruitment over the medium-term
5. there will be a review of all other current commitments against the Band 5 vacancy level to ensure there is sufficient flexibility to cover the Band 4 recruitment
6. there will be an annual assessment of the impact of the introduction of this new role.

There is inevitably a level of risk associated with realigning the budget to support this new initiative over the medium-term. Given the current pressures on workforce and limitations on recruitment, this initiative will create capacity which would otherwise not be available to the system. Additionally, the NHS Fife Board recently agreed to a refreshed risk appetite where a "moderate" level of risk was agreed in relation to delivery against;

- Improving the quality of health and care services
- Improving staff experience and wellbeing
- Delivering value and sustainability.

Assessment of this initiative against this risk appetite would indicate it sits within that "moderate" level of risk and therefore is within the risk tolerance of the Board.

2.7 Risk Assessment/Management

In line with the assessment commentary, the risks to staff wellbeing and patient safety will potentially decrease by the development and introduction of the Assistant Practitioner role. The staffing level risk is a linked risk in the Quality and Safety BAF and the Workforce BAF.

2.8 Equality and Diversity, including health inequalities

N/A

2.9 Other impact

The recruitment of Trainee Assistant Practitioner posts from our substantive workforce will create vacancies in the band 2 / 3 HCSW workforce. Recruitment to these posts will run in parallel with trainee Assistant Practitioner recruitment.

2.10 Communication, involvement, engagement, and consultation

Engagement with staff has been taking place through drop-in sessions and in team meetings, and a more formal communication plan is being developed by the CAPWG.

2.11 Route to the Meeting

Reports on the development of the Assistant Practitioner role have previously been discussed at EDG meetings.

Colleagues from across Nursing, Workforce, Finance, Partnership and Services have contributed to the development of the paper and their feedback has informed the development of the content presented in this report.

Paper was considered at the Executive Directors Group on 20 April 2023.

3. Recommendations

Assurance

- The Clinical Governance Committee will be asked to note the contextual information and take assurance that the Assistant Practitioner role is being progressed with staff, financial and clinical governance in mind.

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**5 May 2023**
Title:	**Public Protection Accountability and Assurance Framework**
Responsible Executive:	**Janette Keenan, Director of Nursing**
Report Author:	**Janette Keenan, Director of Nursing**

1 Purpose

This report is presented for:

- Assurance
- Discussion

This report relates to:

- Emerging issue
- Government policy / directive
- Legal requirement

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The NHS Public Protection Accountability and Assurance Framework (PPAAF), (appendix 1), was published in October 2022. The Framework has been developed to guide health boards in assessing the adequacy and effectiveness of their public protection arrangements at both strategic and operational levels and informs existing health board and shared multi-agency governance and assurance arrangements.

This report has been prepared to offer assurance to the Committee that work is already being taken forward to assess the adequacy and effectiveness of public protection arrangements in NHS Fife, pending the publication of the PPAAF Self Evaluation Toolkit.

A draft PPAAF Self Evaluation Toolkit v0.8 was presented to the Scottish Executive Nurse Directors (SEND) on 28 April 2023.

2.2 Background

The PPAAF was published by the Scottish Government's Children and Families Directorate in October 2022.

The Framework sets out exemplar evidence of high-quality, safe, and effective services that promote the protection of children and adults. Evidence reflects key recent policy and practice developments, findings from Scotland's Independent Care Review and subsequent publication of The Promise, and a range of sources including inspection findings and reviews of cases where children and adults have died or been significantly harmed.

The aim of the PPAAF is to ensure greater consistency in what children, adults at risk of harm, and families can expect in terms of support and protection from health services in all parts of Scotland. Public protection requires effective joint working between statutory and non-statutory agencies, as well as with staff with different roles and expertise.

Health Boards have structural and organisational responsibilities in respect of child and adult protection. These include use of appropriate policies to keep children and vulnerable adults safe, safe recruitment practices, staff induction and provision of adequate training, procedures for whistleblowing and complaints, robust information sharing agreements, and the promotion of a workplace culture that listens to children, young people, and adults and considers their views and wishes.

Child Protection and Adult Protection Committees are the multi-agency partnerships responsible for monitoring and advising on procedures and practice, ensuring appropriate cooperation between agencies, and improving the skills and knowledge of those with a responsibility for the protection of children and adults at risk. It is crucial that health representation on Committees has sufficient seniority to represent the Health Board in discussions and decisions about policy, resources, and strategy. It is also important that the Health Board is a key contributor to local, multi-agency analyses of child and adult protection data (for example the Minimum Dataset for Child Protection Committees) to ensure that data and intelligence held by health is shared with multi-agency partners and helps build a shared understanding of local needs and service responses.

2.3 Assessment

The PPAAF sets out exemplar evidence of high-quality, safe, and effective services that promote the protection of children and adults for territorial Health Boards.

The Framework states that Chief Executives should consider whether this evidence is reflective of the public protection arrangements in their Health Board, and where further focus is required as part of ongoing development and quality assurance processes.

To initiate work on the PPAAF, a short life working group was established to consider the exemplar evidence described in the Framework and provide an initial gap analysis. This will be further refined on publication of the PPAAF self-evaluation toolkit and establishment of a wider strategic and operational group.

The PPAAF describes 8 recommendations:

1. An executive Health Board lead has overall responsibility for child protection, adult protection, and MAPPA and champions public protection across the Health Board and contracted services.
2. Lead clinicians are resourced and supported to provide advice, expertise, and professional leadership across the Health Board and contracted services.
3. All NHS employees, GP practices, and independent contracted practitioners are supported and directed to the actions they need to take when a child or adult is at risk of harm.
4. The Health Board promotes a children's rights-based approach and a culture of listening to children and young people and taking account of their wishes and feelings, both in individual decisions and in the development of services.
5. Robust governance, accountability, assurance, and reporting arrangements for public protection are in place across Health Board services.
6. Education, learning, and development arrangements support all NHS employees, GP practices, and independent contracted practitioners in their public protection roles and responsibilities.
7. Strategic and operational arrangements between the Health Board and its multi-agency partners support effective joint working and communication.
8. The Health Board provides an effective medical response for children and adults in need of assessment and care.

The initial gap analysis is appended to this SBAR

2.3.1 Quality / Patient Care

Completion of the PPAAF self-evaluation assessment and subsequent ‘options appraisal’ report will strengthen and promote child and adult protection processes in Fife, leading to higher quality care

2.3.2 Workforce

A benchmarking exercise across Scottish Health Boards is being undertaken. There is no Chief Nurse / Lead Nurse for Adult Protection causing a vulnerability in the service.

2.3.3 Financial

Financial implications around particularly workforce, will be factored into options appraisal report

2.3.4 Risk Assessment / Management

The self-evaluation process will inform consequential risks and risk management

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

Public protection is the prevention of harm to children (including unborn babies), and adults. In Scotland, the rights and responsibilities in the United Nations Convention on the Rights of the Child ('UNCRC') should underpin the provision of all services. In addition, public authorities have a legal duty under the Human Rights Act 1998 to act compatibly with the rights enshrined in the European Convention on Human Rights ('ECHR').

2.3.6 Climate Emergency & Sustainability Impact

N/A

2.3.7 Communication, involvement, engagement and consultation

Initial work of SLWG: pulling together baseline in preparation for Self-Evaluation process, with verbal updates to CEO and Director of H&SC have taken place. On publication of the self-evaluation toolkit a Strategic and Operational Oversight Group will be established and will consider engagement.

2.3.8 Route to the Meeting

- PPAAF SLWG

2.4 Recommendation

- **Assurance** – For Members' information.
- **Discussion** – For examining and considering the implications of a matter.

3 List of appendices

The following appendices are included with this report:

- Appendix No. 1, NHS Public Protection Accountability and Assurance Framework
- Appendix No. 2, PPAAF Gap Analysis

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NHS Public Protection Accountability and Assurance Framework

October 2022

Scottish Government
Riaghaltas na h-Alba
gov.scot

NHS Public Protection Accountability and Assurance Framework

Purpose

This Framework sets out exemplar evidence of high-quality, safe, and effective services that promote the protection of children and adults. Evidence reflects key recent policy and practice developments, findings from Scotland's Independent Care Review and subsequent publication of The Promise, and a range of sources including inspection findings and reviews of cases where children and adults have died or been significantly harmed.

The Framework is intended to guide Health Boards in assessing the adequacy and effectiveness of their public protection arrangements at both strategic and operational levels and to inform existing Health Board and shared multi-agency governance and assurance arrangements, covering all levels of staff including independent contractors. The aim is to ensure greater consistency in what children, adults at risk of harm, and families can expect in terms of support and protection from health services in all parts of Scotland.

Introduction

Public protection is the prevention of harm to children (including unborn babies), and adults. In Scotland, the rights and responsibilities in the United Nations Convention on the Rights of the Child ('UNCRC') should underpin the provision of all services. In addition, public authorities have a legal duty under the Human Rights Act 1998 to act compatibly with the rights enshrined in the European Convention on Human Rights ('ECHR').

Public protection requires effective joint working between statutory and non-statutory agencies, as well as with staff with different roles and expertise. To achieve effective joint working, there must be constructive relationships at all levels, with a strong executive lead at Health Board level in respect of its statutory duties, and shared Health Board member accountability. These arrangements should also facilitate clear oversight of the Board's corporate parenting duties and responsibilities as set out in the Children and Young People (Scotland) Act 2014. Moreover, where requested by a local authority, the Board must provide mutual assistance with the exercise of that authority's functions under the Children's Hearings (Scotland) Act 2011. As an employer and contractor of services, Health Boards are required to support staff to uphold professional standards and guidance outlined by their governing bodies.

Under Section 5 of the Adult Support and Protection (Scotland) Act 2007, Health Boards, along with other named public bodies, must, so far as consistent with the proper exercise of their functions, co-operate with the relevant council and each other where they know or believe a person is an adult at risk (in the meaning of that Act).

Health Boards are also Responsible Authorities for the purposes of Multi-Agency Public Protection Arrangements (MAPPA) in Scotland. The Management of Offenders etc. (Scotland) Act 2005 places a statutory duty on Responsible Authorities to jointly establish arrangements for assessing and managing the risks posed by registered sex offenders, restricted patients and other "risk of serious harm" individuals. Health Boards are Responsible Authorities in relation to the management and care of restricted patients.

In addition, Health Boards have a duty to cooperate with other agencies about all individuals who are subject to MAPPA. This statutory duty to cooperate includes the provision and sharing of information relevant to the assessment and management of the risks posed by these individuals. All Health Boards should have robust reporting and escalation mechanisms in place to identify and report on MAPPA activity.

While inspections, Significant Case Reviews, and Learning Reviews have highlighted strong and effective health partnership working in some areas, they have also identified unwarranted variation and inconsistencies in public protection roles and accountability arrangements across the country. Issues identified include:

- A lack of clarity of role in multi-agency planning processes resulting in insufficient join-up and health involvement in risk assessment processes, including lack of representation at key meetings arising from child or adult protection activity.
- Lack of resources and capacity to meet the demands of attending a number of critical protection meetings.
- Communication and information sharing within and between services, including at points of transition between healthcare services and settings, and in transition between other services.
- Cultural issues which impact on shared ownership of case responsibility and in establishing the lead agency.
- The importance of a coordinated approach to the work of the National Child Death Review Hub and local Child Protection Committee requirements to conduct reviews whilst avoiding duplicity of effort in parallel processes.
- A lack of co-ordination and oversight across the range of staff working in different clinical settings, including inconsistent multi-disciplinary approach to protection of adults and children that promotes all individuals feeling their contributions are valued.
- In a few but important number of cases, a lack of health involvement in assessments, including a lack of medical examinations in a small, but again, important number of child protection cases.
- A lack of clarity about the role of capacity in adult protection activity, and inconsistent understanding of the interface between child and adult protection, Adults with Incapacity legislation, the Mental Health (Care and Treatment) (Scotland) Act, and the revised child protection guidance (up to the age of 18).
- A need to consider whether there are any indicators of abuse or assault, including trafficking, as part of pre-birth assessment and planning.
- Inconsistency in the level of Health Board engagement with MAPPA in relation to individuals who are not restricted patients.

- Variation in the level of seniority of the Health Board liaison role and the contribution they make to MAPPA meetings about specific individuals. This can be limited to factual information about the individual's access to health services rather than information supporting multi-agency management of risk and the sharing of expertise in risk management.
- Variation in appropriate and consistent Health Board representation on MAPPA Strategic Oversight Groups (which is the overarching governance forum in each of the 10 MAPPA regions in Scotland). As a result, representatives do not always have the authority to take decisions.

In addition, variations have been highlighted in Health Board designated roles, functions, resourcing, and governance arrangements for public protection. This has led to inconsistencies in lines of accountability, shared understanding of governance, and support for public protection services. Key designated health roles for child protection (including unborn babies) in Scotland are non-statutory, unlike comparative roles in other parts of the UK. This places an even greater responsibility on all agencies to have in place robust and rigorous processes to support staff in carrying out their professional roles.

Furthermore, the establishment of Integration Joint Boards (IJBs) and delegation of functions and budgets has led to more integrated arrangements in adult services (and children's services for those IJBs with strategic planning, commissioning, and oversight of children's services responsibilities), which has impacted on a number of aspects of accountability and assurance arrangements across Scotland. This is apparent at a strategic level, in terms of the role of Chief Officers and members of the Health Board and the Integration Joint Board. It is also the case in relation to operational responsibility, with variation in the responsibilities and reporting lines for Child Health Commissioners, Child Protection Advisors, public protection leads, and lead officers in paediatric and community teams.

While the responsibilities of Chief Officers are set out in national guidance, given the range of factors that impact on public protection responsibilities and the breadth of legislative, policy and practice changes in recent years, there is a strong case for a restatement of critical accountabilities within Health Boards and Integration Joint Boards.

Background

Roles and responsibilities of NHS Boards, employees, and GP contractors in protecting children and adults at risk of harm

Health Boards have structural and organisational responsibilities in respect of child and adult protection. These include use of appropriate policies to keep children and vulnerable adults safe, safe recruitment practices, staff induction and provision of adequate training, procedures for whistleblowing and complaints, robust information sharing agreements, and the promotion of a workplace culture that listens to children, young people, and adults and considers their views and wishes.

Health boards, NHS employees, and contractors have an important role in upholding the wide range of rights which underpin public protection, reinforcing and protecting many of the guarantees set out in the UNCRC (such as Articles 3, 12 and 24) and in the ECHR.

All NHS employees, GP and dental practices, and other independent contractors have a role in protecting the public and **all** regulated staff in Health Boards and services have professional duties to protect children (including unborn babies) and adults. Staff in supporting roles (including administrative, catering, cleaning, and other support roles) across primary, secondary, specialist, and community health services also have public protection responsibilities. These contacts provide opportunities for early and effective interventions and, in many cases, avoiding escalating need.

This role includes:

- Being aware of their responsibilities to identify and promptly share concerns, including making referrals where appropriate, about actual or potential risk of harm from abuse or neglect.
- Undertaking training and learning to ensure they attain and maintain their competencies, skills, and knowledge appropriate to their role.
- Knowing where and when to seek specialist advice and supervision.
- Being aware of their own regulated responsibilities and duties as well as understanding relevant legal frameworks within which they operate and their duty to refer.
- Being aware of the early signs of neglect; recognising the signs of self-harm and self-neglect and the need for co-ordinated assessment.
- In working with or treating adults who are parents/carers, being alert to the possibility that their patient may pose a risk to an unborn baby or child and have a duty to act.
- Working collaboratively with social work and police on multi-agency child and adult protection activity.
- Contributing to GIRFEC and, in relation to Health Visitors holding the named person function for pre-school children, coordinating the assessment and planning for children for whom a GIRFEC response is appropriate.
- Contributing to Looked After Children and other multi-agency child and adult protection processes, including pre-birth assessment and planning, child protection Inter-agency Referral Discussions, Children's Hearings, child protection investigations, Child Protection Planning Meetings, and interim safety planning.
- Working collaboratively with the lead professional when there is a multi-agency child's plan.
- Working collaboratively with the Council Officer undertaking adult protection procedures and contributing to Case Conferences as well as the development and implementation of Protection Plans.
- Maintaining factual, accurate, concise, and up to date records.
- Contributing to ensuring that there are planned and co-ordinated transitions between age and services, particularly where there are multiple and/or complex health needs.

- Having a Protecting Vulnerable Groups (PVG) Scheme in place via Disclosure Scotland.
- Contributing to multi-agency analyses of child and adult protection data (for example the Minimum Dataset for Child Protection Committees) to identify and understand key trends in numbers of vulnerable children and adults, types of concerns, and service responses.
- Using the available qualitative and quantitative data for robust analyses of the protection landscape.

NHS staff must also comply with their regulatory body's codes of practice:

Nursing and Midwifery Council The Code: Professional standards of practice and behaviour for nurses, midwives, and nursing associates

General Medical Council Protecting children and young people – The responsibilities of all doctors

Health and Care Professions Council Standards of conduct, performance and ethics

General Dental Council Standards for the Dental Team

NHS Education for Scotland Core Competency Framework for the Protection of Children

General Pharmaceutical Council Standards for pharmacy professionals

General Optical Council Standards of practice for optometrists and dispensing opticians

The Royal College of Nursing Intercollegiate Framework Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff provides further details of required skills and competencies and applies to all healthcare staff.

Role of Health Boards in Multi-Agency Public Protection Arrangements (MAPPA)

As MAPPA Responsible Authorities, Health Boards are the lead agencies for restricted patients within the meaning of Section 10 of the Management of Offenders etc. (Scotland) Act 2005. They are responsible for both the clinical care and risk management of these patients.

As MAPPA Duty to Co-operate Agencies, Health Boards have a duty to share information which is relevant to risk for all individuals subject to MAPPA. Each Health Board should have a MAPPA health liaison officer who has responsibility for this. The MAPPA health liaison officer also represents the Board at MAPPA meetings about specific individuals and manages information which is relevant to their risk which is provided to them by other MAPPA partners. This information is used to ensure that risk is considered and, when appropriate, managed within a healthcare setting.

Health Boards also have a responsibility to contribute to MAPPA strategic planning. Each Health Board should have a nominated senior manager who attends meetings of the MAPPA Strategic Oversight Groups (the overarching governance forum in each of the 10 MAPPA regions). Senior managers also attend MAPPA meetings about specific individuals who are managed at MAPPA Level 3 (the highest level of MAPPA meeting convened involving the most multi-agency involvement).

The role of the NHS in MAPPA can be summarised as follows:

- Restricted Patients: Health Boards are the lead Responsible Authorities in terms of assessment and management of risk.
- All individuals subject to MAPPA: Health Boards share information with other agencies – receiving and giving information to help protect the public (including NHS employees, contractors, and patients) from serious harm.
- Representation and points of contact – involvement of senior staff who can cover both management and clinical issues.
- Involvement in the strategic management of MAPPA.
- Providing clinical knowledge and resources, where appropriate, to help other agencies in the assessment and management of risk of serious harm posed by sexual and violent offenders.

Health Boards have a critical role in MAPPA, and NHS employees, GP practices, and other independent contractors should be supported to be clear on their role in relation to these arrangements and be appropriately supported. For example, those who attend MAPPA meetings about specific individuals need to know what is expected of them to be able to contribute meaningfully to risk management considerations.

Local leadership, governance, and accountability

Chief Officers in the context of child and adult protection are the Chief Executives of Local Authorities, the Chief Executives of Health Boards, and Police Scotland Divisional Commanders. Chief Officers, both individually and collectively, are responsible for the leadership, direction and scrutiny of child and adult protection services and public protection more broadly. Clear ownership and accountability by Chief Officers is required to ensure that protecting children and adults at risk of harm remains a priority within and across agencies.

Chief Executives of Health Boards are responsible for ensuring that governance, accountability, and assurance reporting frameworks are in place to ensure all health staff, including those contracted, are competent in discharging their child and adult protection responsibilities.

Health Boards also have corporate responsibility for ensuring that NHS staff have access to expert professional leadership and advice from their Health Board designated public protection leads, and it is desirable for this to extend to GP practices and other independent contractors. Whilst Health Board Executive Nurse Directors often have delegated responsibility for child protection, a designated Chief/Lead Nurse or Nurse Consultant (or equivalent) should be in

place in each Health Board with responsibility for child protection. This strategic role carries full-time responsibilities and should have protected time allocation. The lead doctor for child protection is usually a paediatrician who, together with the lead nurse, provides clinical leadership, advice, and strategic planning.

The Chief Officers of Health and Social Care Partnerships are accountable to the Chief Executives of the local authority and the Health Board that make up their partnership, for their role in relation to child and adult protection. These Chief Officers should be appropriately linked to local governance arrangements for the protection of children and adults at risk of harm in their area. This applies regardless of whether children's services are in the scheme of integration and whatever scheme of integration is applied. Health Board Chief Executives should be assured that clinical and care governance has a high profile, ensuring that the quality of care – including attention to child and adult protection - is given the highest priority at every level within integrated services.

Child Protection and Adult Protection Committees are the multi-agency partnerships responsible for monitoring and advising on procedures and practice, ensuring appropriate cooperation between agencies, and improving the skills and knowledge of those with a responsibility for the protection of children and adults at risk. It is crucial that health representation on Committees has sufficient seniority to represent the Health Board in discussions and decisions about policy, resources, and strategy. It is also important that the Health Board is a key contributor to local, multi-agency analyses of child and adult protection data (for example the Minimum Dataset for Child Protection Committees) to ensure that data and intelligence held by health is shared with multi-agency partners and helps build a shared understanding of local needs and service responses.

An overview of national guidance and leadership is provided at Annex A.

Exemplar evidence for Health Boards

The following section sets out exemplar evidence of high-quality, safe, and effective services that promote the protection of children and adults for territorial Health Boards. Some aspects of this evidence will also apply to Special Health Boards. We recognise that some examples provided do not apply equally to all employees and contractors due to varying contractual and management arrangements, in particular with regard to independent general practices.

Chief Executives should consider whether this evidence is reflective of the public protection arrangements in their Health Board, and where further focus is required as part of ongoing development and quality assurance processes.

1. An executive Health Board lead has overall responsibility for child protection, adult protection, and MAPPA and champions public protection across the Health Board and contracted services.

Evidence

- This lead is up to date with their public protection training, has public protection responsibilities reflected in their job description, and participates in relevant Chief Officer and Committee meetings.
- It can be shown that the executive lead promotes a positive culture of safeguarding children (including unborn babies) and adults at risk of harm.
- This lead ensures that local governance arrangements for the protection of children and adults at risk of harm in their area support Chief Officers of Health and Social Care Partnerships.

2. Lead clinicians are resourced and supported to provide advice, expertise, and professional leadership across the Health Board and contracted services.

Evidence

- There is a Chief/Lead Nurse or Nurse Consultant (or equivalent) for child protection. There is a Chief/Lead Nurse or Nurse Consultant (or equivalent) for adult support and protection. If this role is combined it must be shown that the nurse is able to undertake duties within their Health Board area. It can be shown that the Chief/Lead Nurse(s) or Nurse Consultant(s) take the professional lead on all aspects of the health contribution to safeguarding and are central to the Health Board's clinical and care governance processes for public protection.
- In Health Boards providing care to children, there is a Lead Paediatrician for child protection directly employed or contracted through a Service Level Agreement to provide expertise to the Board.

- The Lead Paediatrician and Chief/Lead Nurse or Nurse Consultant (or equivalent) have job descriptions which clearly define their roles, responsibilities, and expectations. They have sufficient protected time and support to carry out their duties and responsibilities.

- There is a designated Health Board Trauma Champion who supports the ongoing development of trauma-informed practice across all services. This role may be undertaken by the Chief/Lead Nurse or Nurse Consultant (or equivalent) in Special Health Boards and smaller territorial Health Boards.

- There is a process in place to monitor the workload of Health Board lead clinicians with a clear reporting mechanism to the executive Health Board lead.

- The Chief/Lead Nurse(s) or Nurse Consultant(s) and Lead Paediatrician have a high degree of visibility across Health Board and contracted services. They are responsible for preparing a child and adult protection annual report for the Health Board to provide assurance that the Board is meeting its obligations in respect of child and adult protection in line with national guidance which highlights areas for improvement.

- Lead clinicians have access to regular supervision appropriate to their role.

- The Chief/Lead Nurse or Nurse Consultant (or equivalent) for adult support and protection has access to relevant resources and support, including links with the NHS Adult Support and Protection Leads Network.

3. All NHS employees, GP practices, and independent contracted practitioners are supported and directed to the actions they need to take when a child or adult is at risk of harm.

Evidence

- The role of Health Board lead clinicians is communicated and understood throughout the Board and contracted services. All employees, GP practices, and independent contracted practitioners know where and when to seek advice, support, and supervision at an appropriate level for their role.

- Public protection protocols and guidance are up to date, aligned with national guidance, and accessible to all employees, GP practices, and independent contractors; information regarding where these protocols and guidance documents can be found is communicated to all.

- Health Board information sharing guidance and advice, including on sharing information during the pre-birth period, is accessible to all employees and contractors. Records are maintained in line with this advice. There are Caldicott Guardians who can advise on sharing information about children and adults at risk of harm.

- There is a mechanism to monitor awareness and understanding of public protection responsibilities and duties including the duty to refer.

- There are arrangements in place to monitor timescales for actions required as part of public protection processes, including the health contribution to Inter-agency Referral Discussions (IRDs), Child Protection Planning Meetings, Adult Protection Case Conferences, MAPPA case review meetings, and reports requested by the Scottish Children's Reporter Administration (SCRA), in line with national guidance. There is a clear reporting mechanism on performance to the executive Health Board lead.

- There is evidence that transitions between age and services, including the Scottish Ambulance Service and NHS 24, particularly where there are multiple and/or complex health needs, are planned and co-ordinated.

4. The Health Board promotes a children's rights-based approach and a culture of listening to children and young people and taking account of their wishes and feelings, both in individual decisions and in the development of services.

- The Health Board can evidence how it meets its statutory duties (including safeguarding and promoting the welfare of children) under the Children (Scotland) Act 1995, which provides a major part of the legal framework for child welfare and protection in Scotland. The Health Board can also evidence how it satisfies its duties under Part 1 of the Children and Young People (Scotland) Act 2014, which embeds duties on public authorities, and can demonstrate how they have secured the better or further effect within its areas of responsibility of the UNCRC requirements.

- Service planning and delivery is developed with an understanding of the evolving capacities of children and young people in relation to decisions which affect them.

- Feedback from children and young people is sought on matters affecting them and used to inform service planning and delivery (Service User feedback), in line with Article 12 of the UNCRC (children and young people have a right to express their views on matters affecting them and for those views to be given due weight).

- The outcomes of individual decisions are evaluated from the perspective of Article 3 of the UNCRC which states that the best interests of the child shall be a primary consideration.

- Complaint procedures are child friendly and adapted according to age, level of maturity, and understanding.

- Support and advocacy are available for children and young people who do not feel their full range of rights, under the UNCRC and otherwise, are being fulfilled.

5. Robust governance, accountability, assurance, and reporting arrangements for public protection are in place across Health Board services.

Evidence

- The Health Board has clear written governance, accountability, and assurance frameworks for public protection that apply to all services, both provided and commissioned. These frameworks link to Scottish Ambulance Service and NHS 24 public protection arrangements. Public protection governance processes and systems apply to IJBs and are embedded in wider Health Board governance arrangements.

- Reporting arrangements enable organisational assurance that all NHS employees and contractors are supported in accessing relevant learning and education appropriate for their role and scope of professional practice.

- There are arrangements to monitor compliance with safer recruitment procedures and selection procedures in relation to children and adults, including Protecting Vulnerable Groups (PVG) scheme membership.

- Guidance and support are in place for employees, GP practices, and independent contractors raising child and adult protection concerns. Audit shows that policy and procedures are adhered to.

- There are clear governance arrangements and processes in place to determine the appropriate review process when the Board is notified about the death of a child or adult who was subject to Adult Support and Protection measures.

6. Education, learning, and development arrangements support all NHS employees, GP practices, and independent contracted practitioners in their public protection roles and responsibilities.

Evidence

- There is an organisational training plan or strategy that ensures all employees and contractors are competent to carry out their public protection responsibilities in line with national guidance.

- All employees and contractors have undertaken training at an appropriate level for their role and area of practice, including the NES eLearning modules to support health professionals in their child and adult protection roles (available on Turas Learn). There is a mechanism in place to ensure that training is up to date.

- An education and learning framework supports all employees and contractors to build confidence and competence in discharging their duty to safeguard and protect children and adults. This framework also

supports all employees and contractors to build confidence and competence in taking a children's rights-based approach.

- Safeguarding training is available on a single and multi-agency basis, accessible to all noted above.

- Senior managers monitor attendance and non-attendance at training.

- Public protection is a mandatory aspect of induction for all employees, GP practices, and contractors, with access to child and adult protection supervision at an appropriate level for their role to support continuous professional development.

- All NHS employees and contractors are trained to the appropriate level, dependant on their role, in line with the Transforming Psychological Trauma Knowledge and Skills Framework, using guidance in the Scottish Psychological Trauma Training Plan.

- NHS employees and contractors are aware of, and suitably skilled, to fulfil their duties in relation to the rights of children and adults.

- All NHS employees and contractors working with children or parents have a clear understanding that young children can be especially vulnerable as they are (often) not able or in a position to verbalise or explain concerns or distress personally.

- All NHS employees and contractors are clear about the interaction of the National Hub for Reviewing and Learning from the Deaths of Children and Young People with other review processes.

7. Strategic and operational arrangements between the Health Board and its multi-agency partners support effective joint working and communication.

Evidence

- There is appropriate and consistent Health Board representation on Chief Officer Groups and Child Protection/Adult Protection/Public Protection Committees with specified reporting mechanisms to the Health Board.

- There is appropriate health representation in Inter-agency Referral Discussions (IRDs), Child Protection Planning Meetings, Adult Protection Case Conferences, Learning Review meetings, and MAPPA Strategic Oversight Group and case review meetings, in line with national guidance. There are systems in place to allow clinicians including, for example, midwives, paediatricians, health visitors, family nurses, and GPs to attend when appropriate. Support and guidance are provided to Board representatives attending these meetings.

- Protocols and guidance are in place to support effective multi-agency working, including Special Health Boards where relevant. This includes that the Health Board can demonstrate its contribution to training and multi-agency audit.

- There are clear arrangements and processes in place to determine the appropriate review process when the Health Board is notified about the death of a child or adult who was subject to Child Protection or Adult Support and Protection measures. There is a process in place for staff to contribute to work across organisations and agencies to undertake one single review wherever this is possible. There is a process in place to notify relevant agencies or bodies if a Health Board-led review is undertaken that may have relevance for wider needs and risk assessment, as well as learning.

- There is a process in place for learning from child and adult protection reviews, including Significant Case Reviews, Learning Reviews, Significant Clinical Incident Reviews, and Significant Adverse Event Reviews, and from inspection findings. Learning is shared across the Health Board and contracted services.

- Health engagement in all risk assessment processes is monitored and reviewed with a clear reporting mechanism to the executive Health Board lead.

- There are clear whistleblowing procedures and a policy for dealing with complaints against employees and contractors.

- The Health Board has clear information sharing guidance which sets out the process and principles for sharing information, relevant to safeguarding and promoting the wellbeing of children and vulnerable adults. This includes guidance on handling and storage of information and records, including responding to requests made under Section 10 of the Adult Support and Protection Act 2007 (Councils may, in certain circumstances, request health records relating to an individual's physical or mental health). Information sharing guidance is accessible to practitioners.

- The Health Board ICT systems allow sharing of information about children and adults for whom there are concerns, and ICT systems allow flagging where there is a concern. Audit work demonstrates public protection learning is disseminated and acted upon.

- The Health Board is a key contributor to local, multi-agency analyses of child and adult protection data (for example the Minimum Dataset for Child Protection Committees) to ensure that data and intelligence held by health is shared with multi-agency partners and helps build a shared understanding of local needs and service responses.

- When the Board is notified about the death of a child or adult who was subject to Adult Support and Protection measures, there is a process in

place to notify relevant agencies or bodies, including those leading on Adult Support and Protection activity, if a Board-led review is undertaken which may have relevance for wider needs and risk assessment, as well as learning.

8. The Health Board provides an effective medical response for children and adults in need of assessment and care.

Evidence

- Arrangements are in place to provide assessment for child abuse and neglect, including joint paediatric/forensic medical assessment examinations (JPFE) when required.

- Medical assessments are conducted in line with sections 9 and/or 11 of the Adult Support and Protection (Scotland) Act 2007 where a Council Officer knows or believes a person is an adult at risk of harm. The assessment may be conducted under an assessment order, if the court has granted an order for a health professional nominated by the council to conduct a private medical examination of the specified person.

- Assessment and care arrangements draw on best practice contained in the Child Protection Scottish National Clinical Guidelines.

- There are clear assessment pathways for accessing assessments of capacity to contribute to protection decisions, including decisions relating to the use of Adult Support and Protection, Adults with Incapacity, and/or Mental Health (Care and Treatment) (Scotland) Act 2003 legislation.

- There is access to appropriately trained medical staff during out of hours periods when there is a requirement for paediatric examination, medical assessment, or a JPFE.

- Processes are in place within Emergency Departments and acute receiving units to respond to suspected abuse and neglect of children and vulnerable adults, with appropriate information sharing mechanisms to support clinical staff and named persons to work in line with Getting it right for every child/everyone.

- Medical assessment and care responses are monitored and reviewed with a clear reporting mechanism to the executive Health Board lead.

Annex A: National Guidance and Leadership

Child protection

Chief Officer guidance

The Protecting Children and Young People: Child Protection Committee and Chief Officer Responsibilities Guidance (2019) sets out Ministers' expectations that Chief Officers work collaboratively with regard to local arrangements for child protection, including to oversee local Child Protection Committees. It also sets out the role of the Chief Social Work Officer in providing professional leadership and supporting performance improvement and management of corporate risk. Additionally, the Chief Social Work Officer has a pivotal role to play in building strong collaborative relationships with Health Board named professional leads for child protection and other professional leads in Health and Social Care Partnerships.

National Guidance for Child Protection in Scotland 2021

The National Child Protection Guidance in Scotland 2021 was published on 2 September 2021, replacing the 2014 version and the 2012 National Guidance for Child Protection in Scotland: Guidance for Health Professionals in Scotland. Revision of the guidance has involved consultation and collaboration with a wide range of partners including a formal Scottish Government consultation. It incorporates understanding of best practice from various sources, including practitioner and stakeholder experience, inspections, research, and learning from Significant Case Reviews.

This guidance sets out the overarching responsibilities for all NHS staff and particular roles and responsibilities for staff within a range of services. The previously separate guidance for health professionals – the 'Pink Book' – has been integrated to underline the multi-agency nature of child protection and the guidance more clearly defines the role, function, and contribution of health professionals and designated services to child protection processes.

The guidance makes clear that NHS employees and contractors working with or treating adults who are parents/carers and/or significant adults must also be alert to the possibility that their patient may pose a risk to an unborn baby or child. Healthcare staff have a duty to act and must raise their concerns in line with local child protection procedures.

The guidance also notes that those experiencing trauma and adversity in childhood, in the absence of compensating protections, are at greater risk of a multiplicity of disadvantage. It states that trauma can leave those most in need of support and protection least able to develop the necessary trusting relationships to engage with health care and wider support and protection services. The need for trauma informed child protection practices is highlighted throughout, specifically in child protection assessment, planning, and interventions that avoid re-traumatising with links to the National Trauma Training Programme.

Further details of the intended outcomes of the new national guidance and key changes from the 2014 version is provided in Annex B.

Linked to the guidance, but published separately is the National Guidance for Child Protection Committees Undertaking Learning Reviews. This guidance supports Child Protection Committees to reflect, learn and improve child protection systems and practice when a child dies, is significantly harmed, or was at risk of death or significant harm, or where effective practice has prevented harm or risk of harm.

Implementation of the National Guidance for Child Protection in Scotland

Implementation of the national guidance will support greater consistency in what children and families can expect in terms of support and protection in all parts of Scotland. However, it is recognised that local structures and protocols must be attuned to local conditions and demands. This may necessitate some flexibility in local implementation, to take account of this context and need.

While a degree of local variability may be seen across the country, the Scottish Government has set out its expectation in the supporting narrative that there should be a clear alignment between local and national guidance, with an expectation that all public bodies in local areas will be able to describe the rationale for any divergent arrangements or practice within the context of their Children's Services and Corporate Parenting Plans. Public bodies will be expected to set out how their practices remain consistent with the national guidance to avoid unwarranted variation and ensure compatibility with their human rights obligations.

A National Child Protection Guidance Implementation Group has been established to provide strategic oversight and offer support to local areas. This group has strong health representation including a Health Board Chief Executive, Executive Nursing Director, clinical and nursing leads, Health Improvement Scotland, and Public Health Scotland. Resources that are currently or soon to be available to support implementation and likely areas of focus include:

- The Minimum Dataset for Child Protection Committees which supports Child Protection Committees to collect, present, and analyse data on key indicators to inform local planning and practice and discussions with Chief Officer Groups. Version 2 of the Minimum Dataset for Child Protection Committees in Scotland was published in June. This includes new key indicators, which align with the guidance and support local areas with implementation. Webinars and bespoke support for CPCs is planned.
- The Chief Officers Public Protection Induction Resource which supports effective leadership and highlights key policy, legislation, and Chief Officers' role within public protection. This resource, which has been developed in response to a request of Chief Officers for induction support, emphasises linkages in the public protection arena, supporting senior leaders to work together and offering opportunities to reflect on their local context and data.
- The development of an NHS Education for Scotland public protection national e-learning education resource to support health professionals in their child and adult protection roles. This "Once for Scotland" approach is

intended to help alleviate some of the current pressures on the resources of individual Health Boards and improve consistency and access to high quality educational resources across Scotland. The aim is to enhance the patient safety culture which the NHS seeks to embed within safe, effective, and person-centred care. The specific focus on public protection is intended to build on each employee's knowledge, competence, and confidence in this area of practice and therefore support, enhance, and maximise their contribution within both a multi-disciplinary and multi-agency context.

Regular updates on the development of implementation supports will be provided to the Chief Executives Group, Scottish Executive Nursing Directors, Scottish Nursing Leadership for Child Protection, Scottish Association of Medical Directors, and Child Protection Managed Clinical Networks.

The National Child Protection Guidance Implementation Group reports to the National Child Protection Leadership Group. Membership of the National Child Protection Leadership Group, which is chaired by the Minister for Children and Young People, includes the Chief Medical Officer and Chief Nursing Officer. It also has Health Board Chief Executive and Executive Nurse Director representation.

Adult support and protection

The Adult Support and Protection (Scotland) Act 2007 provides measures to identify, support and protect certain adults who may be at risk of any type of harm, including neglect; self-harm or self-neglect; physical, psychological, sexual, financial, or institutional harm. Health Boards have duties under the Act to refer adults they know or believe to be at risk of harm and to co-operate with other agencies to aid inquiries and investigations. Additionally, the Adult Support and Protection Code of Practice sets out the roles and responsibilities of named public bodies, including health, and others in relation to supporting and protecting adults at risk of harm.

The Code of Practice has been refreshed to ensure it takes account of policy and practice developments since the Act came into operation in 2008, and brings the guidance up to date with current legislation and relevant changes in policy. The revised Code was published in July 2022.
The substantive amendments are:

- More detail about the three-point criteria in section 3 of the Act, which determines if a person is an "adult at risk" for the purposes of the Act
- Clarification on capacity and consent
- Emphasis on the duty to refer and co-operate in inquiries
- Clarification regarding information sharing expectations
- Clarification of relationship between inquiries and investigations
- New sections on referrals and related matters
- Further detail and clarification on visits and interviews
- New chapter on assessing and managing risk, including case reviews and large scale investigations
- New section on chronologies

In tandem with the refresh of the ASP Code of Practice, revisions have also been made to the Guidance for General Practice. The updated guidance provides greater clarity so that GP practices can be confident that their actions will meet safeguarding expectations and improve outcomes, whilst adhering to their professional guidelines and ethos.
Revisions to note include:

- expanded sections on information sharing
- emphasis on collaboration and co-operation
- trauma and its impacts
- types of harm, locations, and undue pressure
- the role of general practice in ASP
- the referral process – why and when

Both the revised ASP Code of Practice and updated ASP GP Practice Guidance place considerable emphasis on the need for trauma informed approaches to Adult Support and Protection practices.

The Adult Support and Protection (Scotland) Act 2007 recognises that a person may be capable of some decisions and actions and not capable of others. A person lacks capacity to take a particular decision or action when there is evidence that he/she is unable to do so. Adult support and protection applies to those with and without mental capacity. ASP legislation is relevant to those who are "unable to safeguard their own well-being, property, rights or other interests."

Health professionals may be the first professionals to see signs of potential harm, and thus a collaborative approach is vital. Participation of health staff and managers is invaluable when developing or refining local adult protection policy, procedure, and strategy. This includes contributions from GP practices.

Like Child Protection Learning Reviews, the purpose of Adult Protection Significant Case Reviews (SCR) is to learn lessons from circumstances where an adult at risk has died or been significantly harmed.

Scottish Government has revised the ASP Significant Case Review (SCR) Guidance and published National Guidance for Adult Protection Committees Undertaking Learning Reviews, aligning this with the recently published Child Protection Learning Review Guidance. The purpose of the learning review guidance is to promote consistency and to make it easier for learning to be shared. It provides a common set of objectives and criteria for establishing if a learning review is required. The guidance is designed to complement local processes. The Adult Protection Committee is responsible for deciding whether a learning review is warranted using the criteria in this framework, and for agreeing the way in which the review is conducted on behalf of the Chief Officers Group or equivalent. Some Adult Protection Committees may have an established group whose role is to oversee, on behalf of the Adult Protection Committee, matters relating to learning reviews.

Scottish Government is also working with the Care Inspectorate to identify and share learning arising from learning reviews, as well as from Initial Case Reviews and SCRs undertaken since November 2019.

MAPPA

Updated MAPPA National Guidance, which was published on 31 March 2022, provides guidance to support the Responsible Authorities in carrying out their statutory obligations under Section 10 of the Management of Offenders etc. (Scotland) Act 2005.

Annex B: National Guidance for Child Protection in Scotland 2021 – Intended Outcomes and Key Changes

The intended outcomes of the National Child Protection Guidance in Scotland 2021 are to:

- Support a reduction in the incidence of significant harm and child death in Scotland

- Improve professional inter-agency practice, supervision, management, training, and development

- Promote a shared, rights-based inter-agency ethos and philosophy of care and protection, as experienced by children, families, and communities

This guidance integrates child protection within the GIRFEC continuum. It uses GIRFEC language and core components to frame identification and proportionate responses to child protection concerns within the national practice model.

There are tonal changes including a focus on engagement and collaboration with families, on building resilience, strengthening relationships, and ensuring a learning culture in workforce supervision, training, and development, as well as a focus throughout on children's rights.

Standards and principles are augmented with, for example, new guidance on assessment, interviewing, and planning; trauma informed practice; chronologies; timescales; and complex investigations. General principles also underpin the consideration and conduct of investigative activities in relation to children who may be harmed and those who may cause harm to others.

Other key changes in the 2021 National Child Protection Guidance include revisions to core requirements including, for example, new guidance on information sharing and focus on children's rights throughout.

There is additional detail on essential processes such as Inter-agency Referral Discussions (IRDs). Whereas the 2014 National Child Protection Guidance referred only to social work and the police, the 2021 guidance sets out that:

> "Where information is received by Police, Health or Social Work that a child may have been abused or neglected and/or is suffering or is likely to suffer significant harm, an IRD must be convened as soon as reasonably practicable."

In relation to core professionals the guidance states that:

> "Practitioners in police, social work and health must participate in the IRD; and Education/ELC may have an essential contribution. Information gathering should involve Education/ELC; and other services working together to ensure child safety, as appropriate. IRD participants must be sufficiently senior to assess and discuss available information and make

decisions on behalf of their agencies. They must have access to agency guidance, training and supervision in relation to this role."

Within the guidance the term 'child' is taken to mean a child up to 18 years of age (it also considers the protection of unborn babies). Where a child is aged between 16 and 18 and requires support and protection, the guidance sets out the need for multi-agency professional judgement and assessment to consider which legal framework best fits the child's needs and circumstances.

The guidance strengthens the role of adult services and underlines their responsibility to consider the needs of children and their parents where vulnerability and protection needs are identified.

The guidance notes the crucial roles that ambulance crews and NHS 24 staff have in the recognition and timely response to public protection concerns in relation to unborn babies and children.

The guidance also emphasises the requirement for services to work together to ensure the best protection of children at key transition points. This includes transitions between placements; schools; child and adult services (including transition between child and adult protection processes); stages of recovery; and phases of relationships when vulnerabilities may present. There is additional information on child protection in transitions to adult life and services for disabled children.

Child Protection Case Conferences (CPCCs) have been renamed as Child Protection Planning Meetings (CPPMs), allowing families to clearly understand the purpose of the meeting. This change is to terminology alone; these meetings still operate as multi-disciplinary meetings and have the same importance and purpose as a CPCC. The CPPM continues to require paediatricians' input, particularly in the cases where medical evidence is crucial to decision making for the child and family.

Other changes have been made to sections relating to child protection assessment and planning including pre-birth Child Protection Planning Meetings, Joint Investigative Interviews, and health assessment and medical examination. There is also a new section added on multi-agency child protection assessment.

Part 4 of the guidance covering specific support needs and concerns has been re-written and includes many new sections/text on areas including sexual abuse; disabled children; parents with learning disabilities; domestic abuse; Fabricated or Induced Illness (FII); Sudden Unexpected Death in Infants and children (SUDI); transitional phases; when obesity is a cause for escalating concerns about risk of harm; mental ill health in adults and children; and children and families affected by alcohol and drug use.

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NHS PUBLIC PROTECTION ACCOUNTABILITY and ASSURANCE FRAMEWORK
EXEMPLAR EVIDENCE – GAP ANALYSIS

1. An executive Health Board lead has overall responsibility for child protection, adult protection, and MAPPA and champions public protection across the Health Board and contracted services.		
Exemplar Evidence		**Fife Gap Analysis**
1.1	This lead is up to date with their public protection training, has public protection responsibilities reflected in their job description, and participates in relevant Chief Officer and Committee meetings. **NO GAP**	The lead is the Executive Director of Nursing. **TRAINING:** The lead is up to date with TURAS learn modules: • Adult Protection • Gender Based Violence • Human Trafficking • Protecting our Children • MAPPA Has completed Chief Officers' Public Protection Induction resource **JOB DESCRIPTION:** Extract from job description - • *The Executive Director of Nursing, Midwifery and Allied Health Professions will provide energy, drive, leadership and strategic direction, in partnership with Director colleagues, in the delivery of continuous improvement in the clinical performance of NHS Fife, with a specific focus on:* Patient and Public Protection of vulnerable adults and children. • *As an Executive Member of the NHS Fife Board and the Corporate Management Team, fully contribute to and participate in the corporate management and governance of NHS Fife. Specifically, as Lead Director:* responsibility for directing the Head of Public Protection, make the lives of at-risk children and adults safer by providing effective and responsive services which reduce the risk of harm and ensure action is taken to protect them when required, both directly through NHS Fife's actions and in partnership with other relevant agencies. • **PARTICIPATION in MEETINGS**: The lead is a member of COPS, CPC, APC (currently represented by Director of Nursing – Acute Services))

1.2	It can be shown that the executive lead promotes a positive culture of safeguarding children (including unborn babies) and adults at risk of harm. **GAP**	Promotes policies and procedures, education and training; quality and safety. Will be further informed by self-evaluation
1.3	This lead ensures that local governance arrangements for the protection of children and adults at risk of harm in their area support Chief Officers of Health and Social Care Partnerships. **GAP**	Local governance arrangements support CO of HSCP but further work is required and will be informed by self- evaluation

2. Lead clinicians are resourced and supported to provide advice, expertise, and professional leadership across the Health Board and contracted services.		
Exemplar Evidence		**Fife Gap Analysis**
2.1	There is a Chief/Lead Nurse or Nurse Consultant (or equivalent) for child protection. There is a Chief/Lead Nurse or Nurse Consultant (or equivalent) for adult support and protection. If this role is combined it must be shown that the nurse is able to undertake duties within their Health Board area. It can be shown that the Chief/Lead Nurse(s) or Nurse Consultant(s) take the professional lead on all aspects of the health contribution to safeguarding and are central to the Health Board's clinical and care governance processes for public protection. **GAP**	**Child Protection (CP)** – **gap** – Lead Nurse (LN) CP has limited capacity to attend IRD review group. CP Lead Paediatrician (LP) exploring attending. (Evidence - LNCP works to the CP LN job description. LN CP is a member of the Child Protection Committee (CPC) and attends the CPC sub groups - data, self-evaluation, Case review working group. The LNCP chairs the NHS Fife Acute CP group. LNCP is a contributing member of the Child Protection Health Steering group (CPHSG).) **Adult Support and Protection (ASP)** - **gap** – There is no Chief Nurse / Lead role for ASP. Band 6 job description: NHS Fife ASP training coordinator – attends Case Review working group, Learning & Development WG (Deputy Chair), Self Evaluation WG, Hoarding & Self Neglect WG, NHS Fife ASP leads WG and the NHS Scotland ASP leads network. There is not a combined role. Benchmarking across other Boards: some Boards have a Public Protection Chief / Lead Nurse (AfC band 8C / 8D).

2.2	In Health Boards providing care to children, there is a Lead Paediatrician for child protection directly employed or contracted through a Service Level Agreement to provide expertise to the Board **NO GAP**	**CP** - **No gap** (evidence – LNCP and LPCP in post)
2.3	The Lead Paediatrician and Chief/Lead Nurse or Nurse Consultant (or equivalent) have job descriptions which clearly define their roles, responsibilities, and expectations. They have sufficient protected time and support to carry out their duties and responsibilities **GAP**	**CP** - LN CP professional development is compromised as a result of operational and strategic demand. Very limited protected time due to competing demands, new posts progressing to support. LP has protected time but competing priorities with acute general Paediatric role. (evidence – LN CP and CP LP have job descriptions defining roles) **ASP** – Job description and role title does not reflect current responsibilities and expectations.
2.4	There is a designated Health Board Trauma Champion who supports the ongoing development of trauma-informed practice across all services. This role may be undertaken by the Chief/Lead Nurse or Nurse Consultant (or equivalent) in Special Health Boards and smaller territorial Health Boards. **CP – No GAP** **ASP - GAP**	**CP** - No gap (evidence – Health board trauma champions in place, LN CP attends trauma steering group, mandatory trauma informed training across the Children's Service workforce, LP developing trauma informed training with psychology for paediatric services) **ASP** – gap no capacity to attend
2.5	There is a process in place to monitor the workload of Health Board lead clinicians with a clear reporting mechanism to the executive Health Board lead. **GAP**	Lead CP paed – gap

2.6	The Chief/Lead Nurse(s) or Nurse Consultant(s) and Lead Paediatrician have a high degree of visibility across Health Board and contracted services. They are responsible for preparing a child and adult protection annual report for the Health Board to provide assurance that the Board is meeting its obligations in respect of child and adult protection in line with national guidance which highlights areas for improvement. **CP – No GAP** **ASP - GAP**	**CP** - No gap. (evidence – accessible across NHS Fife and FHSCP, visible across all of children's and MW services, member of CHMT, LN CP making links with AP services, LN CP produces annual report, LNCP sits on GIWDG and health GIWDG to progress the implementation of the new national CP guidance, learning from Learning Reviews (LR)) **ASP** – gap - Head of complex care provides ASP annual report
2.7	Lead clinicians have access to regular supervision appropriate to their role **CP – No GAP**	**CP** - LN CP & LP progressing joint case CP reflective supervision sessions. MCN peer review month however, limited capacity to attend. LP has set up multiagency supervision sessions LP attends MCN physical and CSA peer review alongside access to peer supervision with CP Paediatrician colleagues (Evidence - Managerial supervision monthly, professional supervision monthly access to monthly MCN peer review as capacity allows)
2.8	The Chief/Lead Nurse or Nurse Consultant (or equivalent) for adult support and protection has access to relevant resources and support, including links with the NHS Adult Support and Protection Leads Network **ASP - GAP**	GAP – no Chief / Lead Nurse in post

3. All NHS employees, GP practices, and independent contracted practitioners are supported and directed to the actions they need to take when a child or adult is at risk of harm.		
Exemplar Evidence		**Fife Gap Analysis**
3.1	The role of Health Board lead clinicians is communicated and understood throughout the Board and contracted services. All employees, GP practices, and independent contracted practitioners know where and when to seek advice, support, and supervision at an appropriate level for their role. **NO GAP**	**CP** – Advice on where to seek Child Protection advice is on Blink which all health professionals in NHS Fife have access to. (evidence – GP rep on CPHSG) **ASP** – Advise on Blink
3.2	Public protection protocols and guidance are up to date, aligned with national guidance, and accessible to all employees, GP practices, and independent contractors; information regarding where these protocols and guidance documents can be found is communicated to all. **NO GAP**	**CP** - Multiagency policy and protocols all require review and updating in line with the new CP guidance.(evidence – Blink CP page has been reviewed by CP LN and LP and has been updated with multiagency and single agency policy, protocols, guidance and leaflets) ASP – Multiagency procedures in place and updated, single agency protocols require review and updating in line with updated code of conduct and governance. ASP coordinator updates and reviews BLINK with up-to-date information, training, protocols and a link toFife.gov multiagency information.

3.3	Health Board information sharing guidance and advice, including on sharing information during the pre-birth period, is accessible to all employees and contractors. Records are maintained in line with this advice. There are Caldicott Guardians who can advise on sharing information about children and adults at risk of harm **GAP**	**CP** - CPC Information sharing protocol requires review and updating. There has been a delay due to national Police Scotland conflict. Health information governance representative has reviewed November 2022 from health perspective. Caldicott Guardian Memorandum of Understanding will need updated in relation to new CP guidance – unable to progress at present until agreement between partners is reached. No separate pre birth information sharing – not required. (evidence – Caldicott Guardian Memorandum of Understanding in place for information sharing for children up to age 16, updated October 2022) **ASP** - Scottish Accord on the Sharing of Personal Information - Information Sharing Protocol for Fife ASP is under review (since 2016) The Adult Support & Protection Act (Scotland) 2007 and recent updated Code of Conduct July 2022 are widely used in the legal framework for sharing information.
3.4	There is a mechanism to monitor awareness and understanding of public protection responsibilities and duties including the duty to refer. **GAP**	**CP** - Gap - Not all services have oversight of CP training attendance of staff. Children's services are trialling a database to capture. CP team report on number of training sessions offered. How do we evidence understanding and not just delivery – toolkit will help give examples of evidence **ASP** – Currently on workplan to emerge a SLWG to develop an audit tool to yearly address this with the hope to establish a baseline to work with.

3.5	There are arrangements in place to monitor timescales for actions required as part of public protection processes, including the health contribution to Inter-agency Referral Discussions (IRDs), Child Protection Planning Meetings, Adult Protection Case Conferences, MAPPA case review meetings, and reports requested by the Scottish Children's Reporter Administration (SCRA), in line with national guidance. There is a clear reporting mechanism on performance to the executive Health Board lead **GAP**	**CP** – Some detail captured in some services but not reported. (evidence – health IRD contribution captured – 100% for 2022/2023.) **ASP** – This is all under review and developments are being made alongside DATIX to enable reports, monitoring and overview of the ASP process. Progress may be limited due to the inability to have adequate resources in place to track and mange this.
3.6	There is evidence that transitions between age and services, including the Scottish Ambulance Service and NHS 24, particularly where there are multiple and/or complex health needs, are planned and co-ordinated. **GAP**	**CP** - NHS24 PPR1 form process currently being reviewed by CP team & SN service with view to developing a pathway. toolkit may support examples of evidence for other services ie CYPNS/ED/CAMHS **ASP** – NHS 24 are represented on the ASP leads network but no clear links within Fife SAS representative attends ASP NHS Fife Leads steering group Young person's 16-18 years olds under review

4. The Health Board promotes a children's rights-based approach and a culture of listening to children and young people and taking account of their wishes and feelings, both in individual decisions and in the development of services.		
	Exemplar Evidence	**Fife Gap Analysis**
4.1	The Health Board can evidence how it meets its statutory duties (including safeguarding and promoting the welfare of children) under the Children (Scotland) Act 1995, which provides a major part of the legal framework for child welfare and protection in Scotland. The Health Board can also evidence how it satisfies its duties under Part 1 of the Children and Young People (Scotland) Act 2014, which embeds duties on public authorities, and can demonstrate how they have secured the better or further effect within its areas of responsibility of the UNCRC requirements. **GAP**	**CP** - Progress but gaps remain ie awareness of The Promise/UNCRC and implications for children's and adult services, not all services considering Children's Rights and Wellbeing Impact Assessment (CRWIA) – (evidence policy or measure has considered UNCRC is being used by some services, ongoing work of Children's services groups exploring ways to raise awareness of The Promise and Children's rights across the partnership. CP guidance and GIRFEC refresh.)
4.2	Service planning and delivery is developed with an understanding of the evolving capacities of children and young people in relation to decisions which affect them **GAP**	**CP** - Likely gaps, needs exploration with individual services (evidence - SN service when completing LAC Health Needs assessment acknowledge the importance of advocacy for CYP to support attendance at LAC reviews. Parent and child's views considered.)
4.3	Feedback from children and young people is sought on matters affecting them and used to inform service planning and delivery (Service User feedback), in line with Article 12 of the UNCRC (children and young people have a right to express their views on matters affecting them and for those views to be given due weight) **GAP**	**CP** - Likely gaps, needs exploration with individual services. Embedding CRWIA. Adult services. LP - User feedback is being collected from CYP who are in the CP process to inform serice planning and delivery. Results to be reported to CPC. (evidence – SN service when completing LAC Health Needs assessment acknowledge the importance of advocacy for CYP to support attendance at LAC reviews. Parent and child's views considered.)

4.4	The outcomes of individual decisions are evaluated from the perspective of Article 3 of the UNCRC which states that the best interests of the child shall be a primary consideration. **GAP**	**CP** - Likely gaps, needs exploration with individual services
4.5	Complaint procedures are child friendly and adapted according to age, level of maturity, and understanding **GAP**	**CP** - Gap – no complaints procedure for children, National child complaint procedure being developed ? approved spring 2023. (link, Siobhan, head of patient experince)
4.6	Support and advocacy are available for children and young people who do not feel their full range of rights, under the UNCRC and otherwise, are being fulfilled. **GAP**	**CP** – likely gap, some services aware of their role and responsibility in signposting to third sector advocacy support. (link, Vicky Birrell re advocacy strategy)

5. Robust governance, accountability, assurance, and reporting arrangements for public protection are in place across Health Board services		
	Exemplar Evidence	**Fife Gap Analysis**
5.1	The Health Board has clear written governance, accountability, and assurance frameworks for public protection that apply to all services, both provided and commissioned. These frameworks link to Scottish Ambulance Service and NHS 24 public protection arrangements. Public protection governance processes and systems apply to IJBs and are embedded in wider Health Board governance arrangements. **GAP**	**CP** - Governance reporting arrangements in place Gap in relation to SAS/NHS24. Representation on CPHSG LN CP has NHS24 link – Public Protection LN **ASP** – all governance being developed, and risk identified to the NHS ASP risk register.

5.2	Reporting arrangements enable organisational assurance that all NHS employees and contractors are supported in accessing relevant learning and education appropriate for their role and scope of professional practice. **GAP**	**CP** – awaiting appointment of perm CP L&D coordinator All employees must complete their induction training and keep up to date with mandatory training which include Child Protection training appropriate to their level of responsibility **ASP** – a learning review of current ASP training framework being carried out along with competency framework to enable assurance to be given
5.3	There are arrangements to monitor compliance with safer recruitment procedures and selection procedures in relation to children and adults, including Protecting Vulnerable Groups (PVG) scheme membership **NO GAP**	**CP** – HR process in place, no gap **ASP** – As above
5.4	Guidance and support are in place for employees, GP practices, and independent contractors raising child and adult protection concerns. Audit shows that policy and procedures are adhered to. **GAP**	**CP** - CP advice line available for all NHS staff. Individual services require to audit. Category available on Datix to capture same. (RV FROG to determine if info available). Potential gap – audit – Children's services reporting to CPHSG, children's services CP QA framework - doesn't fit with electronic system - Morse. **ASP** - Protocol requires reviewed and audit tool needs to be developed.
5.5	There are clear governance arrangements and processes in place to determine the appropriate review process when the Board is notified about the death of a child or adult who was subject to Adult Support and Protection measures. **NO GAP**	**CP** - Escalation process in place through exception reporting **ASP** – Case Review Working group health representatives notified as per Learning Review guidance.

6. Education, learning, and development arrangements support all NHS employees, GP practices, and independent contracted practitioners in their public protection roles and responsibilities		
	Exemplar Evidence	**Fife Gap Analysis**
6.1	There is an organisational training plan or strategy that ensures all employees and contractors are competent to carry out their public protection responsibilities in line with national guidance **GAP**	**CP** - Backlog regarding training due to staffing capacity in the CP team over past 15 months. No multiagency training. CPC L&D Lead Officer now in post. Awaiting appointment of CP L&D coordinator. **ASP** – No training plan in place currently only x 1 staff member to manage whole NHS Fife/H&SCP training needs. Reviewing all training available. NES offering ASP on TURAS and Multiagency training available but no clear pathway for health staff
6.2	All employees and contractors have undertaken training at an appropriate level for their role and area of practice, including the NES eLearning modules to support health professionals in their child and adult protection roles (available on Turas Learn). There is a mechanism in place to ensure that training is up to date **GAP**	**CP** - NES e learning modules level 2 now utilisied in NHS Fife from January 2023. Level 1 recommended by LN CP – however advised requires discussion from workforce and development. **ASP** – NES e-learning modules level 1 and level 2 are available on TURAS but currently not signposted in Fife. Discussion around core and mandatory training taking place
6.3	An education and learning framework support all employees and contractors to build confidence and competence in discharging their duty to safeguard and protect children and adults. This framework also supports all employees and contractors to build confidence and competence in taking a children's rights-based approach **GAP**	**CP** -CP L&D coordinator post developed and currently out to advert. Temporary post recruitment unsuccessful. **ASP** – Staffing capacity is limited to enable this fully KA reviewing framework

6.4	Safeguarding training is available on a single and multi-agency basis, accessible to all noted above. **GAP**	**CP** - Minimal single agency training provided by CP team in 2022/2023 due to staffing constraints. Available chronologies training sessions have been targeted at HV/FN in the first instance with expansion to SN service if unfilled places. Unable to recruit to temporary CP L&D post, now advertised as permanent. No multiagency training available. Recent recruitment to CPC L&D Lead Officer who will progress this work. (evidence – chronologies training refreshed 2022, Level 2 CP training now progressed to NES PP CP module, Court Room Skills e-learning refreshed and relaunched with input form legal team/SCRA in 2022 following a period of unavailability) **ASP** – Minimal single agency training provided due to staffing capacity. Muti-agency training available although was scaled back significantly 2020-2022
6.5	Senior managers monitor attendance and non-attendance at training. **GAP**	**CP** - Not all services have oversight of CP training attendance of staff. (evidence- TNA reviewed and circulate in 2022 with extension to adult services)
6.6	Public protection is a mandatory aspect of induction for all employees, GP practices, and contractors, with access to child and adult protection supervision at an appropriate level for their role to support continuous professional development. **GAP**	**CP** - NES e learning Level 1 recommended by LN CP – however advised requires discussion from workforce and development. LP - Annual GP training carried out by managed clinical network with training needs analysis sent out prior. **ASP** – as above

6.7	All NHS employees and contractors are trained to the appropriate level, dependant on their role, in line with the Transforming Psychological Trauma Knowledge and Skills Framework, using guidance in the Scottish Psychological Trauma Training Plan. **GAP**	ASP – Unknown and unclear as to development
6.8	NHS employees and contractors are aware of, and suitably skilled, to fulfil their duties in relation to the rights of children and adults **GAP**	**CP** - Ongoing work from CHMT **ASP** – Despite ongoing work in a variety of areas this is not known
6.9	All NHS employees and contractors working with children or parents have a clear understanding that young children can be especially vulnerable as they are (often) not able or in a position to verbalise or explain concerns or distress personally. **NO GAP**	**CP** - (Evidence – covered in CP training, use of voice of the infant by HV/FN/peri mental health team non mobile infant bruising policy.)
6.10	All NHS employees and contractors are clear about the interaction of the National Hub for Reviewing and Learning from the Deaths of Children and Young People with other review processes. **GAP**	**CP** - Gap, Coordinator invited to discuss the Hub and her role at CPHSG in Feb – meeting now rescheduled to June. Consider GPs/dentistry - GP joining commissioning group. comms plan required. 7min briefing produced – does this need to be recirculated.

7. Strategic and operational arrangements between the Health Board and its multi-agency partners support effective joint working and communication		
	Exemplar Evidence	**Fife Gap Analysis**
7.1	There is appropriate and consistent Health Board representation on Chief Officer Groups and Child Protection/Adult Protection/Public Protection Committees with specified reporting mechanisms to the Health Board. **NO GAP**	**CP** – no gap **ASP** – no gap
7.2	There is appropriate health representation in Inter-agency Referral Discussions (IRDs), Child Protection Planning Meetings, Adult Protection Case Conferences, Learning Review meetings, and MAPPA Strategic Oversight Group and case review meetings, in line with national guidance. There are systems in place to allow clinicians including, for example, midwives, paediatricians, health visitors, family nurses, and GPs to attend when appropriate. Support and guidance are provided to Board representatives attending these meetings **NO GAP**	**CP** – no gap **ASP** – feedback from SW identifies that health regularly participate in IRD's, Case Conferences. Whilst no system in place, guidance is available.
7.3	Protocols and guidance are in place to support effective multi-agency working, including Special Health Boards where relevant. This includes that the Health Board can demonstrate its contribution to training and multi-agency audit **NO GAP**	**CP** - (evidence - CP LN attends CPC data group and self evaluation and audit group) **ASP** – Coordinator attends Fife ASP Self Evaluation Working Group and is a consistent in all multi-agency and national audits.

7.4	There are clear arrangements and processes in place to determine the appropriate review process when the Health Board is notified about the death of a child or adult who was subject to Child Protection or Adult Support and Protection measures. There is a process in place for staff to contribute to work across organisations and agencies to undertake one single review wherever this is possible. There is a process in place to notify relevant agencies or bodies if a Health Board-led review is undertaken that may have relevance for wider needs and risk assessment, as well as learning **GAP**	**CP** – LR – consider process for recording reviews when a child is injured **ASP** Senior Manager and coordinator attend the Case review working group which reviews the cases on a multi-agency platform. Processes are required to ensure learning required and risks are shared and upheld with the wider health board.
7.5	There is a process in place for learning from child and adult protection reviews, including Significant Case Reviews, Learning Reviews, Significant Clinical Incident Reviews, and Significant Adverse Event Reviews, and from inspection findings. Learning is shared across the Health Board and contracted services **GAP**	**ASP** – This is currently being developed as nothing in place to date.
7.6	Health engagement in all risk assessment processes is monitored and reviewed with a clear reporting mechanism to the executive Health Board lead. **GAP**	No monitoring system in place
7.7	There are clear whistleblowing procedures and a policy for dealing with complaints against employees and contractors. **NO GAP**	**CP** – no gap **ASP** – no gap

7.8	The Health Board has clear information sharing guidance which sets out the process and principles for sharing information, relevant to safeguarding and promoting the wellbeing of children and vulnerable adults. This includes guidance on handling and storage of information and records, including responding to requests made under Section 10 of the Adult Support and Protection Act 2007 (Councils may, in certain circumstances, request health records relating to an individual's physical or mental health). Information sharing guidance is accessible to practitioners. **GAP**	**CP** - Information sharing protocol requires review – identified as priority of CP guidance group. (evidence – CP team have a MOU with the Caldicott Guardian regarding sharing information of those CYP under 16.)
7.9	The Health Board ICT systems allow sharing of information about children and adults for whom there are concerns, and ICT systems allow flagging where there is a concern. Audit work demonstrates public protection learning is disseminated and acted upon **GAP**	No clear audit process. Challenges KIS LP - There is a SOP in place for flagging children and families involved in the Cp process and this is reviewed regularly. (Evidence- Child protection messaging guidance) **ASP** - Unclear
7.10	The Health Board is a key contributor to local, multi-agency analyses of child and adult protection data (for example the Minimum Dataset for Child Protection Committees) to ensure that data and intelligence held by health is shared with multi-agency partners and helps build a shared understanding of local needs and service responses **CP – NO GAP** **ASP - GAP**	**CP** - No gap. Consideration being given to an additional health dataset to further support the minimum dataset. **ASP** – Minimum dataset is in development currently information given adhoc

7.11	When the Board is notified about the death of a child or adult who was subject to Adult Support and Protection measures, there is a process in place to notify relevant agencies or bodies, including those leading on Adult Support and Protection activity, if a Board-led review is undertaken which may have relevance for wider needs and risk assessment, as well as learning **NO GAP**	Through AE process

8. The Health Board provides an effective medical response for children and adults in need of assessment and care		
	Exemplar Evidence	**Fife Gap Analysis**
8.1	Arrangements are in place to provide assessment for child abuse and neglect, including joint paediatric/forensic medical assessment examinations (JPFE) when required **NO GAP**	**CP** – no gap (Evidence- guideline on consenting YP for medicals, guideline on joint approach to assessment and report writing)
8.2	Medical assessments are conducted in line with sections 9 and/or 11 of the Adult Support and Protection (Scotland) Act 2007 where a Council Officer knows or believes a person is an adult at risk of harm. The assessment may be conducted under an assessment order, if the court has granted an order for a health professional nominated by the council to conduct a private medical examination of the specified person **NO GAP**	**CP** – no gap (Evidence- guideline on consenting YP for medicals, guideline on joint approach to assessment and report writing and national consent proforma used.) **ASP** – No Assessment orders have been applied for in Fife. Medical assessments carried out in line with Sections
8.3	Assessment and care arrangements draw on best practice contained in the Child Protection Scottish National Clinical Guidelines **NO GAP**	National proformas used in assessing CYP in Child protection medicals. Use of GIRFEC tools and neglect toolkits to enable holistic assessments.

8.4	There are clear assessment pathways for accessing assessments of capacity to contribute to protection decisions, including decisions relating to the use of Adult Support and Protection, Adults with Incapacity, and/or Mental Health (Care and Treatment) (Scotland) Act 2003 legislation. **GAP**	Guidance on BLINK intranet on referral pathways for vulnerable adults **ASP** – under review by ASP national leads
8.5	There is access to appropriately trained medical staff during out of hours periods when there is a requirement for paediatric examination, medical assessment, or a JPFE **NO GAP**	**CP** – No gap (evidence – arrangement with Lothian in place for OOH CSA medicals)
8.6	Processes are in place within Emergency Departments and acute receiving units to respond to suspected abuse and neglect of children and vulnerable adults, with appropriate information sharing mechanisms to support clinical staff and named persons to work in line with Getting it right for every child/everyone **NO GAP**	**CP** – Guideline on BLINK with induction training to ED staff with lead CP clinician in ED. Links with Child wellbeing liaison nurse to ED to pick up any well being concerns and escalate concerns to child protection if necessary. Quarterly reports with governance reporting structure for this.
8.7	Medical assessment and care responses are monitored and reviewed with a clear reporting mechanism to the executive Health Board lead. **GAP**	**CP** – National reporting mechanism for those undergoing CSA examinations in keeping with HIS standards. Data is collected on those undergoing all CP examinations (evidence- annual injuries in under 2 audit)

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**5 May 2023**
Title:	**Integrated Performance & Quality Report**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Bryan Archibald, Head of Performance**

1 Purpose

This is presented for:

- Assurance
- Discussion

This report relates to:

- Annual Delivery Plan

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

- Safe
- Effective
- Person Centred

2 Report Summary

2.1 Situation

This report informs the Clinical Governance (CG) Committee of performance in NHS Fife and the Health & Social Care Partnership against a range of key measures (as defined by Scottish Government 'Standards' and local targets). The period covered by the performance data is generally up to the end of February, although there are some measures with a significant time lag and a few which are available up to the end of March.

2.2 Background

The Integrated Performance & Quality Report (IPQR) is the main corporate reporting tool for the NHS Fife Board and is produced monthly.

Improvement actions are included following finalisation of the Annual Delivery Plan for 2022/23 and 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 2022/23 Annual Delivery Plan (ADP), which was submitted to the Scottish Government at the end of July 2022.

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	70%	Not achieving
HSMR	Quarterly	1.00 (Scotland average)	Below Scottish average
Falls [2]	Monthly	6.91 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	Not achieving
Complaints (S1)	Monthly	80%	Not achieving
Complaints (S2) [3]	Monthly	50%	Not achieving

[1] Reporting on the closure rate of actions from Major & Extreme Adverse Events started in December 2022

[2] As part of ongoing improvement work, revised targets for Falls and Pressure Ulcers have been set for FY 2022/23. These are a 10% reduction on the FY 2021/22 target

for Falls, and a 25% reduction on the actual achievement in FY 2020/21 for Pressure Ulcers.

[3] An improvement target of 50% by March 2023, rising to 65% by March 2024 was agreed by the Director of Nursing. However, performance has been very much lower than the 50% provisional target, generally due to closing long-term complaints. A further measure (Stage 2 Complaints Raised in Month and Closed Within 20 Working Days) has been added. This has no target.

2.3.1 Quality/ Patient Care

IPQR contains quality measures.

2.3.2 Workforce

IPQR contains workforce measures.

2.3.3 Financial

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

2.3.4 Risk Assessment/Management

A mapping of key Corporate Risks to measures within the IPQR is provided via a Risk Summary Table and the Executive Summary narratives.

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

Not applicable.

2.3.6 Climate Emergency & Sustainability Impact

Not applicable.

2.3.7 Communication, involvement, engagement and consultation

The NHS Fife Board Members and existing Standing Committees are aware of the approach to the production of the IPQR and the performance framework in which it resides.

The Clinical Governance extract of the February IPQR will be available for discussion at the meeting on 05 May.

2.3.8 Route to the Meeting

The IPQR was ratified by EDG on 20 April and approved for release by the Director of Finance & Strategy.

2.4 Recommendation

The report is being presented to the CG Committee for:

- **Assurance**
- **Discussion** – Examine and consider the NHS Fife performance as summarised in the IPQR

3 List of appendices

- Integrated Performance and Quality Report

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Fife Integrated Performance & Quality Report

CLINICAL GOVERNANCE

Produced in April 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 for Patient TTG, New Outpatients and Diagnostics.

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) 2022/23, 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
20 April 2023

Prepared by:
SUSAN FRASER
Associate Director of Planning & Performance

a. Corporate Risk Summary

To be cross referenced with in depth Risk Report presented at Committees and NHS Board

Strategic Priority	Total Risks	Current Strategic Risk Profile				Risk Movement	Risk Appetite
To improve health and wellbeing	5	3	2	-	-	◀ ▶	High
To improve the quality of health and care services	5	5	-	-	-	◀ ▶	Moderate
To improve staff experience and wellbeing	2	2	-	-	-	◀ ▶	Moderate
To deliver value and sustainability	6	4	2	-	-	◀ ▶	Moderate
Total	**18**	**14**	**4**	**0**	**0**		

Summary Statement on Risk Profile

Current assessment indicates delivery against 3 of the 4 strategic priorities facing a risk profile in excess of risk appetite.

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

Risk Improvement Trajectory for high risks and Corporate Risk Register assessment in place.

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

b. Indicator Summary

Section	Indicator	Target 2022/23	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	Feb-23	45	○	▲	▼	●	
	Major/Extreme Adverse Events - % Actions Closed on Time	70%	Month	Feb-23	55.6%	●	▲	▲	●	
	HSMR	N/A	Year Ending	Sep-22	0.98	●	–	–	●	
	Inpatient Falls	6.91	Month	Feb-23	8.54	○	▼	▼	●	
	Inpatient Falls with Harm	1.65	Month	Feb-23	2.15	○	▼	▼	●	
	Pressure Ulcers	0.89	Month	Feb-23	1.17	○	▲	▲	●	
	SAB - HAI/HCAI	18.8	Month	Feb-23	14.4	○	▲	▲	●	QE Sep-22
	C Diff - HAI/HCAI	6.5	Month	Feb-23	14.4	○	▲	▼	●	QE Sep-22
	ECB - HAI/HCAI	33.0	Month	Feb-23	36.0	○	▼	▼	●	QE Sep-22
	S1 Complaints Closed in Month on Time	80%	Month	Feb-23	48.8%	●	▼	▼	●	2021/22
	S2 Complaints Closed in Month on Time	50%	Month	Feb-23	8.6%	○	▲	▼	●	2021/22
	S2 Complaints Due in Month and Closed On Time	N/A	Month	Feb-23	12.9%	●	▲	▲	●	
Operational Performance	IVF Treatment Waiting Times	90%	Month	Dec-22	100.0%	●	◀▶	◀▶		
	4-Hour Emergency Access	95%	Month	Mar-23	69.7%	○	▼	▼	●	Feb-23
	Patient TTG % <= 12 Weeks	100%	Month	Feb-23	44.9%	●	▼	▼	●	Dec-22
	New Outpatients % <= 12 Weeks	95%	Month	Feb-23	46.6%	●	▲	▼	●	Dec-22
	Diagnostics % <= 6 Weeks	100%	Month	Feb-23	59.9%	●	▲	▼	●	Dec-22
	Cancer 31-Day DTT	95%	Month	Feb-23	90.1%	○	▼	▼	●	QE Dec-22
	Cancer 62-Day RTT	95%	Month	Feb-23	67.5%	○	◀▶	▼	●	QE Dec-22
	Detect Cancer Early	29%	Year Ending	Jun-22	25.7%	●	▲	▲	●	2020, 2021
	Freedom of Information Requests	85%	Month	Mar-23	77.1%	●	▼	▼	●	
	Delayed Discharge % Bed Days Lost (All)	N/A	Month	Mar-23	9.0%	●	▲	▲	●	QE Sep-22
	Delayed Discharge % Bed Days Lost (Standard)	5%	Month	Mar-23	4.6%	○	▲	▲	●	QE Sep-22
	Antenatal Access	80%	Month	Dec-22	86.1%	●	▼	▲	●	CY 2022
Finance	Revenue Resource Limit Performance	(£16.0m)	Month	Feb-23	(£20.0m)	●	–	–	●	
	Capital Resource Limit Performance	£30.7m	Month	Feb-23	£24.7m	●	–	–	●	
Staff Governance	Sickness Absence	4.00%	Month	Feb-23	6.95%	○	▲	▼	●	YE Mar-22
	Personal Development Plan & Review (PDPR)	80%	Month	Mar-23	37.9%	●	▲	–	●	
Public Health & Wellbeing	Smoking Cessation (FY 2022/23)	473	YTD	Nov-22	218	●	–	–	●	YT Jun-22
	CAMHS Waiting Times	90%	Month	Feb-23	83.2%	○	▲	▲	●	QE Dec-22
	Psychological Therapies Waiting Times	90%	Month	Feb-23	69.6%	○	▼	▼	●	QE Dec-22
	Drugs & Alcohol Waiting Times	90%	Month	Jan-23	96.7%	●	▼	▲	●	QE Dec-22
	Immunisation: 6-in-1 at Age 12 Months	95%	Quarter	Dec-22	95.1%	○	▲	▲	●	QE Dec-22
	Immunisation: MMR2 at 5 Years	92%	Quarter	Dec-22	86.3%	○	▼	▼	●	QE Dec-22

Performance Key

- on schedule to meet Standard/Delivery trajectory
- behind (but within 5% of) the Standard/Delivery trajectory
- more than 5% behind the Standard/Delivery trajectory

SPC Key

- ○ Within control limits
- ○ Special cause variation, out with control limits
- ● No SPC applied

Change Key

- ▲ "Better" than comparator period
- ◀▶ No Change
- ▼ "Worse" than comparator period
- – Not Applicable

Benchmarking Key

- ● Upper Quartile
- ● Mid Range
- ● Lower Quartile
- ● Not Available

c. Projected and Actual Activity

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

		Quarter End Jun-22	Quarter End Sep-22	Quarter End Dec-22	Month End Jan-23	Month End Feb-23	Month End Mar-23	Quarter End Mar-23
TTG Inpatient/Daycase Activity (Definitions as per Waiting Times Datamart)	Projected	3,036	3,053	3,087	1,029	1,029	1,029	3,087
	Actual	2,880	2,994	3,145	1,029	1,091	1,189	3,309
	Variance	-156	-59	58	0	62	160	222
New OP Activity (F2F, NearMe, Telephone, Virtual) (Definitions as per Waiting Times Datamart)	Projected	18,567	18,806	19,156	6,376	6,395	6,395	19,166
	Actual	20,962	21,455	21,810	7,415	7,736	8,667	23,818
	Variance	2,395	2,649	2,654	1,039	1,341	2,272	4,652
Elective Scope Activity (Definitions as per Diagnostic Monthly Management Information)	Projected	1,491	1,491	1,491	497	497	497	1,491
	Actual	1,550	1,609	1,678	560	498	555	1,613
	Variance	59	118	187	63	1	58	122
Elective Imaging Activity (Definitions as per Diagnostic Monthly Management Information)	Projected	11,988	11,988	11,988	3,996	3,996	3,996	11,988
	Actual	13,471	12,936	11,875	4,238	3,930		8,168
	Variance	1,483	948	-113	242	-66		

d. Assessment

CLINICAL GOVERNANCE

To improve the quality of health and care services | 5 | 5 | - | - | - | Moderate

		Target	Current
Major & Extreme Adverse Events	*70% of Action from Major and Extreme Adverse Events to be closed within time*	**70%**	**55.6%**

There were 45 major/extreme adverse events reported in February of a total of 1,352 incidents. Over the past 12 months, Pressure Ulcer developing on ward has been the most common major/extreme incident reported.

There were 15 actions relating to LAER/SAER in February, from total of 27 closed, 55.6%. There was a total of 380 actions open at the beginning of February, with 72 (18%) being within time.

Poor compliance with closure of actions from Major and Extreme Adverse Events is recognised and escalated through the Clinical Governance Oversight Group. There will be a significant focus on all aspects of actions management in the ongoing adverse events improvement plan in 2023 which will include collaboration with the Organisation Learning Group.

HSMR		**1.00**	**0.98**

Data for 2021 and Q1-3 of 2022 demonstrates a return to a typical ratio for NHS Fife, with the data for year ending September 2022 showing a ratio below the Scottish average.

Inpatient Falls	*Reduce all patient falls rate by 10% in FY 2022/23 compared to the target for FY 2021/22*	**6.91**	**8.58**

The number of inpatient falls fell slightly in in February, with an increase in Acute Services being more than offset by a fall across the Partnership. However, with it only being a 28-day month, the OBD figure was also reduced, and the actual falls rate therefore increased. It was the highest recorded since February 2021.

The overall rate remained higher than target for March 2023 and above the rate in February 2022 (7.33). The rate in FY 2022/23 to date is 7.52; for the same period of FY 2021/22, it was 7.75. The reduction is attributable to improvement within the Partnership.

The majority of falls in the last 3 months (95%) were classified as 'Minor Harm' or 'No Harm' but the actual number resulting in Major/Extreme Harm remained high.

The updated Falls Toolkit was delayed and will now be launched in May 2023. The Link Practitioner framework has been agreed with testing in Acute & HSCP underway.

Pressure Ulcers	*Reduce pressure ulcer rate by 25% in FY 2022/23 compared to the rate in FY 2021/22*	**0.89**	**1.17**

The rate of pressure ulcers reduced in February, to around the 2-year average (1.15). This was mainly a result of only recording two incidents across the Partnership; the rate in Acute Services remained high.

The cumulative rate in the first 11 months of FY 2022/23 was slightly less than for the same period in FY 2021/22 (1.13 against 1.19) but remains above the target for FY 2022/23. On the positive side, the Acute Services rate is also lower when comparing the two periods.

Early intervention by Acute Services Tissue Viability teams has not yet had an impact but this will be monitored. HSCP has completed a pressure ulcer audit which identified some learning to take forward for inpatient settings. Community nursing have identified a checklist which is showing effectiveness using QI methodology, this is now being used in other areas and impact will continue to be monitored. HON from both the HSCP and ASD have been identified as leads for commencing an Operational Group, the first meeting will be planned when HON meet this week, TOR and membership still to be established. Tissue viability teams are developing an SBAR to consider future of tissue viability across NHS Fife.

SAB (MRSA/MSSA)	*We will reduce the rate of HAI/HCAI by 10% between March 2019 and March 2023*	**18.8**	**14.4**

		Target	Current

The SAB infection rate varies from month to month and has been below the March 2023 target in 9 of the last 12 months. Of the 51 HAI/HCAI reported in last 12 months (infection rate of 12.3), 13 have been categorised as VAD with 12 'Skin and Soft Tissue, while 12 have been categorised as either 'Other' or 'Not Known'.

Fife has been below the Scottish average for 8 successive quarters. This has been achieved by enhanced surveillance of SAB, standardising vascular access devices (VAD) care, the implementation of ePVC insertion and maintenance bundles and targeted QI work.

The IPCT performs the following actions:

- Enhanced surveillance and analysis of SAB data to understand the magnitude of the risks to patients in Fife
- Timely feedback of data to key stakeholders to assist teams in minimising the occurrence of SABs
- Examination of the impact of interventions targeted at reducing SABs
- Uses results locally for prioritising resources
- Uses data such as the weekly ePVC compliance report to inform clinical practice improvements
- Continues to liaise and support Drug Addiction Services with people who inject drugs (PWID) and SABs Note: 2022 has seen a marked increase in PWIDs cohort SAB infections (n=11), when compared to 2021 (n=4)

In order to maintain such low rates and to further reduce SABs, the local and national intelligence highlights the following areas for focus; medical devices (including VADs) and non-vascular access medical devices, skin & soft tissue infections (including PWIDs).

C Diff	*We will reduce the rate of HAI/HCAI by 10% between March 2019 and March 2023*	**6.5**	**14.4**

The C Diff infection rate varies from month to month but has been above the March 2023 target for much of FY 2022/23. There have been 13 infections reported over the past 3 months, highest quarterly total since November 2019, with a rate of 14.5. A key improvement aim is the reduction of 'recurrent' infections, and this continues to be a challenge, with 8 of the 41 HAI/HCAI and Community infections in the past year being identified under this category.

Fife has been below the Scottish average for each of the last 14 quarters. This has been achieved with strong antimicrobial stewardship, Consultant Microbiologist establishing optimum antimicrobial therapy for patients at high risk of recurrent CDI, enhanced surveillance and analysis of risk factors.

The challenge is to further reduce the noted low rates of CDI. Work focuses on recurrent CDI (2022 equalled the previous year with the number of recurrent infections); each CDI case is assessed for suitability of extended pulsed Fidaxomicin (EPFX) regime aiming to prevent recurrent disease in high-risk patients. Bezlotoxumab has been used in cases where other modalities have failed.

ECB	*We will reduce the rate of HAI/HCAI by 25% between March 2019 and March 2023*	**33.0**	**36.0**

The total number of HCAI ECB cases in 2022 was slightly lower than the previous 2 years (2022 n=123, 2021 n=127 and 2020 n=137) However, Q3 2022 National Report, Fife was slightly above the Scottish rate for HCAI. In both hospital-acquired and non-hospital-acquired infections, the renal tract is the major source of infection (with cystitis/lower UTI the major entry point) along with hepato-biliary infections.

To achieve the reduction target, NHS Fife continues to focus on enhanced surveillance, to gain learning, evaluate preventative measures and improve practices. One current initiative within the HSCP includes the Infection Control Surveillance team alerting the patient`s care team Manager by Datix when an ECB is a urinary catheter associated infection and exploring the case via a Complex Care Review (CCR). The aim of the process is to provide further learning from all ECB CAUTIs.

Ongoing work to support best practice in urinary catheter care continues with NHS Fife`s Urinary Catheter Improvement Group (UCIG) targeting quality improvement work. This group aims to minimize urinary catheters, thus helping to prevent catheter associated healthcare infections and trauma and, furthermore, to establish catheter improvement work in Fife.

CAUTI insertion and maintenance bundles were developed and installed onto Patientrack in February 2022 and this has been piloted, currently the tool is being reviewed prior to roll out across the board. This bundle should ensure that the correct processes for the insertion and maintenance of all urinary catheters are adhered to within NHS Fife inpatient wards.

A QI project led by the IPC Care Home Senior IPCN for NHS Fife has introduced CAUTI maintenance bundles within 4 care homes in Fife. The staff are supported with an education package and the aim is to eventually roll it out

		Target	Current
across all Fife care homes, thus optimising urinary catheter maintenance and reducing the risk of CAUTIS and ECBs.			
Complaints – Stage 2	*At least 50% of Stage 2 complaints will be completed within 20 working days by March 2023, rising to 65% by March 2024*	**50%**	**8.6%**

There were 25 stage 2 complaints received in February, all acknowledged within timescales, with 35 closed. Of those closed, 3 (8.6%) were within timescales with 21 greater than 40 days after deadline. 31 complaints were due in the month with of 4 (12.9%) closed.

Nearly two thirds of open complaints have been open for more than 40 days with a third more than 80 days.

The Patient Experience Team (PET) Lead is focusing on quality checking response letters, ensuring all complaint points have been answered, readability of response along with spelling and grammar.

The complaint “complexity scoring” tool to triage complaints and categorise them as low, moderate, or high complexity continues to be tested. The complexity categorisation score will provide insight into the volume of complex complaints that NHS Fife receives and handles.

A "complaints escalation" standard operating procedure (SOP) is being drafted. This will highlight and support with processing complaints within the agreed national timescales, in line with the model handling complaint procedure.

A new process has been implemented to ensure compliance with acknowledgement timeframes for complaints. This has seen an improvement in compliance for February with 100% of acknowledgement letters being sent withing the timeframe (3 working days).

The digital & information team has created a preliminary summary page for the PET Dashboard. This will be reviewed over the next month to agree on data metrics and reporting priorities. A further request has been submitted and will be passed to a business analyst to review the current processes and recommend a suitable system to support documentation systems within the complaint-handling process.

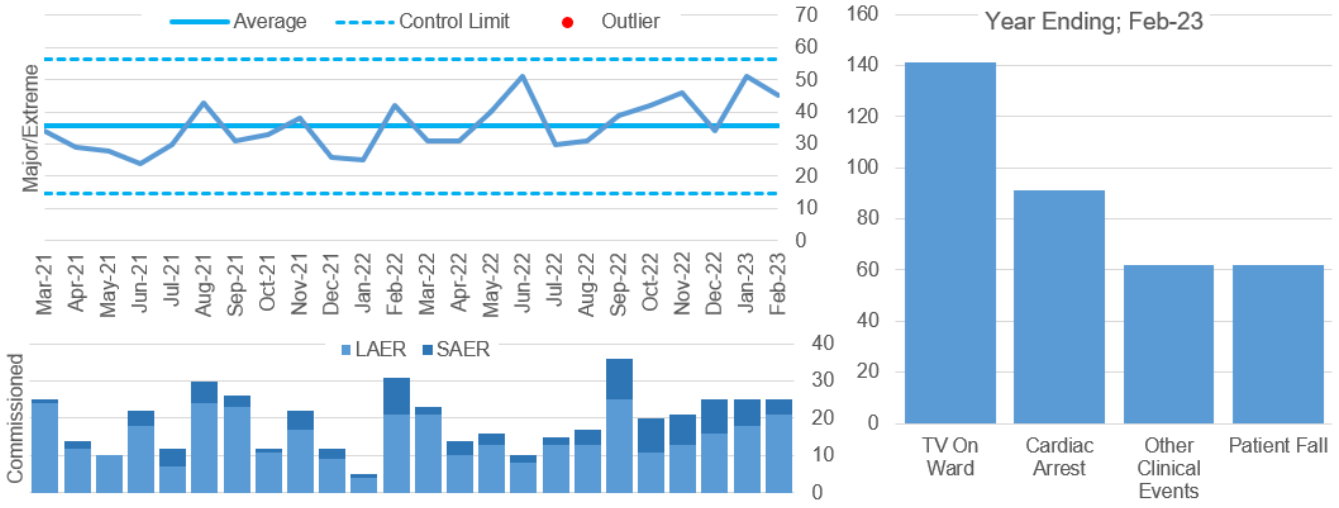
Due to vacancies arising within the Patient Experience Team, 2 Band 6 PET Officers post (1.8 WTE) and a Band 4 Support Officer will be advertised. The Band 4 PET Administrator post, which will focus on the administration and the navigation of complaints, has been advertised and shortlisted.

We continue to work with services, review new ways of working, and understand challenges. Clinical pressures continue to impact performance with obtaining statements and approval of final responses. An MS Forms questionnaire has been created to gather information and to try to understand the barriers staff are experiencing with providing statements. This will be tested before widespread dissemination.

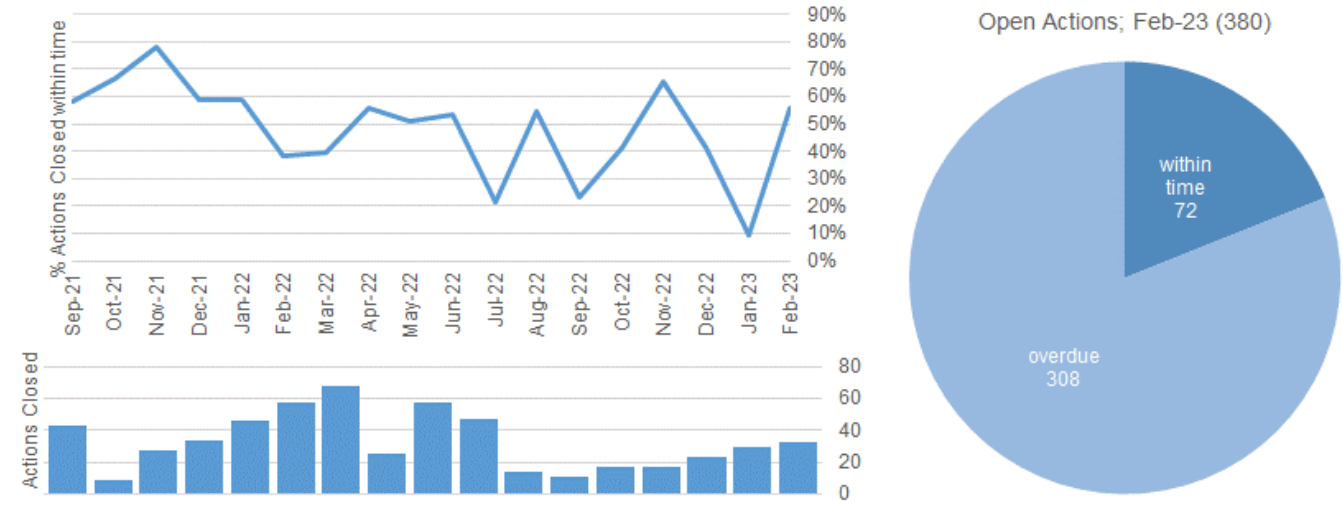
At the end of February 2023, 84% of all live complaints were awaiting statements or final approval by the divisions. The number of live complaints has reduced from 145 to 141 since the start of Quarter 4 (January 2023) despite 53 new complaints being submitted during that period.

e. Performance Exception Reports

Adverse Events	Number 45



Actions from Significant and Local Adverse Event Reviews	Closure Rate 55.6%



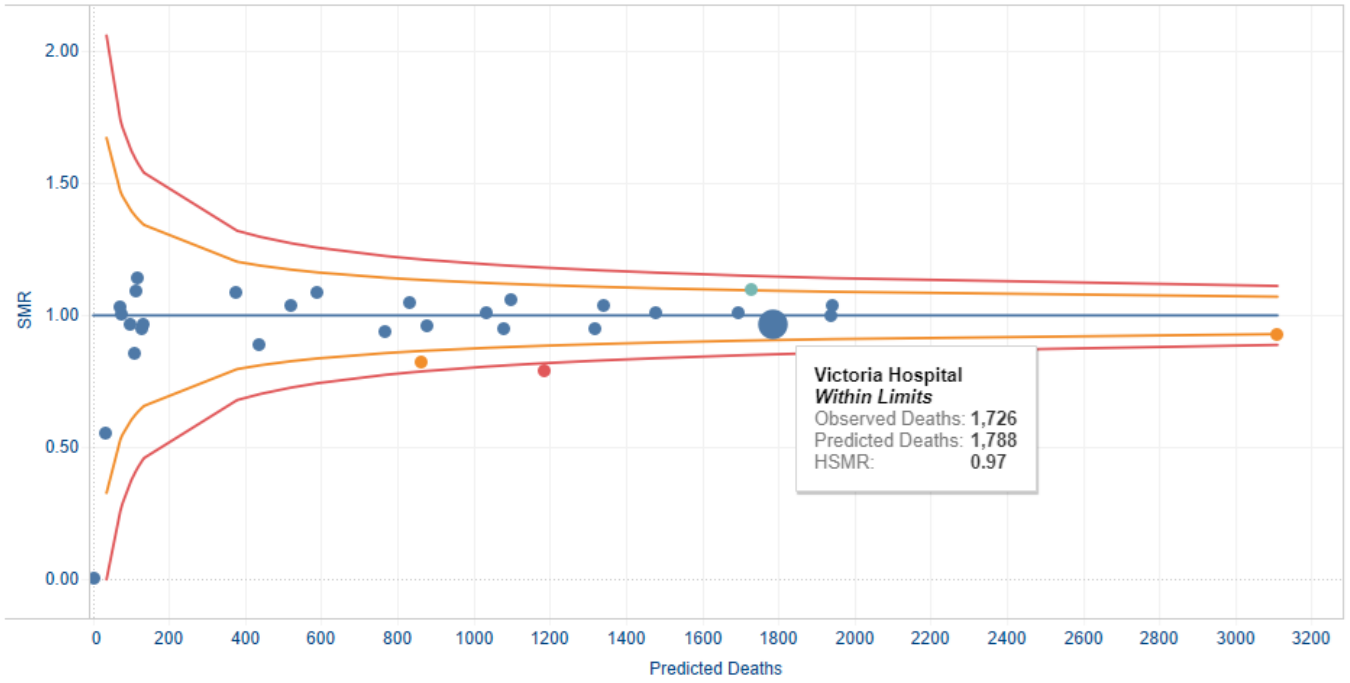
Key Deliverable		End Date
Adverse Event Process and Policy		Mar-23 Complete
Key Milestones	Review of Policy	Dec-22 Complete
	Increased focus on governance/assurance in relation to improvement actions from adverse events reviews	Mar-23 Complete
	Training and Education	Mar-23 Complete

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 0.98

Reporting Period; October 2021 to September 2022[p]

Please note that as of August 2019, HSMR is presented using a 12-month reporting period when making comparisons against the national average. This will be advanced by three months with each quarterly update.

The rate for Victoria Hospital is shown within the Funnel Plot.



Commentary

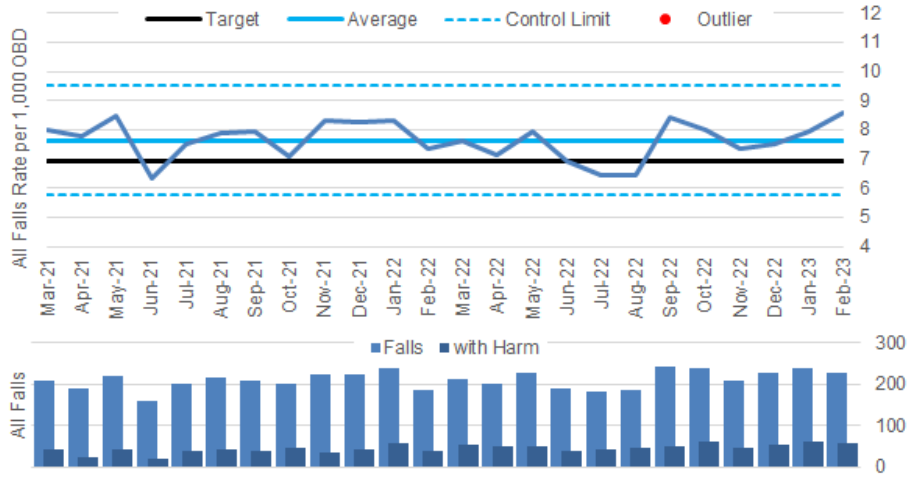
Data for 2021 and Q1-3 of 2022 demonstrates a return to a typical ratio for NHS Fife, with the data for year ending September 2022 showing a ratio below the Scottish average.

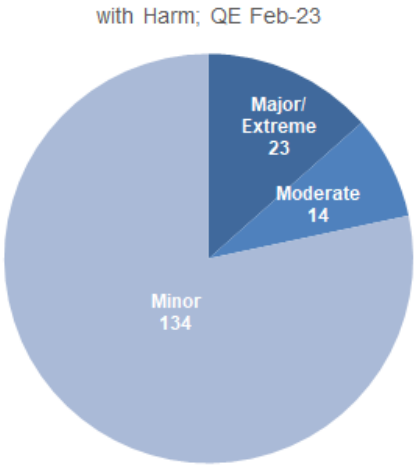
Inpatient Falls

Reduce Inpatient Falls rate per 1,000 Occupied Bed Days (OBD)
Target Rate (by end March 2023) = 6.91 per 1,000 OBD

Performance 8.58

Local Performance





Performance by Service Area

	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23
NHS Fife	7.33	7.62	7.13	7.94	6.91	6.44	6.45	8.44	8.00	7.37	7.54	7.91	8.58
Acute	7.55	7.10	8.25	8.18	7.83	8.06	6.67	9.56	7.81	8.29	7.41	8.29	10.23
HSCP	7.16	8.08	6.14	7.72	6.08	4.97	6.25	7.47	8.18	6.58	7.65	7.58	7.21

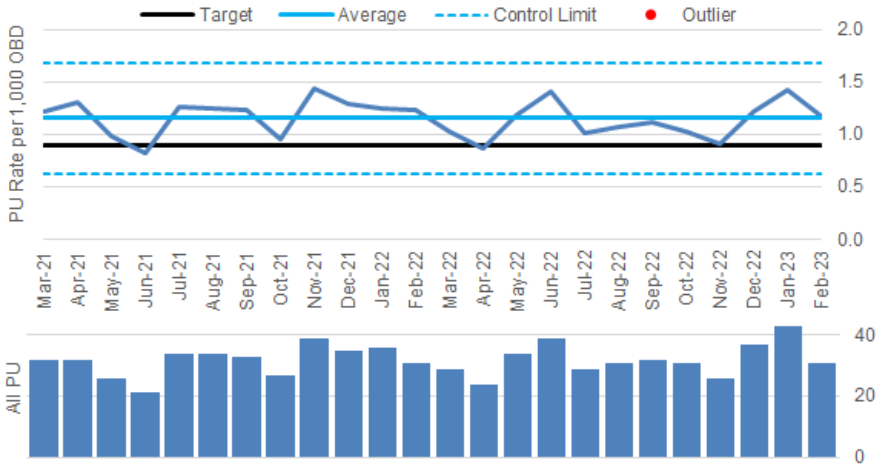
Key Deliverable	End Date
Reduction in number of Patient Falls in order to achieve specified reduction target in this FY	Mar-24 At risk
Key Milestones Refresh Falls Champions Register and Network	Sep-23 On Track
Ensure that monthly falls data continues to be discussed and displayed in each ward setting along with associated improvement plans	Sep-23 At risk
Develop an Audit programme for 2022/23	Jun-22 Complete
Review and refresh Falls Toolkit	Apr-23 Complete
Review Related policies- Supervision, Boarding and Bed rails as identified/required by the policy timescales	Apr-23 On track
Review LEARN summaries to support shared learning	May-23 On track
Explore feasibility of implementation of Falls module on Patient Trak	Apr-23 Suspended
Explore QI resource to support clinical staff and enhance local improvement work	Apr-23 Complete

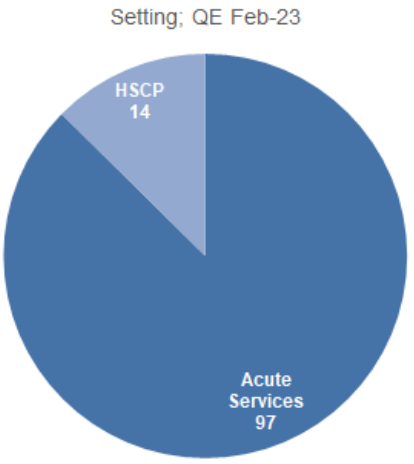
Pressure Ulcers

Reduce pressure ulcers (grades 2 to 4) developed in a healthcare setting
Target Rate (by end March 2023) = 0.89 per 1,000 OBD

Performance 1.17

Local Performance





Performance by Service Area

	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23
NHS Fife	1.23	1.03	0.87	1.18	1.40	1.02	1.07	1.11	1.03	0.91	1.22	1.42	1.17
Acute	1.84	1.76	1.37	1.77	2.05	1.48	1.69	2.02	1.90	1.28	2.20	2.53	2.41
HSCP	0.72	0.40	0.41	0.66	0.82	0.60	0.52	0.32	0.25	0.59	0.32	0.44	0.14

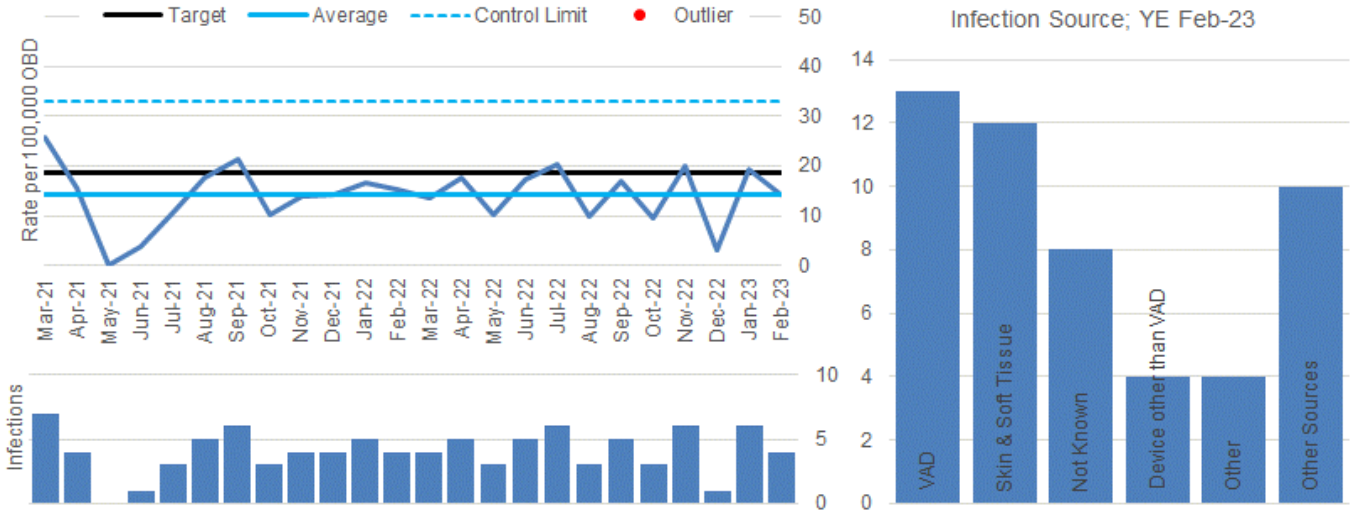
	Key Deliverable	End Date
	Reduction in number of Pressure Ulcers (PU) developed on case load across all health care setting in order to achieve specified reduction target in this FY	Jun-23 Off track
Key Milestones	Refresh PU Link Practitioner Register and Network	Oct-22 Complete
	Ensure that monthly PU data continues to be discussed and displayed in each ward setting, associated improvement plans developed and implemented where required	Mar-23 Complete
	PU data discussed and shared with senior HSCP management team at bi-weekly QMASH meeting	Mar-23 Complete
	PU Documentation Audit to support compliance	Mar-23 On track
	Review LEARN summaries to support shared learning	Mar-23 On track
	Measurement against the revised HIS Prevention and Management of Pressure Ulcer Standards (October 2020)	Mar-23 Suspended
	Establish an operational TV group	Mar-23 Complete
	Embed the revised HIS Pressure Ulcer Standards (October 2020)	Oct-23 Suspended
	Develop and test electronic PURA and SSKIN bundle on Patientrack	Oct-22 Complete
	Embed the use of the CAIR resource	Jun-23 Off Track
	Clinical teams with an increase in PU harms to collect process measures to identify and plan improvements	Mar-23 Complete
	Develop a training and education plan	Oct-22 Complete

SAB (HAI/HCAI)

Reduce Hospital Infection Rate by 10% (in comparison to FY 2018/19 rate) by the end of FY 2022/23

Performance 14.4

Local Performance



National Benchmarking

Quarter Ending	2020/21	2021/22				2022/23	
	Mar	Jun	Sep	Dec	Mar	Jun	Sep
NHS Fife	17.8	6.3	16.6	12.7	15.2	14.9	15.7
Scotland	18.4	18.6	18.3	17.3	16.3	17.3	17.1

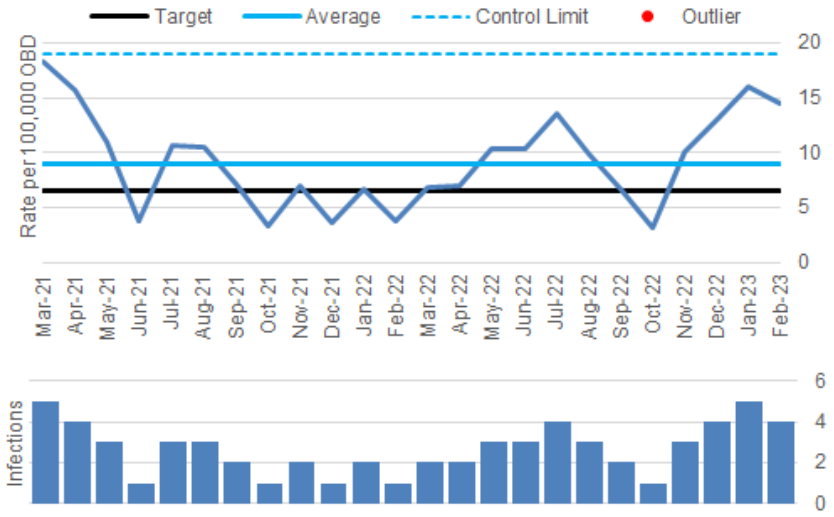
Key Deliverable	End Date
Local and national programme of surveillance; to undertake surveillance programmes which are compliant with mandatory national requirements and identify areas for improvement	Mar-24 On track
Programme of audit; monitor IPC standard operating procedures, guidelines and practice in all patient care areas using the agreed tools to a pre-set plan, with feedback of findings provided in the form of written reports/ action plans	Jul-23 On track
IPC Education & training: Infection Prevention and Control knowledge and training for staff are fundamental for safe patient care	Mar-24 On track

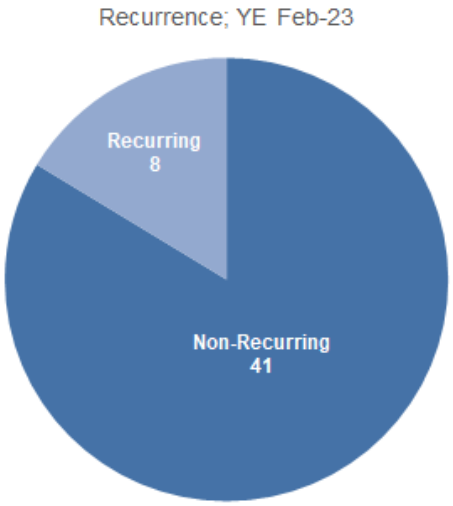
C Diff (HAI/HCAI)

Reduce Hospital Infection Rate by 10% (in comparison to FY 2018/19 rate) by the end of FY 2022/23

Performance 14.4

Local Performance





National Benchmarking

Quarter Ending	2020/21	2021/22				2022/23	
	Mar	Jun	Sep	Dec	Mar	Jun	Sep
NHS Fife	14.0	10.0	9.5	4.6	7.0	9.2	10.1
Scotland	15.8	14.6	16.8	13.3	12.6	14.3	13.1

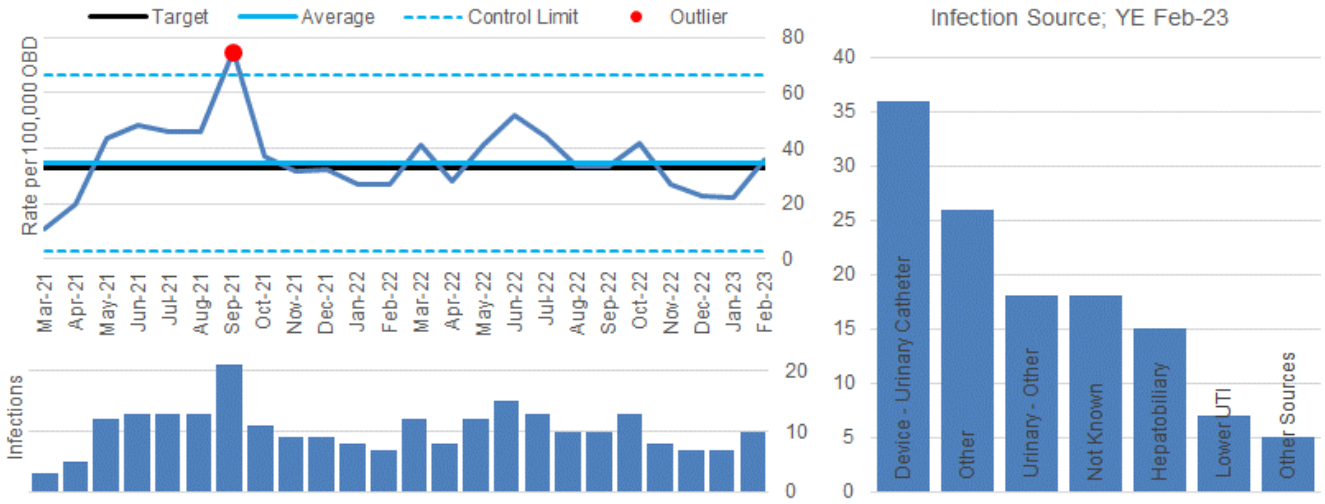
Key Deliverable		End Date
Local and national programme of surveillance; to undertake surveillance programmes which are compliant with mandatory national requirements and identify areas for improvement		Mar-24 On track
Key Milestones	Optimise communications with all clinical teams in ASD & the HSCP	Jul-23 On track
	Reduce overall prescribing of antibiotics	Mar-24 On track
	Reducing recurrence of CDI	Mar-24 At risk
Programme of audit; monitor IPC standard operating procedures, guidelines and practice in all patient care areas using the agreed tools to a pre-set plan, with feedback of findings provided in the form of written reports/ action plans		Jul-23 On track
IPC Education & training: Infection Prevention and Control knowledge and training for staff are fundamental for safe patient care		Mar-24 On track

ECB (HAI/HCAI)

Reduce Hospital Infection Rate by 25% (in comparison to FY 2018/19 rate) by the end of FY 2022/23

Performance 36.0

Local Performance



National Benchmarking

Quarter Ending	2020/21	2021/22				2022/23	
	Mar	Jun	Sep	Dec	Mar	Jun	Sep
NHS Fife	21.6	37.6	60.3	33.6	31.6	40.2	36.9
Scotland	34.7	38.2	41.5	34.1	30.5	34.8	36.2

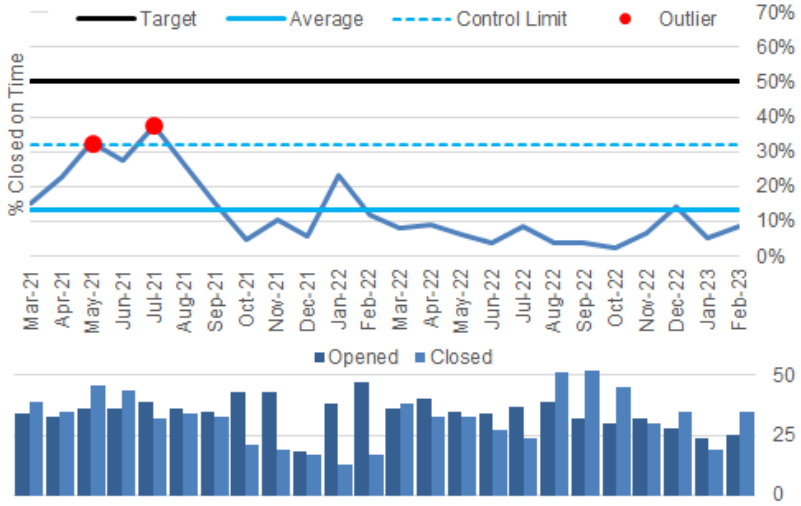
Key Deliverable		End Date
Local and national programme of surveillance; to undertake surveillance programmes which are compliant with mandatory national requirements and identify areas for improvement		Mar-24 On track
Key Milestones	Optimise communications with all clinical teams in ASD & the HSCP	Jul-23 On track
	Ongoing work of Urinary Catheter Improvement Group (UCIG) eCatheter insertion & maintenance bundle on Patientrack- further rollout	Oct-23 At risk
	Enhanced surveillance - led by Consultant Microbiologist	Mar-24 At risk
Programme of audit; monitor IPC standard operating procedures, guidelines and practice in all patient care areas using the agreed tools to a pre-set plan, with feedback of findings provided in the form of written reports/ action plans		Jul-23 On track
IPC Education & training: Infection Prevention and Control knowledge and training for staff are fundamental for safe patient care		Mar-24 On track

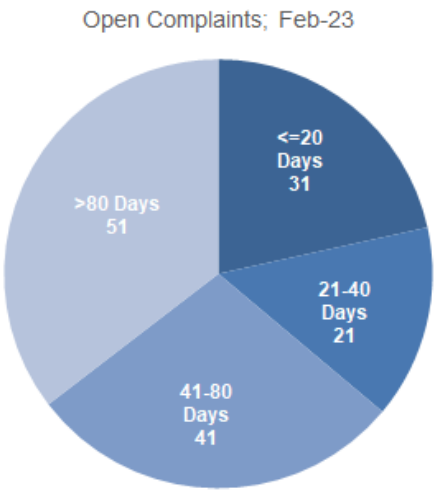
Complaints | Stage 2

At least 50% of Stage 2 complaints are completed within 20 working days by March 2023, rising to 65% by March 2024

Performance 8.6%

Local Performance





Performance by Service Area

		Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23
NHS Fife	Opened in Month	36	40	35	34	37	39	32	30	32	28	24	25
	% Acknowledged on time	94.4%	92.5%	71.4%	76.5%	81.1%	87.2%	90.6%	96.7%	93.8%	100.0%	100.0%	100.0%
	Due in Month	44	37	49	32	30	47	37	21	30	27	32	31
	% Closed on time	6.8%	5.4%	4.1%	6.3%	3.3%	6.4%	5.4%	4.8%	3.3%	14.8%	6.3%	12.9%
	Closed in Month	38	33	33	27	24	51	52	45	30	35	19	35
	% Closed on time	7.9%	9.1%	6.1%	3.7%	8.3%	3.9%	3.8%	2.2%	6.7%	14.3%	5.3%	8.6%
Acute	Closed in Month	28	25	22	20	14	43	34	29	22	26	17	24
	% Closed on time	3.6%	12.0%	4.5%	5.0%	14.3%	2.3%	0.0%	0.0%	9.1%	19.2%	5.9%	12.5%
HSCP	Closed in Month	7	7	11	7	10	6	16	16	7	9	2	10
	% Closed on time	14.3%	0.0%	9.1%	0.0%	0.0%	0.0%	6.3%	6.3%	0.0%	0.0%	0.0%	0.0%

Key Deliverable	End Date
Adherence to the NHS Scotland Model Complaints Handling Procedures (DH 2017)	Mar-24 Off track
Adherence to NHS Fife's Participation and Engagement Framework	Mar-23 Complete
Rebrand Patient Relations to Patient Experience Team	Dec-22 Complete

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**5 May 2023**
Title:	**Healthcare Associated Infection Report (HAIRT)**
Responsible Executive:	**Janette Owens**
Report Author:	**Julia Cook Infection Control Manager**

1 Purpose

Update for Infection Prevention and Control for April 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 April 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 April 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 Q3 2022 (Jul-Sep), NHS Fife was below the national rate for healthcare associated infection (HCAI), but above for community associated infection (CAI).
- Vascular access devices (VAD) remain the greatest challenge for hospital acquired SABs, ongoing improvement work continues.
- There was a significant 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 Feb 23), there has been 1 PWID related SAB case.
- There have been 5 dialysis line related SABs since the start of 2023. This is an unusually high number of cases, especially considering there were only 2 cases for the whole of 2022. Renal services have been alerted and are in the process of organising a `Super SAER `, to review all of the patients, and identify any areas for improvement.

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. The most recent meeting took place on 16/01/23.

CDI

- During Q3 2022 (Jul-Sep), NHS Fife was below the national rate for HCAI & CAI.

- January -end February 2023 has seen a rise in the cumulative number of CDI cases (n=12), compared to the same time-period the previous year (n=3). This increase is also reflected in the number of HCAI cases, Jan-Feb 2023 (n=9), compared to Jan-Feb 2022 (n=3).

Current CDI initiatives

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

ECB

- During Q3 2023 (July-Sep), NHS Fife was above the national rate for HCAI & CAI.
- The 12 month period, March 2022 – end of February 2023, there was a rise in the number of ECB cases (n=271) but a lower number of HCAI cases (n=125), compared to the same time-period the previous year (n=256 cases, of which 128 were HCAI).

Current ECB Initiatives

- The Infection Prevention and Control team continue to work with the Urinary Catheter Improvement Group (UCIG).
- Infection control surveillance alert the patients care team Manager by Datix when an ECB is associated with a traumatic catheter insertion, removal or maintenance.
- Monthly ECB reports and graphs are distributed within HSCP and Acute services
- Catheter insertion/Maintenance bundles now in MORSE for District nurse documentation
- Patientrack CAUTI bundles have now been installed onto Patientrack and have now been trailed on V54 ward. Amendments to the tool are now awaited by Patientrack, prior to to this being rolled out across the board. This bundle should ensure that the correct processes are adhered to for the implementation and maintenance of all urinary catheters within NHS Fife inpatient wards.
- CAUTI bundles have been implemented within 4 care homes as a trial, with the aim to roll out across all care homes, to optimise urinary catheter maintenance to all care home residents. This work is to be led by the IPC Care Home Senior IPCN for NHS Fife.

COVID-19 pandemic

From ARHAI Scotland weekly report a further spike in probable and definite hospital onset COVID-19 cases were reported across Scotland in December 2022/January2023.

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 (January - February 2023)

- **Norovirus**

There has been no new ward closure due to a Norovirus outbreak

- **Seasonal Influenza**

There has been 2 new closures due to confirmed Influenza

- **COVID-19**

Twenty-two new ARHAI Scotland reportable outbreaks/incidents of COVID-19 which are detailed in the HAIRT

Hospital Inspection Team

Healthcare Improvement Scotland (HIS): Unannounced Infection Prevention and Control Inspections of Mental Health Units Queen Margaret Hospital, NHS Fife. QMH wards 1,2 and 4 and WMBH Ravenscarig ward on Wednesday 8th of February. The report for factual accuracy is expected week commencing 17 April.

Hand Hygiene

Ward Dashboard is no longer available to display Hand Hygiene audit via LanQIP dashboard no longer supported by NHS eHealth. IPCT have been liaising with and have submitted a request for Digital & Information support.

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 3 (Oct - Dec 2022) was **95.9%**.

National Cleaning Services Specification

The National Cleaning Services Specification – quarterly compliance report result for Quarter 3 (Oct - Dec 2022) shows NHS Fife achieving **Green** status.

Estates Monitoring

The National Cleaning Services Specification – quarterly compliance report result for shows Quarter 3 (Oct - Dec 2022) NHS Fife achieving **Green** status.

2.3.1 Quality/ Patient Care

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

2.3.2 Workforce

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

2.3.3 Financial

No financial costs identified in this report.

2.3.4 Risk Assessment/Management

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

2.3.5 Equality and Diversity, including health inequalities 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 April 2023.

The report has also been submitted to the Executive Directors Group on 20 April 2023.

2.4 Recommendation

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

3 List of appendices

The following appendices are included with this report:

- HAIRT Report

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

Infection Prevention
and Control Team

Fife Health & Social Care Partnership

NHS Fife

HAIRT Report

HAIRT Report for Infection Control Committee on 5th April 2023.

(Validated Data up to February 2023)

April 2023

Contents

Board Wide Issues

Key Healthcare Associated Infection Headlines

1.1 Achievements:

***Staphylococcus aureus* Bacteraemia Prevention (SAB)**

During Q3 2022 (Jul-Sep), NHS Fife was below the national rate for healthcare associated infection (HCAI), but above for community associated infection (CAI).

Q4 2022 (Oct-Dec), has seen a reduction in the number of cases from Q3; – 22 down from 24. This reduction is also reflected in the number of HCAI cases (from 14 cases in Q3 2022 to 10 cases in Q4 2022). Awaiting national comparison.

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

During Q3 2022 (Jul-Sep), NHS Fife was below the national rate for HCAI & CAI.

Q4 2022 (Oct-Dec), has seen a slight reduction in the number of cases from Q3; – 10 down from 11. This reduction is also reflected in the number of HCAI cases (from 9 cases in Q3 2022 to 8 cases in Q4 2022). Awaiting national comparison.

***Escherichia coli* bacteraemia (ECB)**

During Q3 2022 (Jul-Sep), NHS Fife was above the national rate for HCAI & CAI.

Q4 2022 (Oct-Dec), has seen a reduction in the number of cases from Q3; – 64 down from 77. This reduction is also reflected in the number of HCAI cases (from 33 cases in Q3 2022 to 28 cases in Q4 2022). Awaiting national comparison.

1.2 Challenges:

NHS Fife received a 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.

SABs

Vascular access devices (VAD) remain the greatest challenge for hospital acquired SABs, ongoing improvement work continues.

There was a significant 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 Feb 23), there has been 1 PWID related SAB case.

There have been 5 dialysis line related SABs since the start of 2023. This is an unusually high number of cases, especially considering there were only 2 cases for the whole of 2022. Renal services have

been alerted and are in the process of organising a `Super SAER `, to review all of the patients, and identify any areas for improvement.

ECBs

The 12 month period, March 2022 – end of February 2023, there was a rise in the number of ECB cases (n=271) but a lower number of HCAI cases (n=125), compared to the same time-period the previous year (n=256 cases, of which 128 were HCAI)

CDI

So far, 2023 (Jan-end Feb) has seen a rise in the number of CDI cases (n=12), compared to the same time-period the previous year (n=3). This increase is also reflected in the number of HCAI cases, Jan-Feb 2023 (n=9), compared to Jan-Feb 2022 (n=3). IPCT will continue to monitor cases to assess if there is a sustained rise.

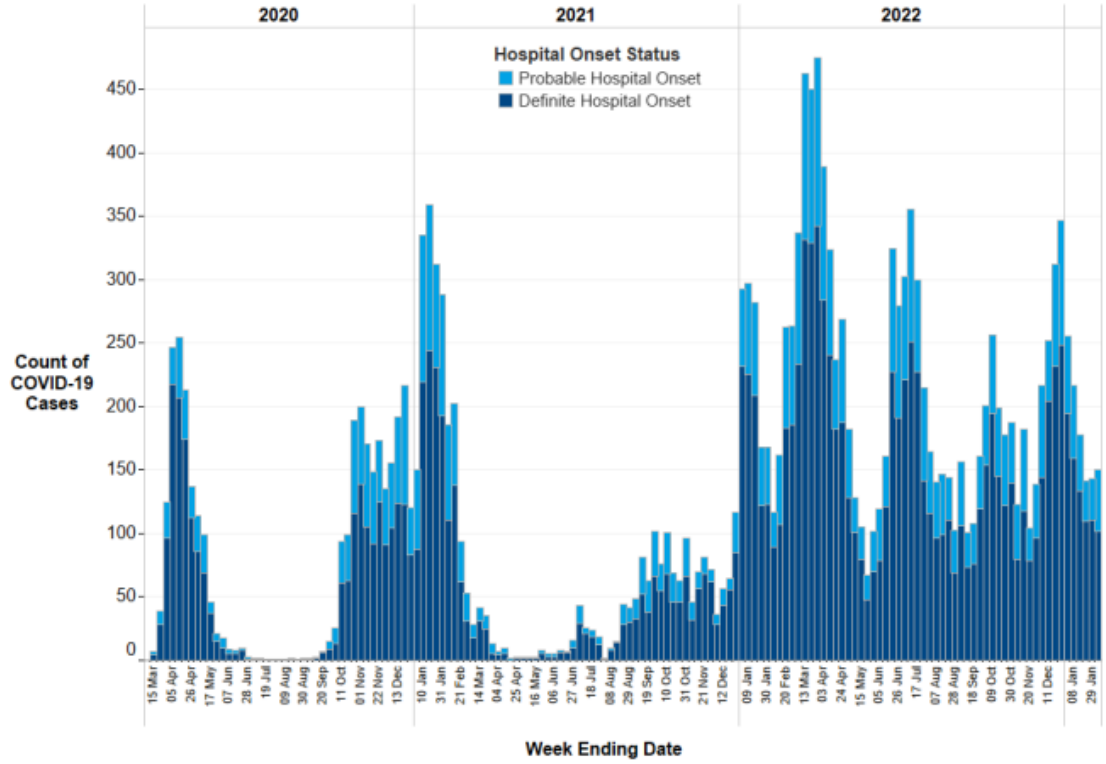
Caesarean Section SSI/ Large Bowel Surgery SSI/ Orthopaedic Surgery SSI

National surveillance programme for SSI has been paused due to the COVID-19 pandemic. DL (2023) 06 published February 2023 advises surgical site infection (SSI) and enhanced surveillance reporting remains paused for the time being.

COVID-19

As outlined in Figure 1, a further spike in probable and definite hospital onset COVID-19 cases were reported across Scotland in December 2022/January2023.

Figure 1: Epidemic curve of probable and definite hospital onset COVID-19 cases (first positive specimen of COVID-19 episode taken on day eight of inpatient stay or later), by onset status: week ending 01 March 2020 to week ending 05 February 2023 (n=19,572).[1,2,3]

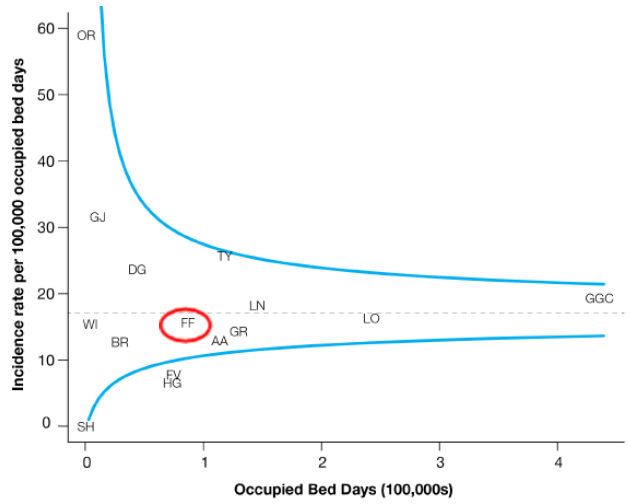
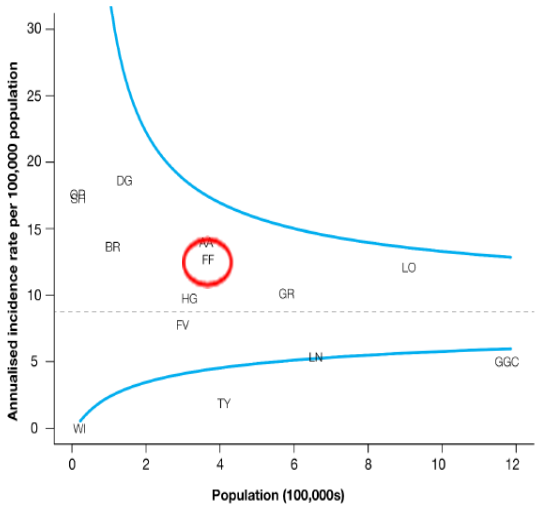


Surveillance

2. Staphylococcus aureus incorporating MRSA/CPE screening compliance

2.1 Trends – Quarterly

Staphylococcus aureus Bacteraemias (SABs)				
Local Data: Q4 2022 (Oct-Dec) **(Q4 2022 National comparison awaited)**				
In Q4 2022 NHS Fife had:	22 SABs	10 HCAI/HAI 12 CAI	This is **LOWER** than:	24 Cases in Q3 2022

Q3 2022 (Jul-Sep) - ARHAI Validated data with commentary			
Healthcare associated SABs		**Community associated SABs infection**	
HCAI SAB rate: **15.7**	Per 100,000 bed days	CAI SABs rate: **12.7**	Per 100,000 Pop
No of HCAI SABs: 14		No of CAI SABs: 12	
This is **BELOW** National rate of 17.1		This is **ABOVE** National rate of 8.8	
			
NHS Fife was **WITHIN** the 95% confidence interval in the funnel plot analysis for HCAI & CAI.			

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 Sep 2022 (HPS)		
SAB by rate 100,000 Total bed days	**14.6** per 100,000 TBDs	
SAB by Number of HCAI cases	**51**	

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 5 dialysis line related SABs since the last report. Renal services are organising a `Super SAER` meeting to review all 5 cases together and identify if there are any areas of concern requiring improvement.

As of **01/03/2023** the number of days since the last confirmed SAB is as follows:	
CVC SABs	219 Days
PWID (IVDU)	26 Days
Renal Services Dialysis Line SABs	7 Days
Acute services PVC (Peripheral venous cannula) SABs	136 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. The most recent meeting took place on 16/01/2023; the Wound Care Protocol was updated early December and PGD training is being rolled out.

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 **100%** compliance with the **MRSA** CRA in Q4 (Oct-Dec) 2022

This was **UP** from 98% in Q3 2022 & **ABOVE** the compliance target of 90%.

It was **ABOVE** the national average of 74%.

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

Quarter	Q4 2020 Oct-Dec	Q1 2021 Jan-Mar	Q2 2021 Apr-Jun	Q3 2021 Jul-Sep	Q4 2021 Oct-Dec	Q1 2022 Jan-Mar	Q2 2022 Apr- Jun	Q3 2022 Jul-Sep	Q4 2022 Oct-Dec
Fife	98%	95%	98%	88%	93%	98%	98%	98%	100%
Scotland	82%	83%	84%	81%	82%	81%	80%	78%	74%

CPE (Carbapenemase Producing Enterobacteriaceae)
From April 2018, CRA has also included screening for CPE.
NHS Fife achieved **100%** compliance with the **CPE** CRA for Q4 2022 (Oct-Dec)
This was equal to the compliance rate in Q3 2022
It was **ABOVE** the national average of 76%.
CPE Critical risk assessment (CRA) screening KPI compliance summary:

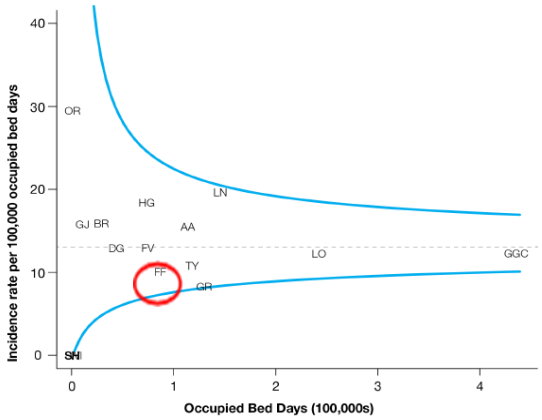
Quarter	Q4 2020 Oct-Dec	Q1 2021 Jan-Mar	Q2 2021 Apr-Jun	Q3 2021 Jul-Sep	Q4 2021 Oct-Dec	Q1 2022 Jan-Mar	Q2 2022 Apr- Jun	Q3 2022 Jul-Sep	Q4 2022 Oct-Dec
Fife	98%	88%	90%	100%	98%	100%	98%	100%	100%
Scotland	79%	82%	83%	82%	80%	80%	79%	78%	76%

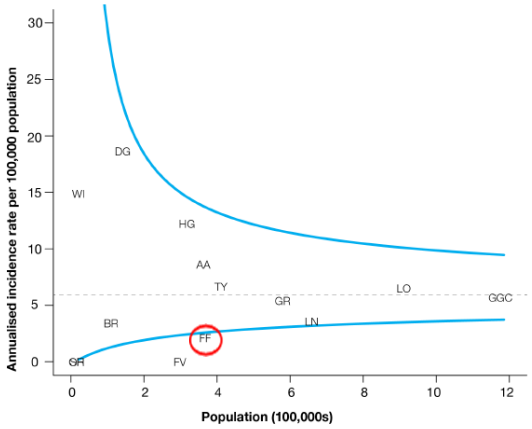
3 Clostridioides difficile Infection (CDI)

3.1 Trends

Clostridioides difficile Infection (CDI)				
Local Data: Q4 Oct-Dec 2022 **(Q4 2022 HPS National comparison awaited)**				
In Q4 2022 NHS Fife had:	10 CDIs	8 HCAI/HAI/Unknown 2 CAI	This is **DOWN** from	11 Cases in Q3 2022
Q3 (Jul-Sep) 2022 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: **10.1**	Per 100,000 bed days	CAI CDIs rate: **2.1**	Per 100,000 Pop
No of HCAI CDIs: 9		No of CAI CDIs: 2	
This is **BELOW** National rate of 13.1		This is **BELOW** National rate of 5.9	





NHS Fife was **WITHIN** the 95% confidence interval in the funnel plot analysis for HCAI & **BELOW** for 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 September 2022 (HPS)		
CDI by rate 100,000 Total bed days	**7.8** per 100,000 TBDs	
CDI by Number of HCAI cases	**27**	

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

3.2 Current CDI initiatives

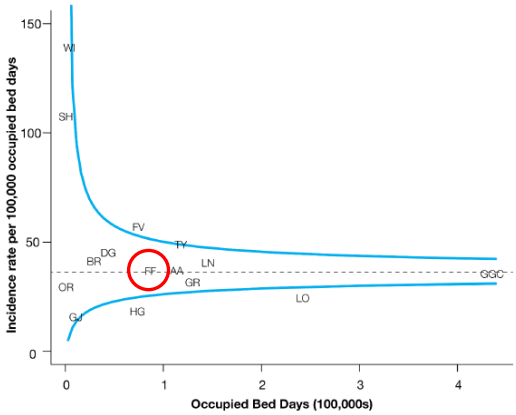
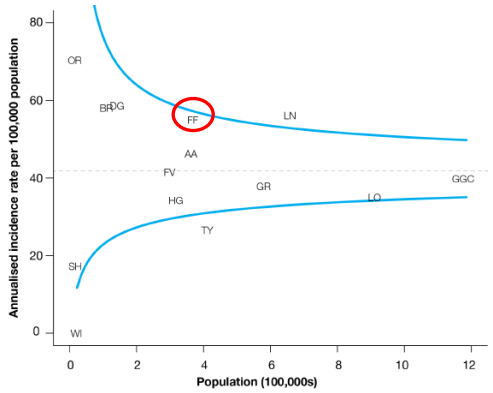
Follow up of all hospital and community cases continues to establish risk factors for CDI

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

4.0 Escherichia coli Bacteraemias (ECB)

4.1 Trends:

Escherichia coli Bacteraemias (ECB)				
Local Data: Q4 (Oct-Dec) 2022 **(Q4 2022 HPS National comparison awaited)**				
In Q4 2022 NHS Fife had:	64 ECBs	28 HAI/HCAIs 36 CAIs	This is **DOWN** from	77 Cases in Q3 2022
Q4 2022 There were **11** Urinary catheter associated (2 of which were from Suprapubic catheters) ECBs, which was significantly higher than during Q3 2022, when there were 5 CAUTIs.				

Q3 (Jul-Sep) 2022			
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: **36.9**	Per 100,000 bed days	CAI ECBs rate: **55.1**	Per 100,000 Pop
No of HCAI ECBs: 33		No of CAI ECBs: 52	
This is **ABOVE** National rate of 36.2		This is **ABOVE** National rate of 41.8	
			
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 September 2022 (HPS)		
ECB by rate 100,000 Total bed days	**35.6** per 100,000 TBDs	
ECB by Number of HCAI cases	**124**	

2021-2017 NHS Fife's Urinary catheter Associated ECBs –

HPS data Q4 2022 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
2022 Q4 2022	TBC	***38%**	* Locally calculated data- TBC by HPS when Q4 data published on Discovery
2022 Q3 2022	15.0%	**0%**	
2022 Q2 2022	16.4%	**26.7%**	
2022 Q1	17.6%	**0%**	
2021 TOTAL	16.0%	**15.4%**	
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
2022 Q4 2022	TBC	***40%**	* Locally calculated data- TBC by HPS when Q4 data published on Discovery
2022 Q3	23.5%	**20%**	
2022 Q2	20.1%	**35%**	
2022 Q1	21.2%	**33.3 %**	
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	18.3 %	**35.3 %**	
Data from NSS Discovery ARHAI Indicators			

4.2 Current Risk Register Rating

Corporate Directorate – Nursing Directorate Infection Control Team Risk Register		
ID: 1728 ECB LDP Standard		
Initial Risk Level	Current Risk Level	Target Risk Level
Moderate Risk 12	Moderate Risk 12	Low Risk 6

4.3 Current ECB Initiatives

The Urinary Catheter Improvement Group (UCIG) work was commissioned in 2018 to address the issues associated with ECB CAUTI incidence and reduce the CAUI incidence. This group developed from a previous Traumatic Catheter group in 2017 which aimed to reduce the incidence of Catheters associated with trauma. The IPC Surveillance team continue to liaise with the UCIG last held in March 2023. This group aims to minimize 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 February 2023 there has been 3 CAUTI ECBs (2 from urinary & 1 from a supra-pubic catheter). 2 of these have been associated with trauma.

Infection control surveillance alert the patients care team Manager by Datix when an ECB is a urinary catheter associated infection, to then undergo a CCR to provide further learning from all ECB CAUTIs.

CAUTI insertion & maintenance bundles have now been installed onto Patientrack in February 2022 and have now been trailed on V54 ward. Amendments to the tool are now awaited by Patientrack and this can then be rolled out across the board. This bundle should ensure that the correct processes are adhered to for the implementation and maintenance of all urinary catheters within NHS Fife inpatient

wards. Acute services engagement and a HON lead will be required to assist the roll out of this CAUTI bundle.

CAUTI bundles have been implemented within 4 care homes as a trial, with the aim to roll out across all care homes, to optimise urinary catheter maintenance to all care home residents. This work is to be led by the IPC Care Home Senior IPCN for NHS Fife.

5. Hand Hygiene

- Good hand hygiene by staff, patients and visitors is a key way to prevent the spread of infections.
- NHS Boards monitor hand hygiene and ensure a zero tolerance approach to non-compliance.
- A minimum of 20 observations are required to be audited, per month, per ward.
- Reporting of Hand Hygiene performance was based on data submitted by each ward via LanQIP
- LanQIP is no longer supported by NHS eHealth and Wards are no longer submitting their Hand Hygiene. There is therefore no current electronic recording system for reporting HH compliance or an overview dashboard to monitor compliance.
- IPCT have submitted a request for Digital & Information support

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 3 (Oct-Dec 2022) was **95.9%**.
- The cleaning compliance score for NHS Fife & each acute hospital can be found in Section 11

6.1 Trends

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

- **National Cleaning Services Specification**

Domestic Location	Q3 Oct-Dec 22	Q2 Jul-Sep 22
Fife	95.9↓	96.2%
Scotland	95.3	95.3%

- The National Cleaning Services Specification – quarterly compliance report result for

  Quarter 3 (Oct-Dec) 23 shows NHS Fife achieving **GREEN** status.

- **Estates Monitoring**

Estates Location	Q3 Oct-Dec 22	Q2 Jul-Sep 22
Fife	96.5↑	96.3
Scotland	96.5	96.4

- The Estates Monitoring – quarterly compliance report result for Quarter 3 (Oct-Dec) 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).

January – February 2023 Norovirus

There have been NO new ward closures due to Norovirus or suspected outbreak since last ICC report

Seasonal Influenza

There has been 2 new closures due to confirmed Influenza since the last reporting period.

Weekly national seasonal respiratory report- Week 8, **week ending 26th of February 2023**

Weekly respiratory main points

- Influenza remained at **Baseline** activity level (0.9 per 100,000 population).
- Adenovirus and rhinovirus remained at **Low** activity level and HMPV decreased from Moderate to **Low** activity level

7.2 COVID-19 pandemic

COVID weekly main points

- In Scotland, in the week ending 14 February 2023, the estimated number of people testing positive for COVID-19 was 114,800 (95% credible interval: 95,400 to 134,800), equating to 2.18% of the population, or around 1 in 45 people (Source: Coronavirus (COVID-19) Infection Survey, UK - Office for National Statistics)
- There were on average 715 patients in hospital with COVID-19, the same as previous week ending 19 February 2023

COVID-19 incidents/clusters/outbreaks January – February 2023, there has been 22 new COVID-19 outbreaks/incidents reportable to ARHAI Scotland during this reporting period.

Hospital	Ward	First reported	Total No. Patients	Total No. HCWs	Total Number of deaths
Cameron	Balcurvie	06 01 2023	8	2	1
	Balgonie	13 01 2023	2	0	0
Glenrothes	Ward 2 Bay 7	14 02 2023	3	2	0
	Ward 2	22 01 2023	4	3	0
	Ward 3	22 01 2023	11	3	1
QMH	Ward 6	22 01 2023	4	0	0
	Hospice	27 01 2023	2	3	1
	Ward 4	22 01 2023	2	0	0
St Andrews	Ward 2	28 02 2023	2	1	0
Stratheden	Elmview	10 02 2023	7	5	0
	Hollyview	10 02 2023	2	3	0
	Lomond	31 01 2023	2	3	0
VHK	V32 Bay 1	31 01 2023	3	0	0
	V41	10 02 2023	2	0	0
	V41	13 01 2023	2	0	0
	V42	22 01 2023	2	0	0
	V44	13 01 2023	13	1	2
	V6	28 02 2023	10	1	0
	V41	17 02 2023	6	3	0

	V43	13 01 2023	4	0	0
	V42	24 02 2023	3	2	0
	V9	13 01 2023	8	3	0

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, and we are currently awaiting further instruction.

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

Healthcare Improvement Scotland (HIS): Unannounced Infection Prevention and Control Inspections of Mental Health Units Queen Margaret Hospital, NHS Fife. QMH wards 1,2 and 4 and WMBH Ravenscarig ward on Wednesday 8th of February. The report for factual accuracy is expected week commencing 17 April.

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 preparing time 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.

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

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-22	5	2	7	2	2	4	8	15	23
May-22	3	5	8	3	2	5	12	10	22
Jun-22	5	3	8	3	0	3	15	10	25
Jul-22	6	3	9	4	1	5	13	14	27
Aug-22	3	5	8	3	1	4	10	15	25
Sep-22	5	2	7	2	0	2	10	15	25
Oct-22	3	4	7	1	0	1	13	12	25
Nov-22	6	3	9	3	0	3	8	10	18
Dec-22	1	5	6	4	2	6	7	14	21
Jan-23	6	1	7	5	3	8	7	10	17
Feb-23	4	3	7	4	0	4	10	8	18

Cleaning Compliance (%) TOTAL FIFE												
	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23
Overall	96.1	96.2	95.9	95.8	96.4	96.3	96.1	95.6	96.2	96.2	96.0	96.4

Estates Monitoring Compliance (%) TOTAL FIFE												
	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23
Overall	96.6	96.6	96.3	96.2	96.0	96.6	96.2	96.3	96.6	96.6	96.6	96.3

Victoria Hospital

	VHK		
	SAB >48hrs admx	CDI >48hrs admx	ECB >48hrs admx
Month	HAI	HAI	HAI
Apr-22	2	1	2
May-22	2	2	8
Jun-22	2	1	5
Jul-22	1	1	3
Aug-22	2	0	2
Sep-22	2	0	2
Oct-22	2	0	3
Nov-22	5	2	4
Dec-22	0	2	3
Jan-23	4	0	4
Feb-23	3	3	2

Cleaning Compliance (%) Victoria Hospital												
	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23
Overall	96.0	95.9	95.7	95.9	95.7	96.5	95.9	95.6	95.6	96.3	95.9	96.6

Estates Monitoring Compliance (%) Victoria Hospital												
	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23
Overall	98.0	97.4	97.2	97.0	96.8	97.4	97.1	97.1	97.6	97.2	97.1	96.5

Queen Margaret Hospital

	QMH		
	SAB >48hrs admx	CDI >48hrs admx	ECB >48hrs admx
Month	HAI	HAI	HAI
Apr-22	0	0	0
May-22	0	1	0
Jun-22	0	0	0
Jul-22	2	0	0
Aug-22	0	1	0
Sep-22	2	0	1
Oct-22	0	0	3
Nov-22	0	0	0
Dec-22	0	0	0
Jan-23	1	1	0
Feb-23	0	0	0

Cleaning Compliance (%) Queen Margaret's hospital												
	Mar 22	Apr 22	May 22	Jun 22	Jul-22	Aug-22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23
Overall	96.0	97.2	97.1	96.4	97.6	96.5	96.3	95.8	96.4	96.3	96.9	96.5

Estates Monitoring Compliance (%)Queen Margaret's hospital												
	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23
Overall	96.6	96.0	95.4	96.6	95.5	95.9	95.4	96.6	95.9	96.6	96.1	95.5

Community Hospitals

	COMMUNITY HOSPITALS		
	SAB >48hrs admx	CDI >48hrs admx	ECB >48hrs admx
Month	HAI	HAI	HAI
Apr-22	0	0	0
May-22	0	0	0
Jun-22	0	0	0
Jul-22	0	0	0
Aug-22	0	1	0
Sep-22	0	1	0
Oct-22	1	0	0
Nov-22	0	0	0
Dec-22	0	0	0
Jan-23	0	1	0
Feb-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-22	3	2	1	2	6	15
May-22	1	5	0	2	4	10
Jun-22	3	3	2	0	10	10
Jul-22	3	3	3	1	10	14
Aug-22	1	5	1	1	8	15
Sep-22	1	2	1	0	7	15
Oct-22	0	4	1	0	7	12
Nov-22	1	3	1	0	4	10
Dec-22	1	5	2	2	4	14
Jan-23	1	1	3	3	3	10
Feb-23	1	3	1	0	8	8

Appendix 1 References and Links

References & Links
Understanding the Report Cards – Infection Case Numbers *Clostridioides difficile infections (CDI)* and *Staphylococcus aureus* bacteraemia *(SAB)* cases are presented for each hospital, broken down by month by Healthcare Associated (HCAI & HAI) & Community (Community/Unknown) onset. More information on these organisms can be found on the NHS24 website: *Clostridioides difficile*: https://www.hps.scot.nhs.uk/a-to-z-of-topics/clostridioides-difficile-infection/ *Staphylococcus aureus* : https://www.hps.scot.nhs.uk/a-to-z-of-topics/staphylococcus-aureus-bacteraemia-surveillance/ For each hospital, the total number of cases for each month are those, which have been reported as positive from a laboratory report on samples taken more than 48 hours after admission. For the purposes of these reports, positive samples taken from patients within 48 hours of admission will be considered confirmation that the infection was contracted prior to hospital admission and will be shown in the "out of hospital" report card. **Targets** There are national targets associated with reductions in C.diff and SABs and from 2019 for e.coli bacteraemias (ECBs). More information on these can be found on the Scotland Performs website: http://www.scotland.gov.uk/About/Performance/scotPerforms/partnerstories/NHSScotlandperformance **Understanding the Report Cards – Hand Hygiene Compliance** Hospitals carry out regular audits of how well their staff are complying with hand hygiene. Each hospital report card presents the combined percentage of hand hygiene compliance with both opportunity taken and technique used. **Understanding the Report Cards – Cleaning Compliance** Hospitals strive to keep the care environment as clean as possible. This is monitored through cleaning and estates compliance audits. More information on how hospitals carry out these audits can be found on the Health Facilities Scotland website: http://www.hfs.scot.nhs.uk/online-services/publications/hai/ **Understanding the Report Cards – *'Out of Hospital Infections'*** *Clostridium difficile infections* and *Staphylococcus aureus bacteraemia* cases can be associated with being treated in hospitals. However, this is not the only place a patient may contract an infection. This total will also include infections from community sources. The final Report Card report in this section covers '*Out of Hospital Infections*' and reports on SAB and CDI cases reported to NHS Fife which are not attributable to a hospital.
For HPS categories for Healthcare Associated Infections: **https://www.hps.scot.nhs.uk/web-resources-container/quarterly-epidemiological-commentary-for-the-surveillance-of-healthcare-associated-infections-in-scotland-methods-caveats/**

Appendix 2 Categories of Healthcare & Community Infections

Categories of Healthcare & community Infections

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

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

Hospital Acquired Infection (HAI):
Positive Blood culture obtained from patient who has been
-Hospitalised for >48 hours
If the patient was transferred from another hospital the duration of the in-patient stay is calculated from the date of the first hospital admission

OR

-The patient was discharged from hospital in the 48 hours prior to the positive blood culture being obtained

OR

-A patient receives regular haemodialysis as an outpatient

Community Infection
-Positive Blood culture obtained from a patient with 48 hours of admission to hospital who does not fulfil any of the criteria for the healthcare associated blood stream infections

Not known:
-Only to be used if the ECB is not a HAI and unable to determine if community or HCAI

Healthcare Associated Infection (HCAI):-
Positive blood culture obtained within 48 hours of admission to hospital and fulfils one or more of the following criteria:
-Was hospitalised overnight in the 30 days prior to the +ve blood culture being obtained.

OR

-Resides in a Nursing home, long term facility or residential home

OR

-IV,IM, Intra-articular or sub cut medication in the 30 days prior to the positive blood culture,
but EXCLUDING IV illicit drug use.

OR

-Underwent venepuncture in the 30 days before +ve BC

OR

-Underwent medical procedure which broke mucous or skin barrier i.e. biopsies or dental extraction in the 30 days before +ve BC

OR

-Underwent any care for chronic medical condition or manipulation of medical device by a healthcare worker in the community in the 30 days prior to the +ve BC being obtained i.e. podiatry or dressing of chronic ulcers, catheter change or insertion

OR

-Has a long term indwelling device (i.e. catheter, central line, drain (excluding a haemodialysis line)

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

HPS Linkage Origin Definitions

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

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

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NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**5 May 2023**
Title:	**Medical Devices**
Responsible Executive:	**Neil McCormick, Director of Property & Asset Management**
Report Author:	**Iain MacLeod, Deputy Medical Director**
	Neil McCormick, Director of Property & Asset Management

1 Purpose

This report is presented for:

- Assurance
- Approval

This report relates to:

- Government policy / directive
- Legal requirement

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The definition of medical devices now includes a wide range of instruments, apparatus, appliances, software, materials or other article used in the process of delivering healthcare.

Changes are required following our exit from the European Union and the Medicines and Healthcare products Agency (MHRA) have been consulting on wide-ranging changes to the regulatory framework.

2.2 Background

The MHRA is in the process of implementing changes to the Medical Devices Regulatory Framework which will come into force in a phased manner over the next 2 years.

This future legislation for medical devices is intended to deliver:

- improved patient and public safety
- greater transparency of regulatory decision making and medical device information
- close alignment with international best practice, and
- more flexible, responsive and proportionate regulation of medical devices

In addition, the Scan for Safety Programme will rollout Point of Care (PoC) scanning as part of the implementation of a new Inventory Management System (IMS) in a way which optimises the opportunities to improve patient safety but also has the flexibility to recognise the practicalities of implementing change in a Health Board operational environment.

The Scan for Safety Programme aims to implement a system wide approach to the tracking and tracing of high-risk implantable devices in Scotland through digital data capture at the point of care.

It will take a “Once for Scotland” approach and will capture implantable medical device data electronically in a consistent format across the NHS, including information on the patient, procedure, clinical staff, information about the device itself and where the procedure takes place.

This work will improve patient safety through enabling device traceability, supporting efficient patient recall and contribute to the wider monitoring of device performance and clinical outcomes.

2.3 Assessment

It is proposed to set up a clinically led Medical Devices Group to identify and oversee the work that needs to be carried out to give us the foundation to deliver the implementation of the new legislation and the scan for Safety Programme.

A Terms of Reference (see appendix 1) has been developed by a group which have been working for a number of months to identify the role and remit of the group.

An initial review of Medical Equipment Management has been undertaken by an independent Medical Physics Lead from another NHS Board which has identified several areas for improvement including:

- workshop facilities
- department structure
- Equipment Management Database and Tracking System
- purchase of equipment

The Medical Devices Group will consider/approve an Action Plan to address areas for improvement at their next meeting in June 2023.

2.3.1 Quality / Patient Care

This work will improve the quality and safety of patient care through improved traceability and efficiency of use of medical devices.

2.3.2 Workforce

There should be no immediate impact on workforce other than balancing what can be done in-house or outsourced by Medical Physics Technicians which is likely to result in an increase in locally employed staff.

2.3.3 Financial

There are potential efficiencies that can be delivered through the traceability and efficient use of medical devices and equipment.

2.3.4 Risk Assessment / Management

The majority of risks identified would be as a result of not being able to implement future guidance and legislation.

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

An EQIA Impact Assessment has not yet been carried out.

2.3.6 Climate Emergency & Sustainability Impact

There is potential for old equipment to be recycled and or repurposed for use by charities.

2.3.7 Communication, involvement, engagement and consultation

A communication plan will be developed at a future date.

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:

- EDG, 20 April 2023
- Clinical Governance Committee, 5 May 2023

2.4 Recommendation

Committee members are asked to:

- Take **assurance** from the report and **approve** the Terms of Reference

3 List of appendices

The following appendices are included with this report:

- Appendix 1 - Terms of Reference for Medical Devices Group

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

MEDICAL DEVICES GROUP
TERMS OF REFERENCE

1 PURPOSE

The purpose of the Medical Devices Group is to ensure there is a systematic approach to the purchasing, deployment, training, maintenance, repair and de-commissioning of reusable medical equipment within the Board and to ensure that all risks associated with the acquisition and use of this equipment is minimised.

As part of this remit, the Group will work with the Capital Equipment Management Group to prioritise bids and allocate Capital Funds for the procurement of medical equipment while also endeavouring to ensure standardisation of medical equipment across NHS Fife.

The role of the Group will also cover the formulation, review and updating of policies, procedures and risk management relating to medical equipment.

The group will be responsible for producing an acquisition strategy ensuring that there is a strategic approach to purchasing, deployment, training, maintenance, repair and decommissioning.

The group will consider the following scope:

2 MEDICAL DEVICES

According to the Medical Devices Regulations 2002 (SI 2002 No 618, as amended) (UK MDR 2002), a medical device is described as any instrument, apparatus, appliance, software, material or other article, whether used alone or in combination, together with any accessories, including the software intended by its manufacturer to be used specifically for diagnosis or therapeutic purposes or both and necessary for its proper application, which is intended by the manufacturer to be used for human beings for the purpose of:

diagnosis, prevention, monitoring, treatment or alleviation of disease diagnosis, monitoring, treatment, alleviation of or compensation for an injury or handicap investigation, replacement or modification of the anatomy or of a physiological process, or control of conception

A medical device does not achieve its main intended action by pharmacological, immunological or metabolic means although it can be assisted by these.

A medical device includes devices intended to administer a medicinal product or which incorporate as an integral part a substance which, if used separately, would be a medicinal product and which is liable to act upon the body with action ancillary to that of the device. (gov.uk website)

3 MEDICAL EQUIPMENT

Medical equipment is generally used in the direct or indirect care of patients and can include equipment that is not regulated as a medical device.

The World Health Organisation (WHO) defines medical equipment as medical devices requiring calibration, maintenance, repair, user training and decommissioning - activities usually managed by clinical staff.

The WHO also categorises a comprehensive range of medical devices as hospital medical equipment. This equipment is used for the specific purposes of diagnosis and treatment of disease or rehabilitation following disease or injury. It can be used alone or in combination with any accessory, consumable or other piece of medical equipment.

Medical equipment excludes implantable, disposable or single-use medical devices.

(SHTN 00-04 Guidance on Management of Medical Devices and Equipment in Scotland's Health and Social Care Services)

4 COMPOSITION

4.1 The Medical Devices Group shall be led by a designated Senior Clinician and membership will include:

- Iain McLeod, Deputy Medical Director (Chair)
- Neil McCormick, Director of Property & Asset Management (Vice Chair)
- Maxine Michie, Deputy Director of Finance
- Rose Robertson, Assistant Director of Finance (Chair of CEMG)
- Iain Forrest, Medical Equipment Technical Services Manager
- Alistair Graham, Associate Director of Digital & Information

In addition, representatives from the following Directorates/Departments:

- Woman & Children's Directorate
- Planned Care
- Emergency Care Directorate
- Quality and Clinical Governance
- Infection Control
- Risk Management
- Pharmacy
- Laboratories

- Radiology
- Health & Social Care Partnership
- Allied Health Professionals
- Procurement

4.2 In the event of members being unable to attend, a deputy should be sought to attend on the members behalf.

4.3 The Group will be administratively supported by Property & Asset Management.

5 ROLE & REMIT

5.1 **Objectives**

The Medical Devices Group will be responsible for the strategic management of medical equipment including the development and implementation of procurement, maintenance and replacement procedures that comply with relevant guidelines highlighted within Scottish Government Circular CEL35(2010) and relevant healthcare standards including healthcare associated infection.

The Group's remit will include advising the Fife NHS Board on:

- Purchasing and acquisition of medical devices and equipment, including comparisons of alternatives, reliability of ongoing support and the opportunities to rationalise the number of model types of medical devices or equipment in use.

- Technical specifications, regulatory compliance information and related issues.

- Financial data, including consideration of full recurring maintenance and consumable costs when preparing a medical device or equipment bid. This financial appraisal should include disposal costs (taking into account legislative requirements ie WEE regulations etc) and also relevant replacement costs, when required.

- Co-ordinating the medical device and equipment inventory, including the core data set included in the Asset Management Policy and any other data required by the Board to include Scan for Safety.

- Having an oversight of systems to monitor staff training records maintained by Service Managers thus ensuring staff are appropriately trained in the use of equipment.

- Ensuring that action is taken in relation to advisory guidance and directives issued by Scottish Government, the MHRA and any other regulatory body.

6 MEETING & REPORTING ARRANGEMENTS

6.1 Meetings will be held quarterly. The agenda and any other supporting papers will be sent out at least five working days in advance of each meeting.

6.2 The quorum for any meeting will be half of the membership (9 members) including either the Chair or Vice Chair.

6.3 The NHS Fife Medical Devices Group will report to the NHS Fife Clinical Governance Committee (see appendix for reporting Structure).

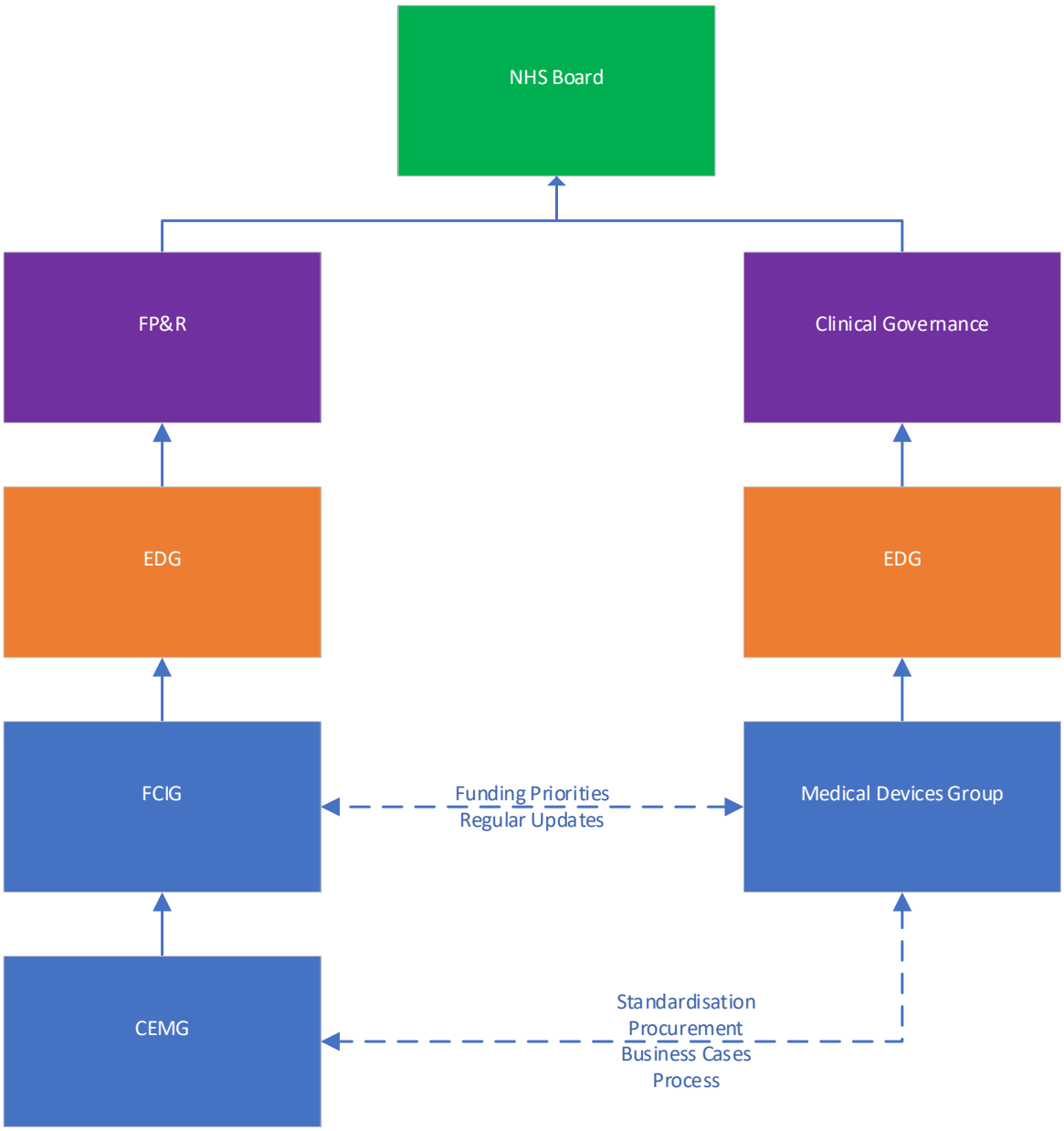
6.4 In order to fulfil its remit, the group will escalate identified risks or issues of importance to EDG for onward consideration of the NHS Fife Clinical Governance Committee.

6.5 A Governance Assurance Statement will be submitted to the NHS Fife Clinical Governance Committee on an Annual Basis.

Iain MacLeod (Chair)
Deputy Medical Director
NHS Fife

Neil McCormick (Vice Chair)
Director of Property & Asset Management
NHS Fife

Appendix 1 – Reporting Structure



NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**5 May 2023**
Title:	**Integrated Unscheduled Care Programme Update**
Responsible Executive:	**Dr Chris McKenna, Executive Medical Director**
Report Authors:	**Belinda Morgan, General Manager** **Lisa Cooper, Head of Primary & Preventative Care Services** **Miriam Watts, General Manager** **Lynne Garvey, Head of Community Care Services**

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Government policy / directive
- 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 progress in relation to the Unscheduled Care Programme. It provides an update on the work that has been undertaken since the launch of the Urgent & Unscheduled Care Collaborative in June 2022.

It provides assurance that there is commitment and coordination across NHS Fife and Fife Health & Social Care Partnership to continue progress and delivery of the programme in line with both local and national strategic objectives.

2.2 Background

The Scottish Government relaunched the Urgent & Unscheduled Care National Collaborative on the 1 June 2022. As a result of this, Fife were required to undertake a self-assessment to identify the highest impact changes for improvement. This process was undertaken collaboratively between NHS Fife and Fife Health & Social Care Partnership colleagues and identified the following areas for focus:

- Care Closer to Home
- Redesign of Urgent Care
- New Models of Acute Care
- Discharge without Delay

Since July 2022 work has been underway within each high impact area to identify improvement work that meets the aims of the national programme 'Right Care, Right Place, Every time'.

2.3 Assessment

It is recognised that the winter of 2022- 2023 has been the most challenging yet with a great deal of pressure on the system.

As part of reporting to Scottish Government, a trajectory was set against the 4 hour access target from November to end March 2023. Whilst winter performance was variable we have tracked within 9% our performance trajectory ending within a 2% variance of 65%. Chart 1 below details performance data tracked to the 4 recovery trajectory. Chart 2 details all attendances – planned and unplanned, noting that whilst attendance levels remained consistent throughout winter, in part due to redirections, the patients admitted to hospital are generally showing very high levels of frailty, co-morbidity and higher acuity.

Chart 1: ED Performance

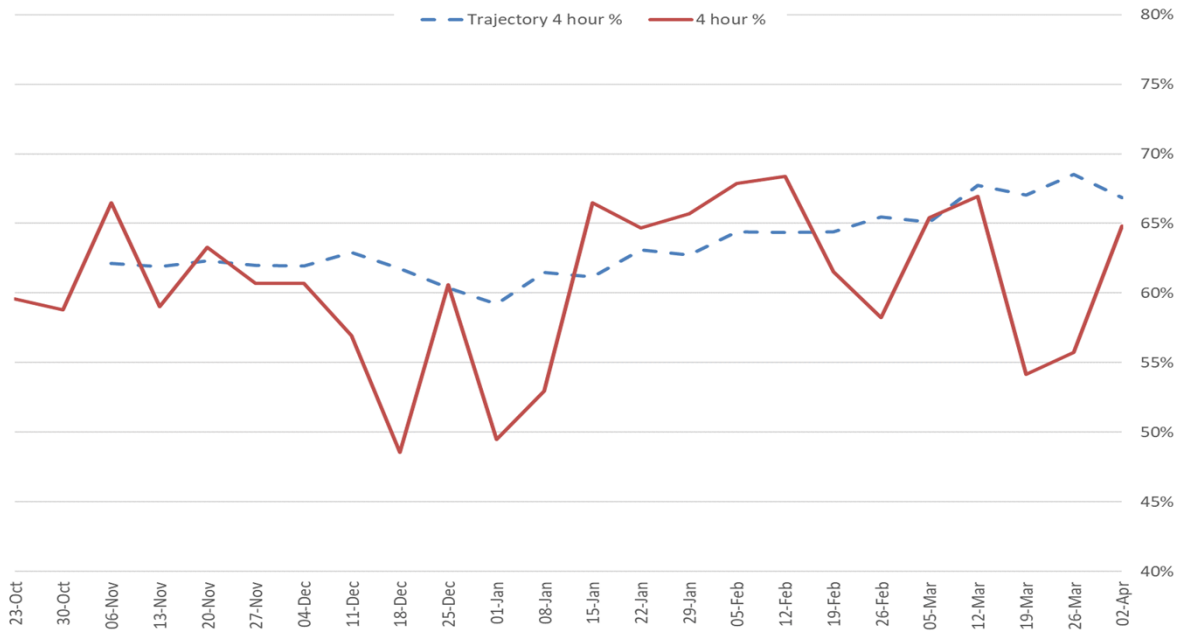
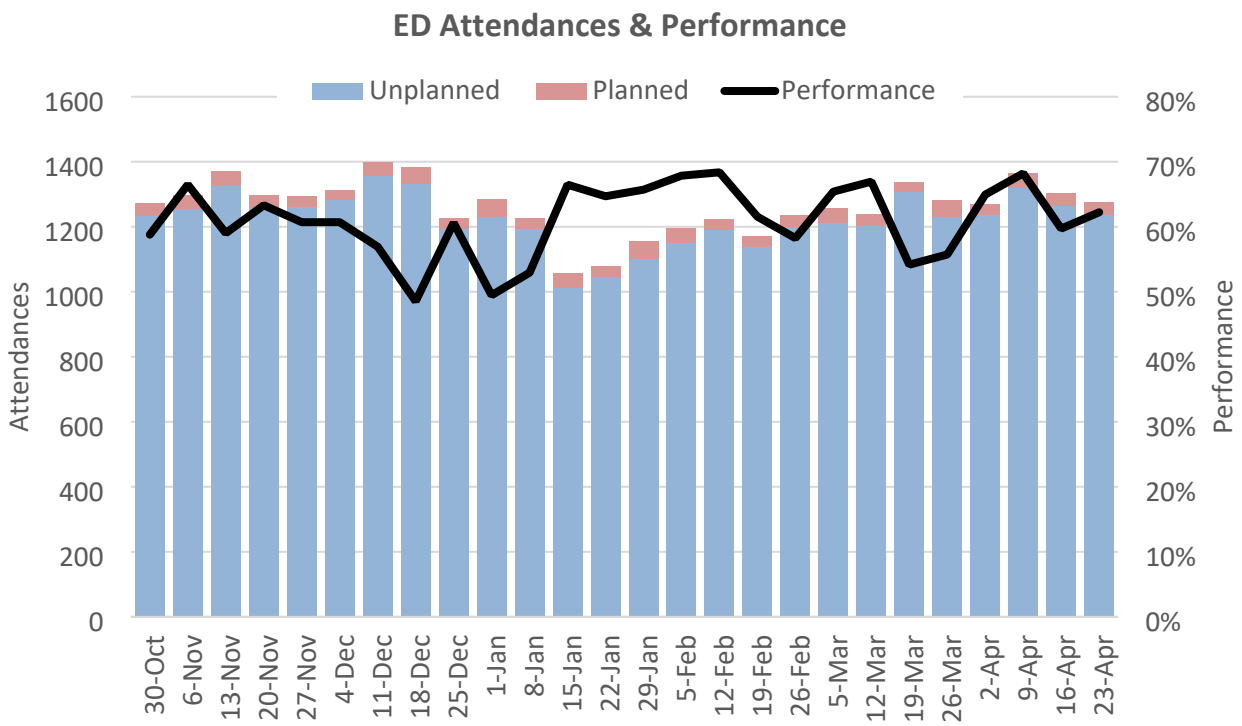


Chart 2: ED Attendances



A number of improvement projects have been underway to help support an improvement in the 4 hour access target. For the purposes of this paper they are noted under the heading of the high impact change areas:

1. Care Closer to Home

This High Impact Change area primarily focuses on Primary Care, with the key aims for this work being:

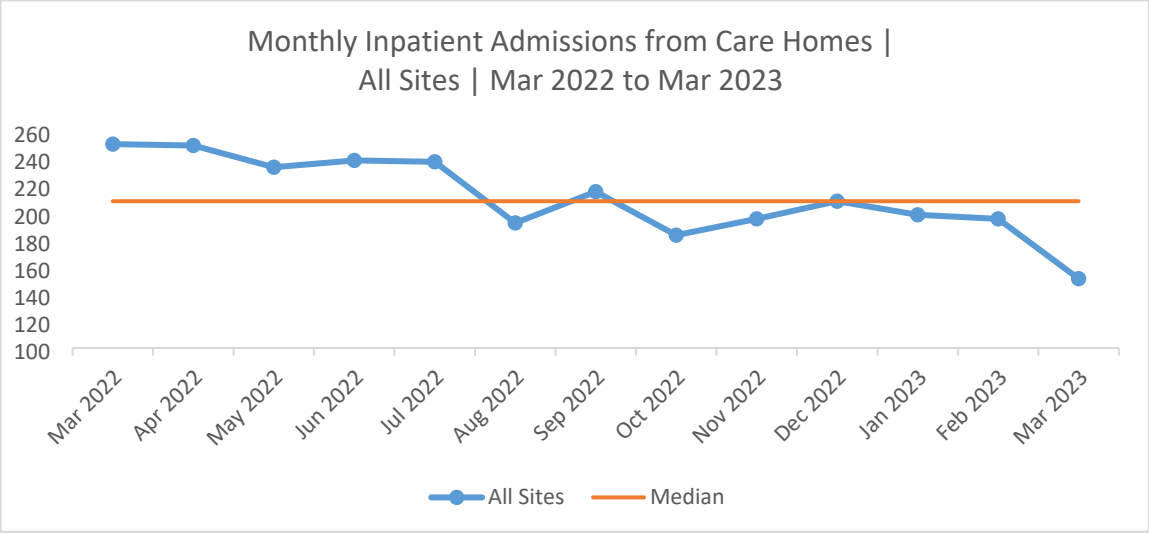
- Highly capable and accessible MDTs built around the needs of communities and people
- Safe, resilient and sustainable Out of Hours primary care services
- Further develop the digitally enabled gateway to the NHS in Scotland
- Improve the interface before and after urgent care to provide a seamless service to the patient

A key area of focus for CCH during has been on improving access to Urgent Care for Care Home residents across Fife. This work saw 3 key test areas, detailed below:

- Direct access to Urgent Care Services Fife (UCSF) via Prof to Prof line for Fife Care Homes
- Care Home ANPs delivering scheduled MDT reviews, ward rounds and direct support to care homes across all 7 locality clusters, supported via the recruitment of 5 additional ANPs
- Testing SAS delivering direct unscheduled care within Care Homes within one locality

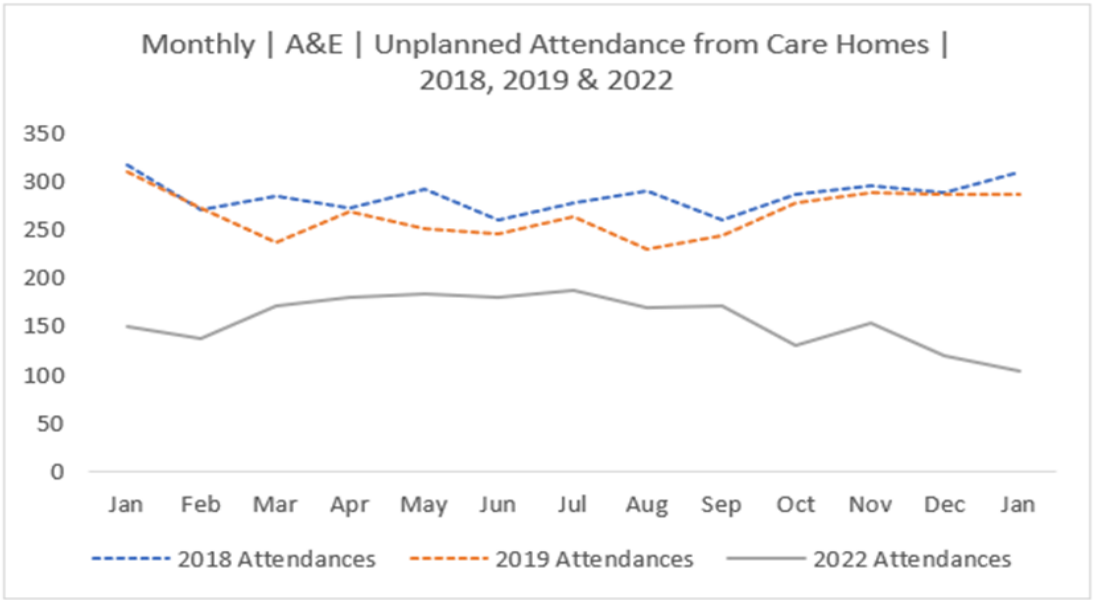
As a result of these tests there has been a reduction in the number of unplanned Acute attendances from Care Homes, since September 2022. Chart 3 shows all unplanned admissions to all locations within VHK. The highest monthly unplanned attendances per month were in March 2022 and the lowest monthly attendances were in March 2023.

Chart 3: Monthly Care Home All Site Attendances



The number of unplanned attendances from Care Homes at A&E in previous years is detailed in chart 4. There has been a decrease in attendances from December to January 2018 to December to January 2022 of 1459 attendances.

Chart 4: Monthly Care Home A&E Attendances (Annual comparison)



2. Redesign of Urgent Care

The main area of focus has been:

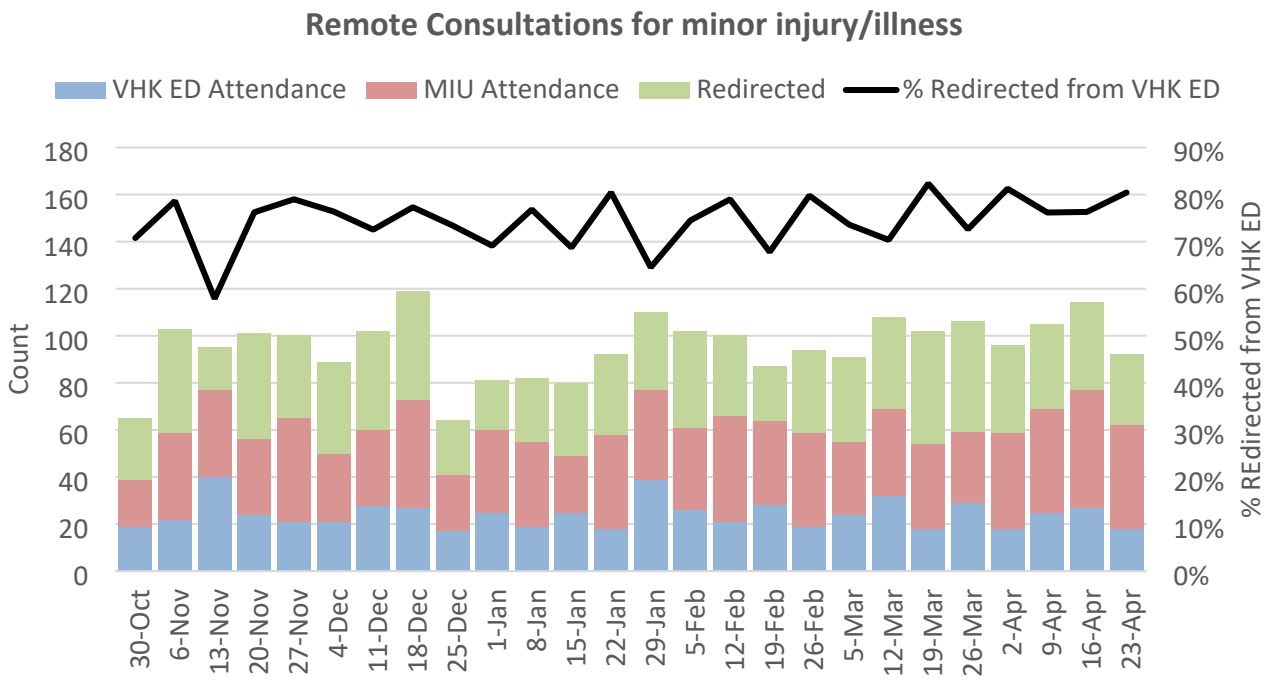
1. Scheduling of minor's patients to Queen Margaret
2. Call before you Convey

3. Review of Flow Navigation

2.1 Scheduling of minor's patients to Queen Margaret

A test of change was undertaken commencing in July with an aim to increase the scheduling of minor patients to Queen Margaret hospital instead of an attendance at VHK. Graph 5 below details the improvement. The workforce model to support this has been achieved through remodelling hours and shifts from ED for ENP's to increase the numbers and times available within QMH. Senior Clinical decision making is supported by Consultant's within ED. The redirection rate from ED VHK has improved from 66% at commencement to 80%, an improvement of 21%. This model will now be mainstreamed as part of ED core work.

Graph 5: MIU Remote consultations



2.2 Call before you Convey

Call Before you Convey, has been an ongoing piece of work where Scottish Ambulance Service crews have been calling the Flow Navigation Centre for patients who meet a certain criterion to discuss whether the patient needs to be brought to hospital and if they do where they need to be brought. The purpose is to ensure patients receive treatment at the right place. The test of change has had limited success, with the highest number of outcomes for patients being conveyed to AU1.

Graph 6 below shows the call outcomes by ED, AU1 and Other. Graph 7 highlights the outcomes classified under 'Other'.

Chart 6: CBC Outcomes

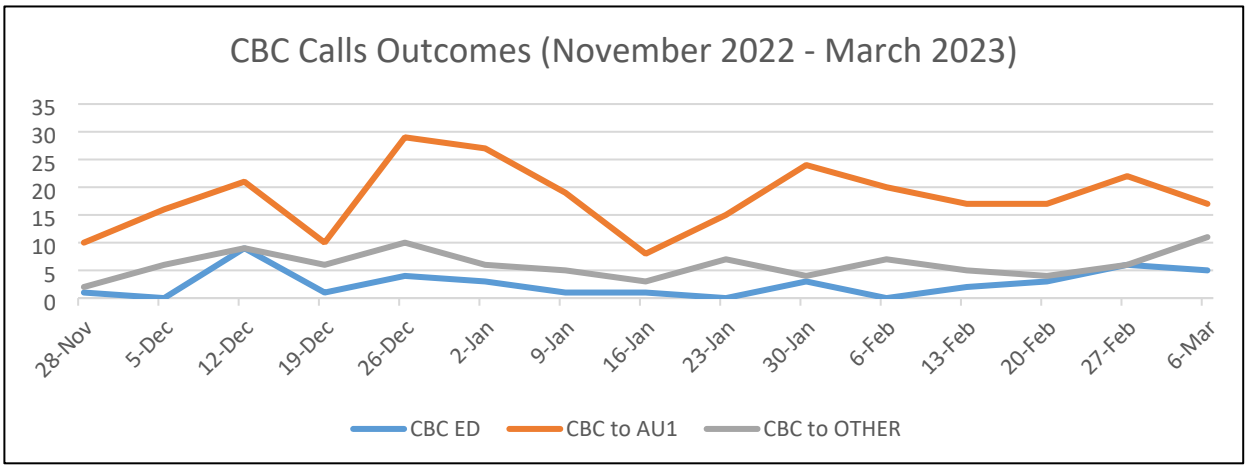
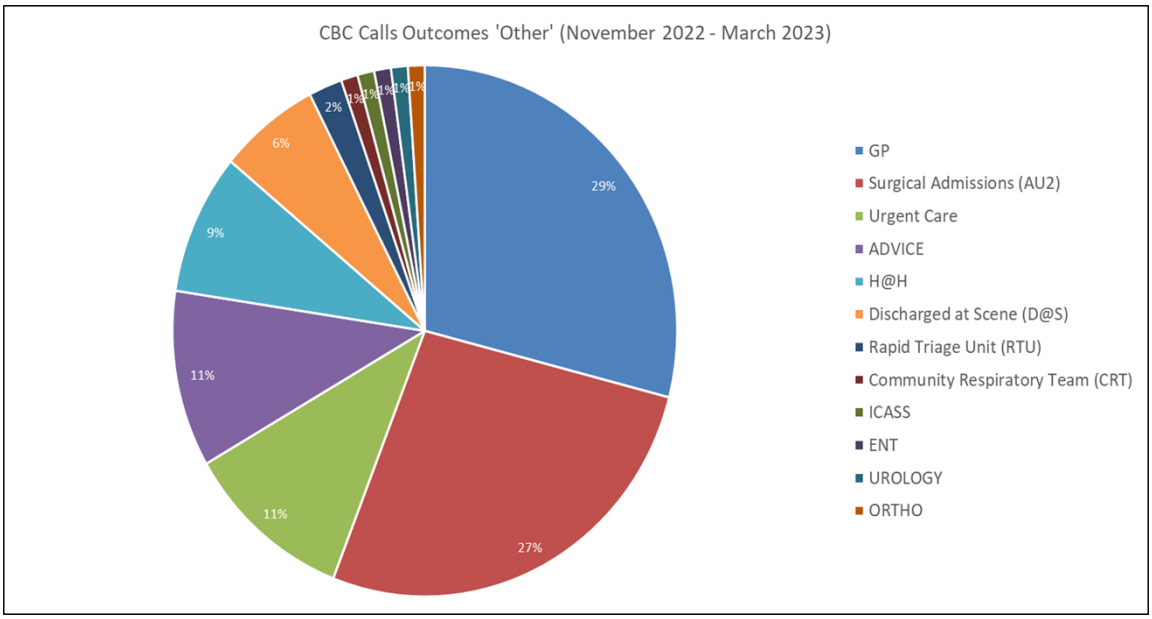


Chart 7: CBC 'Other' Outcomes



Despite this conveyancing rates from ambulances in Fife remains consistently above the National average therefore work is currently underway to look at additional support for the model which will see paramedics being given direct access to an ED Consultant for a clinical discussion and decision on the patient. The TOC commenced 26/4/23 for two weeks to enable workforce and financial decisions to be made against any patient and system benefits that may be achieved.

2.3 Review of Flow Navigation

Fife established the Flow Navigation Centre (FNC) in December 2020. The Flow Navigation Centre guiding principle aims to ensure the safety and wellbeing of patients and staff, and support the public to access the right care, at the right time, first time for urgent care. A workshop was held in February 2023 to review the progress to date of the FNC, a main driver for this discussion is that the current model will not be fully funded by Scottish Government and there is a recognition that the model needs to be reviewed so that its financially sustainable and supports the main aims of the FNC.

The following charts show current performance of the FNC since October 2022:

Chart 8: FNC Pathways & Redirections

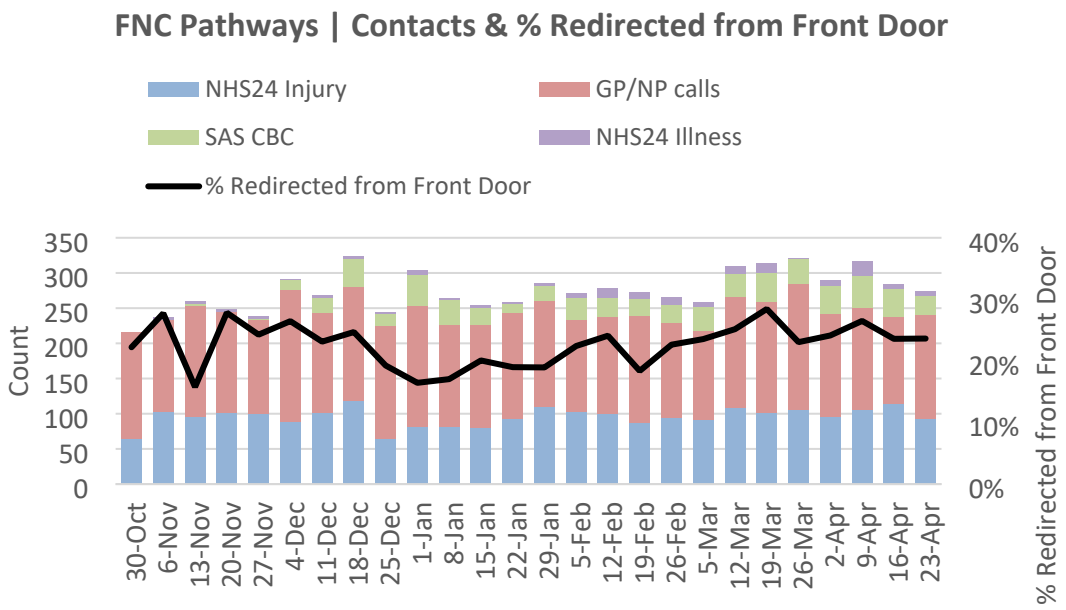
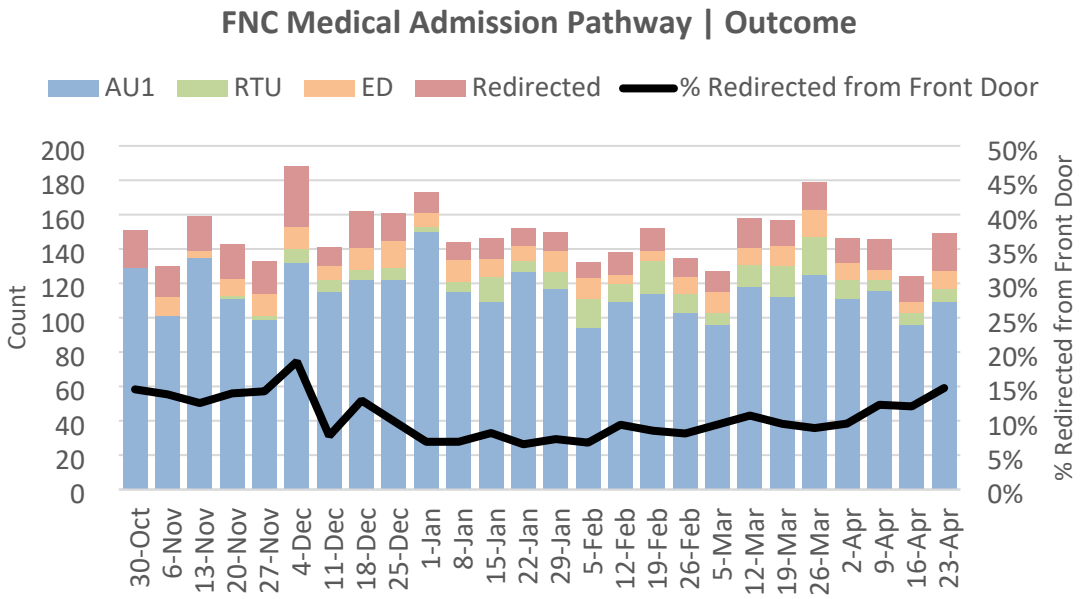


Chart 9: Medical Admission Pathway



An improvement project is being established at pace with the objectives of:

- Develop a workforce and delivery model that is financially sustainable.
- Improve existing pathways and develop new pathways that ensure patients receive the right care at the right time.
- Develop and report data metrics and KPIs that provide rigour and assurance of the FNC.
- Develop communication and engagement plans to ensure people access care in the right place, at the right time.

The aim of the review is to achieve the following improvements:

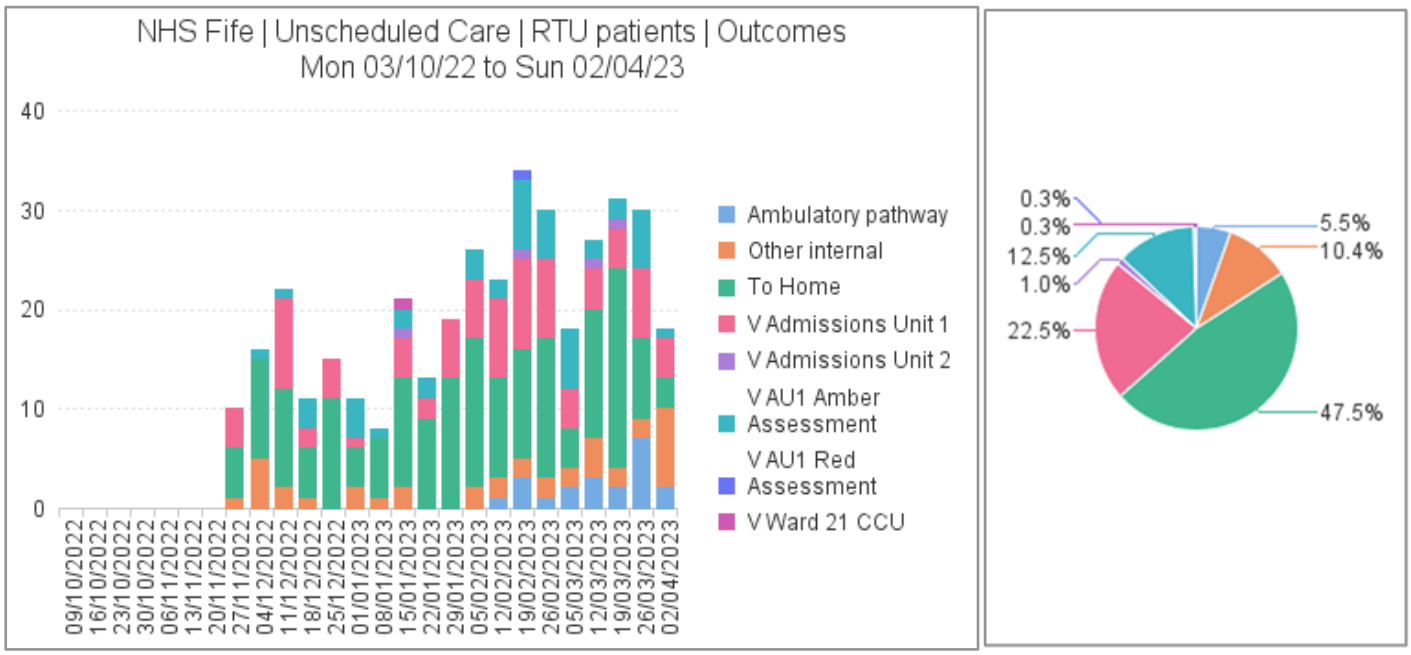
1. To increase admission avoidance by redirecting people away from the front door (initial target 25% by end May 23 with a stretch aim of 40% by October 23)
2. To develop reliable pathways to avoid hospital admission for Chest Pain, Mental Health and Respiratory as a priority and other pathways being improved e.g., Social Care
3. To integrate Prof to Prof – Care Home pathway within overall FNC governance
4. To enhance the pathway between FNC with the Rapid Triage Unit
5. To develop the workforce model including access to Senior Clinical Decision Making to ensure person centred care
6. To engage and communicate with stakeholders so they know how to access care in the right place at the right time
7. To develop a reliable data dashboard of key metrics

3. New Models of Acute Care

3.1 Rapid Triage Unit

The Rapid Triage Unit (RTU) is an assessment model that was established in October 2022 to streamline the assessment process of GP patients, reduce the demand for assessment beds and optimise ambulatory pathways. All patients are initially triaged via FNC and then seen within the RTU. From commencement until 2nd April 2023 a total of 388 patients have been assessed in the RTU. The below chart shows that 47.5% of patients went directly home after assessment, indicating further redirections from FNC could be achieved.

Chart 10: RTU Patients Outcomes



A short life working group is reviewing the progress made within the 4 months since commencement to revise the inclusion criteria and increase the number of patients being supported through the unit. Patient and family feedback has been very positive, and we continue to collect this patient experience data as we grow the model. A deep dive through a weekly verification process has also been established to review all GP patients attending

to maximise alternative community-based pathways and support streaming further of Acute ambulatory pathways such as ECAS or OPAT.

As part of the wider plans to re shaping our front door phase 2 will see a single admission pathway into our medical admission unit with the removal of the C-19 respiratory and non-respiratory pathways. At risk patients will be identified as per guidance in line with other respiratory and communicable diseases. This will also allow a re-design of the nursing and medical model to prioritise assessment and triage functions and support flow throughout the unit. The current LOS within Au1 is 20 hrs with a stretch aim to achieve 15 hrs by July 2023.

3.2 Virtual Board Round

A 'Virtual Board Round' was established in August 2022, the purpose to discuss unplanned care patients boarding in planned care beds. The round has offered a more joined up approach to managing boarded patients. The surge/boarding situation has had highs and lows, which has been due to performance. There are a number of risks when patients are having to be boarded out with speciality wards.

Below are some charts which highlight that when emergency admissions are higher than acuity levels are higher:

Chart 11: Average Surge Numbers

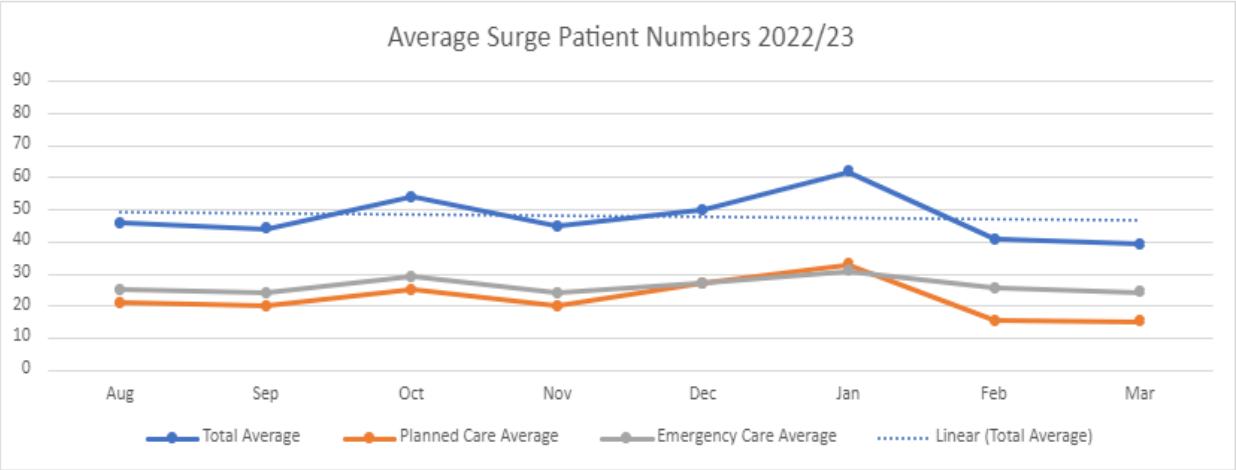
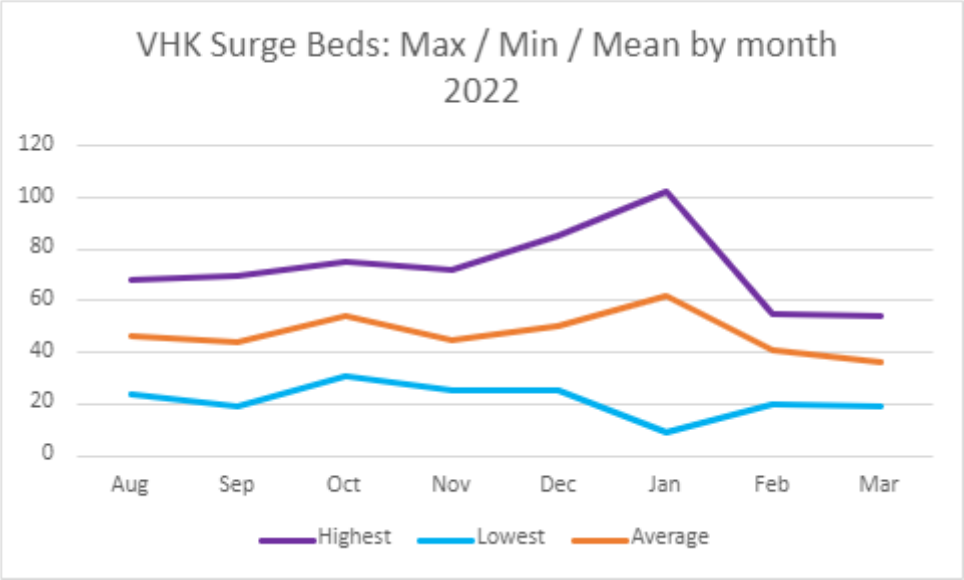


Chart 12: VHK Surge Numbers



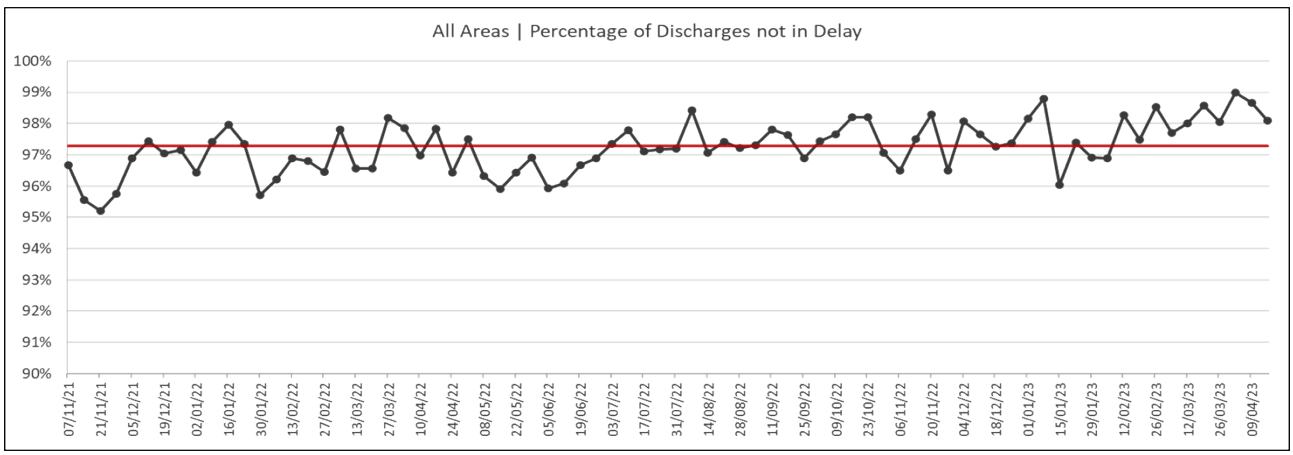
4. Discharge without Delay (Planned Discharge Date)

The Discharge without Delay (DWD) project has been managed as a joint piece of work with NHS Fife and Fife Health & Social Care Partnership. The project has supported staff to start planning patient's discharge from the point of admission. This is to ensure that all aspects which need to be in place for the patient leaving hospital are organised in a timely manner and delays are minimised. The need for planned discharges is greater than ever with the increased frailty of patients leading to an increased period until they are deemed fit to leave hospital which is creating a decrease in overall bed availability.

The introduction of Planned Discharge Dates (PDDs) for patients, set by the multidisciplinary teams on the ward helps to focus discussions and plan for discharge at an early stage.

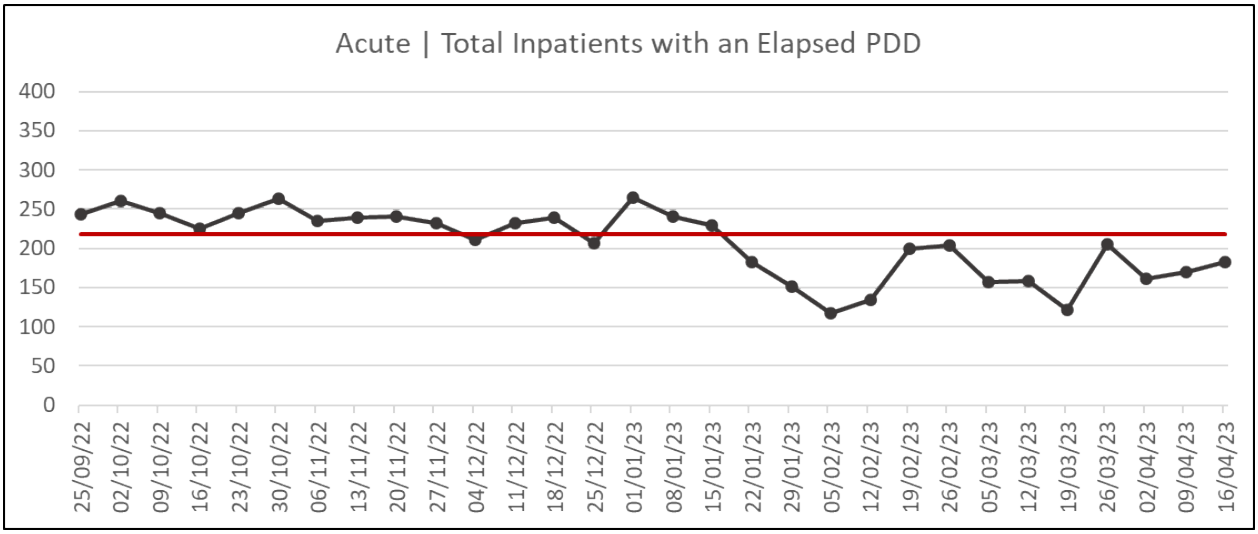
The improvement to the percentage of patients not in delay is detailed in the below chart with the percentage not in delay, around 98%, being above the red median line since the middle of January 2023.

Chart 13: Discharges not in delay



The chart 14 shows the acute patients with an elapsed Planned Discharge Date, indicate an improvement, with decreases in the number of elapsed PDDs.

Chart 14: Elapsed PDD



DWD was funded until March 2023 which enabled the project to be initiated and embedded. The project will continue in 2023 - 2024 to continue and maintain the improvements which have been proven.

4.1 Community PDD / Delays

Fife Health & Social Care Partnership have multidisciplinary 'verification' meetings which take place regularly each week to ensure continuous review of patients clinically fit for next stage of care with confirmed pathways of care in place and identified Planned Dates of Discharge. The **Daily** verification meeting includes a range community and acute health and care professionals who review and confirm pathways and packages of care and timely escalation / progress any issues with these. The **Weekly** verification runs twice - once in the morning and once in the afternoon - to ensure review of all Fife-wide community hospital patients in delay or clinically fit for discharge and patients with planned dates of discharge (PDD). This meeting includes a range of community health and care professionals. Daily and Weekly Verification meetings feed into the weekly **Whole System** verification meeting (Wednesday) where assurance at a senior level (Head of Service chairs) is provided covering patients in all delays, referred to the Discharge Hub as clinically fit for discharge, and / or patients identified as part of the pathfinder Planned Date of Discharge work. All three verification meetings are underpinned from daily Planned Date of Discharge / Discharge without Delay meetings. These multidisciplinary meetings aim to ensure that delays to discharge (Planned Date of Discharge) are avoided. All meetings have a terms of reference. The graphs below provide some performance data:

Chart 15: Discharge Hub Performance:

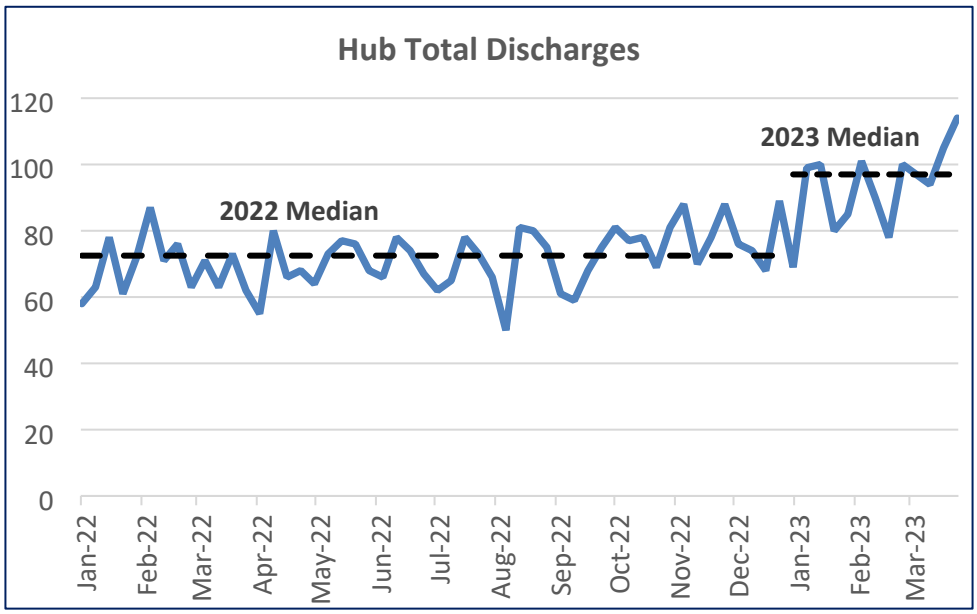


Chart 16: Referrals v discharges

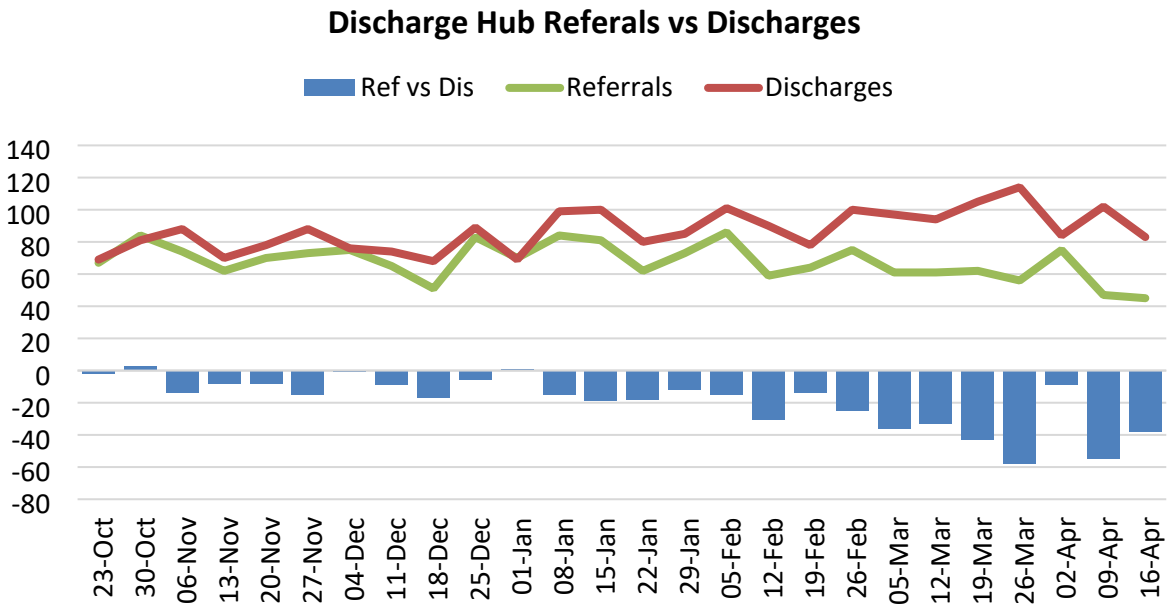
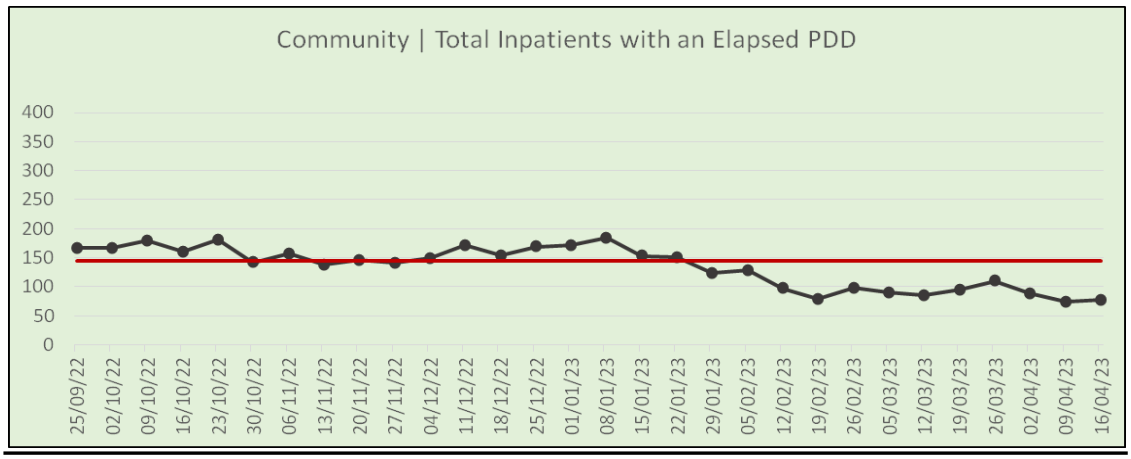
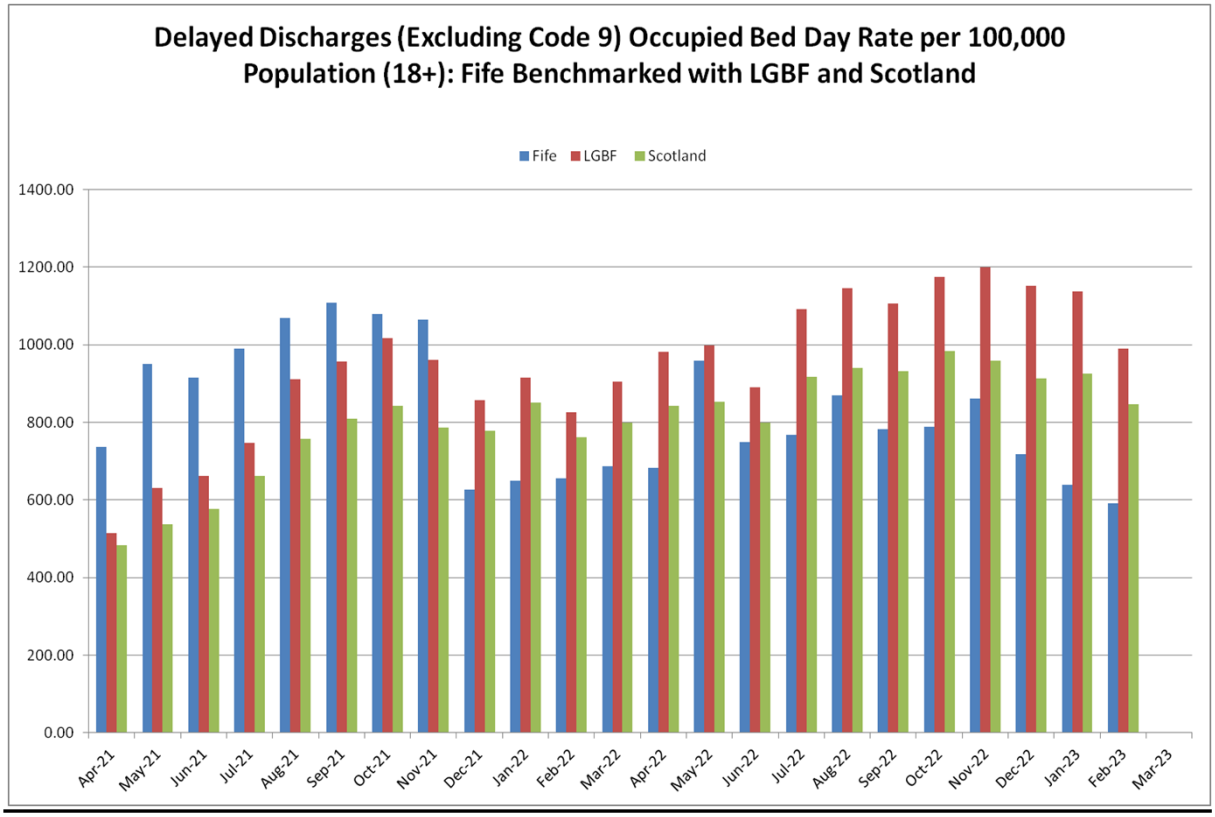


Chart 17: Community PDD



Performance against standard delays compared to Scottish average and Local Government Benchmarking Family

Chart 18: Performance against Scottish Average



Front Door Assessment Team

The Front Door Assessment Team (FDAT) was implemented September 2022. The FDAT has operated a 7 day service since November 2022. It is available for patients presenting to Accident & Emergency Department, Acute Medical Unit and the Rapid Assessment Discharge Ward 9 (RAD) at the Victoria Hospital Kirkcaldy. This model is to enable early intervention and assessment resulting in discharge planning commencing as soon as the individual presents to hospital.

A process map was developed to inform appropriate patients to be assessed by the FDAT, this was carried out in collaboration with the Integrated Assessment Team (IAT). The process map also informed the current measurement plan which has the patient's assessment, intervention and discharge to be completed within 72 hours.

The team attend the Multidisciplinary Team Meeting in RAD ward 9 daily as well as the frailty huddle in AU1.

Average length of stay (LOS) in the RAD has significantly fallen during February and March and is continuing on a downward trend going into April.

Chart 19: RAD Unit LOS

22/01/23	12.01
29/01/23	7.67
05/02/23	3.10
12/02/23	3.25
19/02/23	3.62
26/02/23	3.45
05/03/23	4.87
12/03/23	3.54
19/03/23	3.17
26/03/23	4.64
02/04/23	4.27

Prevention of Admission

The Respiratory team is currently working closely with the Acute Respiratory Nurse Team, Managed Clinical network (MCN) and Scottish Ambulance Service (SAS) with test of change projects to reduce 20% of respiratory hospital admissions and facilitate a 20% increase of respiratory discharges from hospital into the community. The SAS pilot has recently been expanded from one post code to include Fife wide referrals originating from the SAS dispatcher to Fife community respiratory team.

Hospital at Home

InReach Hospital at Home test of change facilitates the implementation of in-reach band 6 NPs (starting Monday-Friday move to 7 days once staffing secured) to commence Hospital at Home step down assessments within the acute setting. This will be crucial for FNH to have direct access to the in reach ANP to redirect before patients reach the front door. By testing this model of care, the Service aims to:

Commencing H@H assessments for step down patients in the acute environment and supporting the front door team will positively impact admission, assessment and

documentation time required in the community and this would result in increased capacity and resilience across H@H and the system by:

- Identifying appropriate referrals for step-down for H@H
- Increase capacity and caseloads as a result of more streamlined and efficient triage and assessment process, specific to H@H
- Aim to offer 7 day a week in reach
- Accepting later step down admissions i.e. move from a 5pm cut off to a 8pm cut off as assessment and documentation will already have been completed. If no treatment is required admission at anytime with review the following day.
- Improving patient experience
- Supporting the front door model

2.3.1 Quality / Patient Care

It is anticipated that the services associated with unscheduled care and the Patient Care experience will be improved through the revised programme of work. This work will enhance care delivery in the right place, by the right person, first time

2.3.2 Workforce

This programme is being delivered in the main within the existing staff profile of both organisations with the following posts recruited to directly to aid delivery within the Flow Navigation Centre:

Staff role	Contribution	Number of Staff
Dispatchers	The Dispatching team are key navigators within the FNC, following clear protocols to make sure patients follow the correct pathways and facilitating the scheduling element of the pathways.	**6.9 WTE**
Senior Dispatchers	This role will oversee and provide leadership and development to the dispatch team and play a crucial role in maintaining governance over current and future processes and protocols	**1.6 WTE**
ENP	This role support's the QMH triage model for direct NHS 24 calls delivering clinical assessment of 4-hour minor injury / illness pathway patients	**3.2 WTE**
ANPs	This role will support the local clinical assessment of 4-hour minor injury pathway patients and medical admission pathway patients.	**6 WTE**
Senior Decision Maker	This role, along with programme lead for the FNC workstream, will provide live time SCDM support to the ANP team	**1 WTE**
GPSI	This role will support the ED team in releasing ED Consultant time to allow them to support the SCDM role for all 4-hour patients	**1.5 WTE**

2.3.3 Financial

The Integrated Unscheduled Care Programme Board are reviewing and monitoring the financial implications of the Programme. The costs to deliver the current Flow Navigation Centre model are being reviewed as they are not sustainable. Based on the current model the FNC is forecast to cost £1.4M in 2023 – 2024 and beyond. These costs are forecast to incur an overspend of £234k in this financial year and £765k in 2024 – 2025. Assurance is given that a programme of work will be completed to ensure services are financially viable within the funding available.

2.3.4 Risk Assessment / Management

Risks for this work are identified and managed as part of the governance arrangements and are recorded on Datix.

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

The Unscheduled Care Programme and its component projects seeks to reduce inequalities. Equality Impact Assessments were previously completed for Phase 2 of the Programme. The current Equality Impact Assessment is in the process of being refreshed to reflect the current phase of the Programme.

2.3.6 Climate Emergency & Sustainability Impact

Not used

2.3.7 Communication, involvement, engagement and consultation

As part of this work there is ongoing stakeholder mapping and engagement activities underway.

A local Winter Communications plan was delivered which actively engaged with the people of Fife through various methods in support of 'Right Care, Right Place, Every time'. This also reinforced the national messages which Scottish Government delivered.

2.3.8 Route to the Meeting

This paper has not been to any previous meetings.

2.4 Recommendation

This report is submitted for discussion and assurance and to provide an update on the work underway as part of the Unscheduled Care Programme.

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

3 List of appendices

The following appendices are included with this report: None

Report Contact
Fiona McLaren
Head of Corporate PMO
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NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**5 May 2023**
Title:	**Fatal Accident Enquiry - Determination Derek Cowan**
Responsible Executive:	**Dr Christopher McKenna, Medical Director**
Report Author:	**Dr Shirley-Anne Savage, Associate Director of Quality and Clinical Governance**

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Legal requirement

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This is presented to the committee for assurance that we have responded to the Fatal Accident Enquiry for Mr Derek Cowan.

2.2 Background

Mr Derek Cowan, who resided in Glenrothes, died in Ward 32, Victoria Hospital, Kirkcaldy, at 1.00 hours on 23 August 2019.

2.3 Assessment

The cause of death was 1(a) dehydration, 1(b) sepsis, 1(c) infected ischaemic tissue damage in feet; 2. Alzheimer's disease; Type II diabetes and chronic kidney disease

The main findings were:

- Mr Cowan should have remained within Victoria Hospital, Kirkcaldy for on-going care and treatment and should not have been discharged on 15 August 2019.
- The process in relation to the discharge of Mr Cowan from Victoria Hospital, Kirkcaldy was defective and, in particular, there was a lack of scrutiny or review in the process of authorisation of his discharge.

The following matters are relevant to the circumstances of the death

- There was a breakdown in understanding between staff at Victoria Hospital, Kirkcaldy and Balfarg Care Home at the time of Mr Cowan's discharge from hospital on 15 August 2019
- That aspects of Mr Cowan's care whilst at Victoria Hospital, Kirkcaldy were substandard
- No referral was made to the Hospital@Home Service on 15 August 2019 as planned by Dr Kelman and noted in Mr Cowan's medical notes on 14 August 2019.

Recommendations from the Enquiry

Having considered the information presented at the inquiry and the changes already implemented by Victoria Hospital, Kirkcaldy since the discharge of Mr Cowan from Victoria Hospital, Kirkcaldy on 15 August 2019, no recommendations were made.

2.3.1 Quality / Patient Care

N/A

2.3.2 Workforce

N/A

2.3.3 Financial

N/A

2.3.4 Risk Assessment / Management

N/A

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

N/A

2.3.6 Climate Emergency & Sustainability Impact

N/A

2.3.7 Communication, involvement, engagement and consultation

N/A

2.3.8 Route to the Meeting

N/A

2.4 Recommendation

- **Assurance** – For Members' information and assurance that the Fatal Accident Enquiry for Mr Derek Cowan has been responded to.

3 List of appendices

The following appendices are included with this report:

- Appendix No. 1, Determination Derek Cowan
- Appendix No. 2, Draft Response Letter to Fatal Accident Enquiry

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

Form 6.1

Determination

The Sheriffdom of Tayside, Central and Fife at Kirkcaldy

Court Ref: KKD-B156-22

SHERIFF ELIZABETH McFARLANE

UNDER THE INQUIRIES INTO FATAL ACCIDENTS AND SUDDEN DEATHS ETC (SCOTLAND) ACT 2016

into the death of

DEREK COWAN

KIRKCALDY, 23 March 2023

DETERMINATION

The Sheriff having considered all of the evidence and the submissions of parties, determines in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths Etc (Scotland) Act 2016 ("the Act") that:

1. In terms of section 26(2)(a): Derek Cowan, born 20 April 1941, ("Mr Cowan") who resided in Glenrothes, died in Ward 32, Victoria Hospital, Kirkcaldy, at 01:00 hours on 23 August 2019.

2. In terms of section 26(2)(b): no accident took place.

3. In terms of section 26(2)(c): the cause of death was 1(a) dehydration, 1(b) sepsis, 1(c) infected ischaemic tissue damage in feet; 2. Alzheimer's disease; Type II diabetes and chronic kidney disease.

4. In terms of section 26(2)(d): no accident having taken place no finding is made under this subsection.

5. In terms of section 26(2)(e): Mr Cowan should have remained within Victoria Hospital, Kirkcaldy for on-going care and treatment and should not have been discharged on 15 August 2019.

6: In terms of section 26(2)(f): the process in relation to the discharge of Mr Cowan from Victoria Hospital, Kirkcaldy was defective and, in particular, there was a lack of scrutiny or review in the process of authorisation of his discharge.

7: In terms of section 26(2)(g): the following matters are relevant to the circumstances of the death:

i. there was a breakdown in understanding between staff at Victoria Hospital, Kirkcaldy and Balfarg Care Home at the time of Mr Cowan's discharge from hospital on 15 August 2019;

ii. that aspects of Mr Cowan's care whilst at Victoria Hospital, Kirkcaldy were substandard;

iii. no referral was made to the Hospital@Home Service on 15 August 2019 as planned by Dr Kelman and noted in Mr Cowan's medical notes on 14 August 2019.

RECOMMENDATIONS

In terms of section 26(1)(b): having considered the information presented at the inquiry and the changes already implemented by Victoria Hospital, Kirkcaldy since the discharge of Mr Cowan from Victoria Hospital, Kirkcaldy on 15 August 2019, no recommendations are made.

NOTE

1. Introduction and Contents

[1] This determination follows an inquiry into the death of Mr Cowan who died on 23 August 2019 in Victoria Hospital, Kirkcaldy. It contains 13 chapters and an appendix, namely:

1. Introduction and contents
2. The legal framework
3. Participants and representation
4. The inquiry process
5. What happened
6. Areas of factual dispute
7. Proposed findings agreed by parties
8. Section 26(2)(e) reasonable precautions which might have avoided death
9. Section 26(2)(f) any defects in any system of working which contributed to the death
10. Section 26(2)(g) any other facts which are relevant to the circumstances of the death
11. System improvements
12. Recommendations
13. Conclusion

Appendix: Witnesses to the Inquiry

2. The legal framework

[2] This was a discretionary inquiry under section 4 of the Act. The Procurator Fiscal required that an inquiry be held as she considered that the death occurred in circumstances giving rise to serious public concern and that it was in the public interest for an inquiry to be held.

[3] Fatal accident inquiries and the procedure to be followed in the conduct of such inquiries are governed by the provisions of the Act and the Act of Sederunt (Fatal Accident Inquiry Rules) 2017. In terms of section 1(3) of the Act, the purpose of an inquiry is to establish the circumstances of the death and to consider what steps, if any, may be taken to prevent other deaths occurring in similar circumstances. It is not the purpose of the inquiry to establish civil or criminal liability (section 1(4) of the Act).

[4] Section 26 of the Act requires the sheriff to make a determination, which in terms of section 26(2) is to set out the following five factors relevant to the circumstances of the death, insofar as they have been established to their satisfaction. These are:

(i) when and where the death occurred;

(ii) the cause or causes of such death;

(iii) any precautions that could have reasonably been taken, and if so might realistically have avoided the death;

(iv) any defects in any system of working which contributed to the death;

(v) any other facts which are relevant to the circumstances of the death.

The provisions in relation to an accident are not relevant to this inquiry.

[5] In terms of section 26 subsections (1)(b) and (4), the inquiry is to make such recommendations (if any) as the sheriff considers appropriate as to:

(a) the taking of reasonable precautions,

(b) the making of improvements to any system of working,

(c) the introduction of a system of working, and

(d) the taking of any other steps.

[6] In order to identify precautions which, had they been taken, might realistically have avoided the death, or to identify defects in the system of working which contributed to the death it is necessary that the sheriff is satisfied on the balance of probabilities that those precautions or the defects in the system of working contributed to the death. Likewise, in order to make recommendations the sheriff has to be satisfied that there is a reasonable possibility that the recommendations may prevent deaths in similar circumstances.

[7] The Procurator Fiscal represents the public interest. An inquiry is an inquisitorial process and the manner in which evidence is presented is not restricted. The Court proceeds on the basis of evidence placed before it by the Procurator Fiscal and by any other party to the inquiry. The determination must be based on the evidence presented at the inquiry and is limited to the matters defined in section 26 of the Act. Section 26(6) of the Act provides that the determination shall not be admissible in evidence or be founded on in any judicial proceedings, of any nature. This prohibition is intended to encourage a full and open exploration of the circumstances of a death, while also reflecting the position that it is not the purpose of a Fatal Accident Inquiry to establish civil or criminal liability (section 1(4)).

[8] The scope of the inquiry extends beyond mere fact-finding. It looks to the future and seeks to prevent deaths occurring in similar circumstances. Where the circumstances have given cause for serious public concern an inquiry may serve to restore public confidence and allay public anxiety.

3. Participants and representation

[9] The Procurator Fiscal represents the public interest in a fatal accident inquiry and Mr Morrison, Procurator Fiscal Depute, appeared.

[10] NHS Fife Health Board ("NHS Fife") was represented by Mr Paterson, Advocate. Dr Sophie Baldwin was represented by Ms Harris, solicitor. Dr Nives Gattazzo was represented by Ms MacNeill, solicitor. Dr Muhammed Adrees was represented by Mr Higgins, solicitor.

[11] I am grateful to all those appearing at the inquiry for their professionalism and assistance in the conduct of the inquiry. The cooperation of those appearing and, in particular, the agreement of uncontentious matters by Joint Minute greatly assisted the inquiry.

4. The inquiry process

[12] The First Notice of an Inquiry was received on 11 March 2022. An order was made for a preliminary hearing on 29 April 2022. An application was made by NHS Fife to discharge that hearing and to fix a new preliminary hearing on 13 May 2022. That application was not opposed. Further preliminary hearings were held on 29 August 2022 and 12 September 2022. The inquiry heard evidence on 17, 18, 19 January 2023. On the fourth day that was assigned for the hearing of evidence, it was intimated that the report of Dr Andrew Coull had been agreed and a joint minute lodged to that effect. Thereafter, written submissions were lodged and a hearing on submissions took place on 6 March 2023.

[13] Evidence was led principally by the Procurator Fiscal Depute in accordance with the duty under section 20(1)(a) of the Act. A list of witnesses is included as an appendix. Two witnesses provided affidavits. The witness for NHS Fife, Dr Andrew Coull, Consultant Physician in Geriatric & General Medicine, Liberton Hospital, Edinburgh and the Royal Infirmary of Edinburgh, provided a report dated 5 December 2022 and in terms of the second Joint Minute of Agreement his report was treated as his evidence.

5. What happened

[14] This chapter sets out a narrative of the important parts of what was established on the evidence. Some of this was non-contentious and was agreed by the parties in the Joint Minute of Agreement. In the following section, I will consider the evidence that was in dispute or on which there was a lack of clarity and I will explain my assessment of that evidence.

[15] Mr Cowan had been ordinarily resident at Balfarg Care Home, Kilmichael Road, Glenrothes, Fife, KY7 6NL having been admitted there on 26 October 2016. He was a registered patient at North Glen Medical practice. The General Practitioner from the practice who usually

attended to patients residing within Balfarg Care Home was Dr Craig Morris.

[16] Prior to his death, Mr Cowan suffered from a number of medical conditions, including: epilepsy; Alzheimer's disease; frontal lobe impairment; high blood pressure; aortic stenosis; type II diabetes; hypothyroidism; low mood.

[17] Mr Cowan was prescribed medication which was administered by staff at Balfarg Care Home. Said medication included: metformin hydrochloride; memantine hydrochloride; gilpzide; aspirin; lansoprazole; mirtazapine; phenytoin sodium; colchicine.

First admission to Victoria Hospital

[18] On the morning of 7 August 2019 within Balfarg Care Home, Mr Cowan was reporting significant pain in his right leg. Paracetamol was provided by staff of said Care Home but to no effect. Advice was sought from a triage nurse who advised that an X-ray should be carried out at hospital. Staff from said Care Home escorted Mr Cowan to Victoria Hospital, Kirkcaldy.

[19] At around 2120 hours on 7 August 2019 Mr Cowan was admitted to Admissions Unit 1 within Victoria Hospital, Kirkcaldy. Mr Cowan was assessed at 2210 hours and had a blood sample taken. Signs of infection were present. A possible urinary tract infection and lower respiratory tract infection were queried. Mr Cowan was commenced on intravenous fluids, oral antibiotics, and an analgesia regimen. He underwent a frailty assessment and was found to be suffering from possible delirium. On 8 August 2019 it was confirmed that Mr Cowan had an acute kidney injury (AKI) on a background of chronic kidney disease.

[20] An X-ray of Mr Cowan's right leg and hip was taken which showed no significant concerns. [21] On 08 August 2019 Mr Cowan was admitted to Ward 32 for continuing care and treatment. On admission to Ward 32 it was noted within Mr Cowan's medical records that he was "alert but confused at times" and that he was on "bedrest due to increased pain".

[22] On 09 August 2019, Dr Adrees, Consultant Physician, reviewed Mr Cowan during his ward round. There were two consultants attached to wards 32 and 13 and they were each responsible for half the patients in those wards. The two consultants at that time were Dr Adrees and Dr Aylene Kelman.

[23] Later on 09 August 2019, Dr Sherlock spoke with Balfarg Care Home staff. Notes of this discussion are recorded within Mr Cowan's medical records and the following is noted: "Recently needing full assistance with all care needs, usually walks with a Zimmer frame and assistance of 1. Care staff report he has very bad long and short term memory. Have discussed this with nursing staff who are going to see how his mobility is and if back to baseline would be suitable for home. If problems then they would refer to physio team".

[24] On 10 August 2019 Mr Cowan was transferred to Ward 13 for continuing care and treatment. Prior to Mr Cowan's transfer to Ward 13, an entry was made in his medical records which notes that his observations were stable, and "Derek screams out in pain upon mobilising, pain in right leg/side". It was further noted that his dietary intake was good and that there were "No new issues".

[25] As at 10 August 2019 Ward 13 was a surge capacity ward for use when the hospital was busy with inpatients who required admission to other wards within the hospital.

[26] On 11 August 2019 an entry is recorded in Mr Cowan's medical records noting "Mobility is very poor".

[27] On 12 August 2019 repeat blood samples were taken from Mr Cowan. In light of the blood results, it was recorded within Mr Cowan's medical records that there was a "need to screen for further sources of infection". An abdominal ultrasound was ordered to check Mr Cowan's gallbladder, kidneys and liver and daily blood tests were planned.

[28] On 13 August 2019 Mr Cowan refused to go for an ultrasound scan.

[29] On 14 August 2019 Mr Cowan was assessed during a ward round by Dr Kelman, Consultant in Geriatric Medicine. It is noted that the Acute Kidney Injury had resolved and that Mr Cowan had sepsis with an "unclear source". Dr Kelman also noted that Mr Cowan's right third toe was necrotic and dry. The plan recorded included uric acid tests and an X-ray of Mr Cowan's feet. Doctor Kelman recorded that "if bloods improving could go back to NH [nursing home] with H@H [Hospital at Home]". This was referred to as the criteria led discharge plan.

[30] An entry is recorded at 1615 hours on 14 August 2019 within Mr Cowan's medical records that Mr Cowan was due to attend for an ultrasound and staff requested an X-ray but that he was very "agitated" and "refused to go" and that "Patient is for bloods today but refusing".

[31] From the date of his admission to Victoria Hospital on 7 August 2019, Linda Ballingall, the long term partner of Mr Cowan, had become increasingly concerned about the care of Mr Cowan and this culminated in a complaint being made by her to the NHS Complaints Team on 14

August 2019. As a result of this, a Stage 2 complaint was investigated and upheld with an apology being sent to Ms Ballingall on 24 September 2019 (Crown Production #12)

Discharge from Victoria Hospital on 15 August 2019

[32] On 15 August 2019 an entry is recorded within Mr Cowan's medical records at 0425 hours which notes that "bloods unable to be taken by ward staff" and further that "H@N [Hospital at Night] reviewed patients bloods and prescribed 'colchicine' for gout".

[33] On 15 August 2019, Dr Sophie Baldwin, a Foundation Year 1 Doctor, was instructed to review the patients on ward 13 including Mr Cowan. She reviewed Mr Cowan at around 1000hrs. In the corresponding entry in Mr Cowan's medical notes, it is recorded "Derek is comfortable and settled. He has no complaints. The nursing home are ready to take him back today" and "For D/C [discharge] back to nursing home today".

[34] Dr Baldwin was advised by a member of the nursing staff on ward 13 that Mr Cowan was ready for discharge. Dr Baldwin was not adequately qualified to make that decision and she had some concerns that certain parts of Dr Kelman's plan for discharge had not been undertaken.

[35] Dr Baldwin contacted Dr Nives Gattazzo, Registrar who was conducting a ward round with Dr Adrees elsewhere in the hospital. This contact was made by telephone. The terms of that telephone discussion appear to have been confused and confusing. However, as a result of that conversation, Dr Baldwin signed the discharge letter.

[36] On 15 August 2019 Mr Cowan was discharged from Victoria Hospital, Kirkcaldy back to the care of Balfarg Care Home. The X-ray of Mr Cowan's feet as planned by Dr Kelman was not carried out prior to his discharge. The blood test results ordered by Dr Kelman were not available prior to his discharge.

[37] Mr Cowan should not have been discharged from hospital on 15 August 2019.

[38] Staff at Balfarg Care Home were not expecting Mr Cowan back from hospital. There is confusion as to whether there were discussions between the Care Home and the hospital as to whether Mr Cowan was fit to be discharged back to the Care Home.

[39] On 16 August 2019, Care Home staff telephoned Mr Cowan's General Practitioner. Dr Craig Morris attended to see Mr Cowan that day. It was noted that Mr Cowan was in pain and confused.

[40] On 19 August 2019 Dr Morris again saw Mr Cowan. A referral was made to the "Hospital@ Home" service but there was no capacity within said service. Dr Morris referred Mr Cowan for readmission to Admissions Unit 1 at Victoria Hospital, Kirkcaldy on 19 August 2019 after discussion with Ms Ballingall.

Second Admission to Victoria Hospital

[41] On admission to Victoria Hospital, Kirkcaldy on 19 August 2019 it was noted that Mr Cowan was dehydrated with poor oral intake, that he was non-communicative and that his feet had pressure breaks. A blood sample was taken and on analysis indicated an infection and significantly raised sodium levels indicated dehydration. An infection of the bones was queried.

[42] On 20 August 2019 Mr Cowan was commenced on a syringe driver to administer analgesic medication and later that evening he was moved to Ward 32. Mr Cowan's treatment plan continued on said ward.

The Death of Mr Cowan

[43] On 22 August 2019 Mr Cowan was seen on a ward round by Dr Morag Patterson, Consultant Geriatrician. It was noted that Mr Cowan was critically ill. Dr Patterson discussed Mr Cowan's condition with Dr Catriona Semple, a Vascular Consultant, and both agreed that Mr Cowan's ongoing treatment would likely be mainly palliative in nature. This was discussed with Mr Cowan's partner and next of kin, Ms Ballingall and it was agreed that Mr Cowan would be kept as comfortable as possible.

[44] Mr Cowan died within Ward 32 on 23 August 2019, and life was formally pronounced extinct at 0100 hours the same date.

6. The areas of factual dispute

[45] Ultimately there are three areas of factual dispute which require to be addressed:

i. Whether the staff at Balfarg Care Home agreed that Mr Cowan was fit to be discharged back to the Home on 15 August 2019.

[46] The evidence I heard regarding this issue was contradictory and it would be difficult to say with any certainty whether there was an agreement on the part of the Care Home to have Mr Cowan back on 15 August 2019. Ms Watson, the Care Home manager said she visited Mr Cowan in hospital on 15 August 2019 and given her assessment of him at that time, she advised the female nurse in charge of the ward he was in, that he was not well enough to be discharged back to the home. In her assessment, Mr Cowan would have needed assistance with his feeding, handling and mobility. He did not meet the criteria for a residential unit. When he was returned to the Care Home, they had a duty of care to accept him back but he was re-admitted to hospital after the weekend on the recommendation of Dr Morris, the GP responsible for the care of residents in the home. The notes relating to this do not record such a conversation with the hospital and when questioned about that, Ms Watson said that she had not had a chance to write up the notes before Mr Cowan returned.

[47] Mrs Gillian Harris was a Team Leader at the Care Home at the time of Mr Cowan's discharge from hospital in August 2019. Her evidence and the notes that she made at the time (Crown Production #2, page 11) confirm that he was very poorly on 16 August 2019 and she noted that he should not have been discharged. Mrs Michelle Coleman a Nursing Assistant at the Care Home said that she had been expecting Mr Cowan back at the Care Home that day but she could not recall how she knew that he was coming back. She agreed that when Mr Cowan returned to the Care Home on 15 August 2019, he was very unwell and she had noted this (Crown Production #2, page 9).

[48] Rona Young is a registered nurse and Patient Flow Co-ordinator within NHS Fife. She was the nurse in charge of Ward 13 on the day of Mr Cowan's discharge from hospital and spoke to Ms Watson, the Care Home manager that day. She said that Ms Watson came to assess Mr Cowan for return to the Care Home and she said that Ms Watson had said that the Home would be happy to accept Mr Cowan back and there were no issues.

[49] Ms Ballingall's evidence in relation to this matter is that when she returned to the Care Home with Mr Cowan on 15 August 2019, the staff were astonished to see him and were horrified at his appearance. They were not expecting him and had to go and make up his bed because his room was not ready.

[50] In the letter of apology sent from NHS Fife to Ms Ballingall on 24 September 2019 (Crown Production #12) at page 2 it states:

> "There was also miscommunication between the ward and the care home manager which resulted in Mr Cowan returning to his home when care home staff were not expecting him."

[51] As indicated, the evidence in relation to this particular aspect of events is unsatisfactory. I find it difficult to accept that the Home would have been happy to accept Mr Cowan back given how unwell he was. This position is supported by the evidence of Ms Ballingall and the terms of the apology letter received by her on 24 September 2019 (Crown Production #12). On the basis that it is agreed by all parties that Mr Cowan should not have been discharged from hospital on 15 August 2019 it seems to me that the position is more supportive of the witnesses from the Care Home who say they were not expecting him back and did not agree with his return. On the balance of probabilities, I accept that the Care Home were not expecting Mr Cowan back and that there was a miscommunication between the ward and the care home staff about this.

ii. Whether there was a defect in the process involved in Mr Cowan's discharge from hospital and how his discharge came about.

[52] It is accepted by all parties that Mr Cowan was not fit for medical discharge on 15 August 2019. How that came about is in dispute. I heard evidence from the four clinicians involved in the care of Mr Cowan. Rona Young and Norma Beveridge also provided evidence in relation to this matter.

[53] Dr Nives Gattazzo was an ST4 specialty registrar in the Victoria Hospital in 2019. She was attached to ward 32 with two consultants, Dr Adrees a locum consultant and Dr Kelman. She said that any doctor above the level of FY1 could discharge a patient. An FY2 could make the decision but that would depend on their level of confidence. She also explained that there were occasions when patients were moved to ward 13 which was a surge capacity ward. Patients were moved to ward 13 if they were medically fit and waiting to go home. They were referred to as boarding patients. The decision to move a patient to ward 13 was usually made by a consultant. Dr Gattazzo confirmed that she did the ward

round with Dr Kelman on 14 August 2019 and took notes. She was there when Dr Kelman devised the criteria led discharge plan referred to in the medical notes (Crown Production #3 page 105). She recalled that Dr Adrees was the consultant responsible for ward 13 on 15 August 2019. She was working that day but did not recall any conversation about Mr Cowan. She could not recall any conversation with Dr Baldwin on the phone about Mr Cowan. However, she did say that she trusted Dr Baldwin implying that she believed if Dr Baldwin said she made the call then the call was made. Even although there was no note of the phone call, she did say in Dr Baldwin's defence that the ward was busy. She did also confirm that given her experience of working with Dr Baldwin that Dr Baldwin would have sought the appropriate assistance from a senior colleague especially given there were outstanding tests to be carried out.

[54] Dr Muhammed Adrees was the other consultant responsible for patients alongside Dr Kelman on ward 32 in August 2019 although he could not specifically recall Dr Kelman being there. He said that the bed manager made the decisions about where a patient should be or if they should be transferred between wards. He also said that it was not up to the consultants to assign where junior doctors should go. That decision was made by the rota coordinator. He confirmed that a consultant would decide if a patient was fit to be discharged. He did not recall Mr Cowan. He did not recall Dr Baldwin. He did not recall Dr Gattazzo. He did not recall if he was working on 15 August 2019, the day of Mr Cowan's discharge. He was keen to pass the responsibility for discharge to the consultant who was last to see Mr Cowan that being Dr Kelman. He did not recall the telephone call referred to by Dr Baldwin and in his opinion, if was not noted then it did not happen. He reiterated that it was likely that no phone call was made.

[55] Dr Sophie Baldwin gave her evidence by way of affidavit. She was an FY1 doctor started working on ward 32 on 7 August 2019. This was her first job following qualification. Her evidence was largely uncontroversial with the exception of one particular passage of importance. Dr Baldwin stated that on the morning of 15 August 2019, she was asked by Dr Adrees to see the "border patients" in ward 13. There were no doctors permanently on the ward and the patients in the ward were usually approaching discharge. The patients were under the care of ward 32. Dr Baldwin recalled a conversation between Dr Gattazzo who was also present and Dr Adrees as to whether Dr Gattazzo should accompany Dr Baldwin and Dr Adrees said that Dr Baldwin could go herself. When reviewing Mr Cowan, Dr Baldwin recalls checking Mr Cowan's notes from the day before and overnight. She was told by one of the senior nurses that Mr Cowan was to be discharged and the nursing home were ready to take him back. As an FY1, Dr Baldwin would not have been in a position to discharge a patient so she had to seek advice from a senior clinician. On that basis, Dr Baldwin stated that she called Dr Gattazzo to check if Mr Cowan was still for discharge even though there were still outstanding investigations to be done in accordance with Dr Kelman's plan detailed in the notes the day before. Dr Baldwin recalls telling Dr Gattazzo that there were outstanding tests and an x-ray to be done. She states that she heard Dr Gattazzo discussing the situation with Dr Adrees with whom she was doing a ward round. She heard Dr Adrees tell Dr Gattazzo that the discharge could go ahead and not to worry about the fact that the bloods and x-ray had not been done. Unfortunately, Dr Baldwin did not make a note of that conversation and according to Dr Baldwin this must have been due to other distractions and pressure of time. There were also some questions about the information Dr Baldwin noted relating to Mr Cowan's blood test results that were available at that time. Following the conversation with Dr Gattazzo, Dr Baldwin states that she prepared the discharge letter and Mr Cowan was discharged.

[56] Dr Aylene Kelman, Consultant Geriatrician at Victoria Hospital recalled seeing Mr Cowan on 14 August 2019. She was the Consultant responsible for Ward 32 along with Dr Adrees at the relevant time. They split responsibility for the patients within the ward. Dr Kelman indicated that it was up to senior doctors to decide where junior doctors would be assigned each day. She also confirmed that boarding patients should be seen by senior doctors and that was the accepted practice in August 2019. Mr Cowan was under Dr Adrees' care. She explained that a senior medical practitioner – ideally a consultant – makes the decision that a patient is medically fit to be discharged. It could be any medical practitioner above Foundation level. Dr Kelman recalled seeing Mr Cowan on the ward round on 14 August 2019. She was accompanied by Dr. Nives Gattazzo, Registrar and she confirmed with reference to the medical notes of Mr Cowan (Crown Production #3 at page 105) that she had noted a plan which would have allowed him to be discharged if certain criteria were met. These were that his bloods were improving and if he had an x-ray of his feet and if his bloods were improving. She also noted that there was to be a referral to Hospital@Home for their involvement. This would have allowed ongoing hospital-level nursing care within the community at the Care Home. She said that in practice, a referral is made to Hospital@Home by a registered member of the team so either a doctor or a nurse. The plan outlined by Dr Kelman in the notes on 14 August 2019 was referred to by her as criteria led discharge. She would have expected the criteria to have been met before Mr Cowan's discharge and they were not. The discharge letter to which Dr Kelman was directed (Crown Production #15) had been signed by Dr Sophie Baldwin, an FY1 doctor. The letter referred to Dr Kelman as being the Discharging Consultant. Dr Kelman said that this was incorrect. She had not been involved in the discharge of Mr Cowan. She was asked about the discussion that Dr Baldwin said she had with Dr Gattazzo and Dr Adrees by telephone to check that Mr Cowan could be discharged. Dr Kelman accepted that knowing Dr Baldwin she would have sought supervision if she was not clear about what to do. She also confirmed that Dr Baldwin should have been the one to note that discussion but in practice, this was not always possible. If Dr Kelman had been the consultant that Dr Baldwin spoke to she would have asked Dr Baldwin to document the change in the clinical plan if there was one or she would not have agreed to the discharge.

[57] Dr Kelman indicated that the discharge process since this event has changed, in that there are now dedicated meetings at 9am and 1pm each day to discuss the discharge of patients. Discussions take place as to whether anything has changed which would delay discharge. Dr

Kelman believes that if this process had been in place on the date of Mr Cowan's discharge then he would not have been discharged.

[58] Rona Young was the nurse in charge of ward 13 on 15 August 2019 and said that she had been told at the handover between the night shift and day shift that Mr Cowan was to be discharged. This suggests that the decision as to whether Mr Cowan was medically fit for discharge had been made prior to Dr Baldwin arriving at ward 13 but it is not clear by whom.

[59] Norma Beveridge is a registered nurse with 35 years experience. She has worked at the Victoria Hospital for her entire career. Her current role is interim Nursing Director for the Acute Division. In August 2019 she was Head of Nursing for the Emergency Care Directorate. Ms Beveridge was involved in the complaint procedure instigated by Ms Ballingall, Mr Cowan's partner regarding the care of Mr Cowan during his period in hospital prior to his discharge on 15 August 2019. I do not need address this issue because the complaint was upheld. However, Ms Beveridge was asked about the discharge process now in place and she indicated that a number of changes had been made since the death of Mr Cowan. There is now a discharge checklist and this is produced at #2 of the Inventory of Productions for NHS Fife. This had existed in some form prior to August 2019 but it was not well used. It highlights what now has to be done and provides an aide memoire for the nurse discharging the patient to note the basis upon which the patient has been determined medically fit for discharge. It is used at the Multi Disciplinary Team meeting that now takes place every day and before a patient is discharged. This is part of the Daily Dynamic Discharge process which is being more robustly implemented. The Multi Disciplinary Team meeting is now a fundamental part of the daily work of the ward. A patient's discharge plan is part of that meeting which involves the consultant, registrar, physiotherapist and a member of the nursing staff. Interestingly, the form refers to Hospital@Home as a support service. Despite her years of experience, Ms Beveridge was not able to say how a referral to Hospital@Home was made. She had never done it and did not know who did it.

[60] In addition to these changes, Ms Beveridge spoke about the Care Home Liaison Working Group which has now been established to improve communication and build relationships between the hospital and Care Homes.

[61] There was also a chapter of evidence in relation to the blood test results for Mr Cowan leading up to his discharge on 15 August 2019. Certain blood tests had been requested on 14 August and the results of these were a crucial part of Dr Kelman's plan for the criteria led discharge. The results of the tests were indicative of dehydration and deteriorating renal function. The evidence relative to the final sample of blood taken from Mr Cowan on 14 August 2019 was that it was not checked prior to his discharge. Dr Baldwin's recollection was that there were no blood test results available on 15 August 2019 having been told by the senior nurse who also told her that Mr Cowan was ready for discharge, that Mr Cowan had refused to have his bloods taken. Dr Baldwin's evidence was that she made Dr Gattazzo and Dr Adrees aware of the fact that there were outstanding blood test results during the telephone call. These blood test results would have indicated on-going infection and dehydration.

[62] My assessment of the witnesses who gave evidence about this issue, with the exception of Dr Adrees, was that they were doing their best to recollect events which were obviously some time ago. They were doing their best to assist the court in explaining and clarifying the process whereby Mr Cowan came to be discharged. I found parts of Dr Adrees' evidence to be quite unhelpful and on some points clearly at odds with the evidence I heard from other witnesses. For example, he said that consultants had no say in where junior doctors were allocated to in the hospital. Dr Kelman refuted that proposition. Dr Adrees said that he was not the consultant responsible for Mr Cowan when Dr Kelman said that he was. Just because Dr Kelman had seen Mr Cowan on 14 August 2019 did not make her the responsible consultant. I formed the impression that Dr Adrees was more concerned in protecting himself against criticism rather than assisting the inquiry in reaching a decision as to why the discharge of Mr Cowan was allowed to happen when it was clearly wrong.

[63] Whilst I accept that Dr Baldwin's evidence was provided by way of affidavit and she was not subject to cross-examination, her evidence about the phone call is supported by Dr Gattazzo and Dr Kelman. They both confirmed that she was a competent and diligent junior doctor and would not have made the decision to discharge Mr Cowan without seeking the appropriate guidance from a senior clinician.

[64] On the balance of probabilities, I believe that the phone call did take place between Dr Baldwin and Dr Gattazzo and whilst Dr Gattazzo could not recall the phone call she was gracious enough to accept that if Dr Baldwin said that she made the call then she was happy to accept that. I was troubled by Dr Adrees' blank refusal to accept the call had been made just because there was no note of it. Others were more accepting of the fact that in a busy ward with other distractions there was a possibility of that not being noted.

[65] Resolving the issue about whether the phone call was made is not the end of the matter. What is not clear, is whether there was some misunderstanding as to what was communicated during that phone call. Dr Baldwin is clear that she heard Dr Gattazzo discussing the matter with Dr Adrees. She heard him say to Dr Gattazzo that Dr Baldwin should not worry about the outstanding investigations and she should proceed with the discharge. Dr Adrees refutes this suggestion and Dr Gattazzo has no recollection of the conversation. It would be surprising that a consultant would make such a statement and this confuses matters. It may be that, given that the information was being relayed through a third party, there may have been some misinterpretation or misunderstanding.

[66] A system whereby an FY1 who has been in post for two weeks is allowed to sign a discharge letter after only being able to have a discussion over the phone with a senior clinician is clearly both inadequate and defective.

iii. Whether Mr Cowan would have tolerated any further medical interventions had he not been discharged on 15 August 2019 and which might have resulted in his death being avoided

[67] The main body of evidence in relation to this matter came from Dr Coull, the expert witness instructed by NHS Fife to prepare a report. It was agreed that his report would form his evidence. The specific remit of Dr Coull's report was to provide an opinion on whether Mr Cowan would have survived beyond 23 August 2019 if he had remained in hospital instead of being discharged to the Care Home on 15 August 2019 taking account of his medical conditions.

[68] At paragraph 4.7 of his report, Dr Coull states that Mr Cowan is likely to have survived beyond 23 August 2019 and if he had consented, tolerated and received adequate rehydration, further radiological investigation and antibiotics. If he had not consented or tolerated these interventions the this would have led to further discussions about his further treatment and whether they were possible or whether Mr Cowan's symptoms should be prioritised over other more invasive treatments.

[69] At paragraph 4.8 of his report, Dr Coull states that Mr Cowan's clinical condition with dehydration, diabetic foot infection and severe peripheral vascular disease on a background of frailty put him at high risk of death from his illness. Even if the treatment had been tolerated and successful it is likely that his life would have been extended only by a few weeks or a small number of months at most.

[70] In the conclusion at paragraph 5.1 of his report Dr Coull states that Mr Cowan was not ready for discharge and he is likely to have survived longer than 23 August 2019 if he had remained in hospital and tolerated interventions such as rehydration and antibiotics.

[71] Finally, Dr Coull concludes at paragraph 5.2 of his report that Mr Cowan was at high risk of dying from his illness and although he may have survived longer than 23 August 2019 if he had tolerated treatment, ultimately his life would have been extended only by a few weeks or a small number of months. He would have been highly likely to succumb to the illness for which he was admitted to hospital on 7 August 2019.

[72] I heard evidence from the medical witnesses with reference to the medical records that there were occasions following his admission to hospital on 7 August 2019 when Mr Cowan refused to allow certain treatments to be carried out. Equally, there were occasions when he clearly had tolerated certain medical interventions following his admission on 7 August 2019. He had an x-ray of his knee on admission and a CT of his pelvis. He tolerated IV fluids although he pulled out the canula on two occasions. However, the IV fluids were ultimately stopped because the Acute Kidney Infection for which he was being treated had resolved. There is also a note in the records on 10 August 2019 that he had a catheter in situ (Crown production #3 page 95). He had bloods taken on 12, 13 and 14 August 2019. He was scheduled to have an abdominal ultrasound on 13 August 2019 but he refused to go. A second attempt was to be made on 14 August 2019 if he was more settled. The notes state that he was to attend but he was very agitated and refused to go for an x-ray of his leg. When he was re-admitted on 19 August 2019, Dr Coull makes reference to him being commenced on IV fluids and a 24 hour syringe driver. These interventions all appear to have been tolerated by him.

[73] In his report at paragraph 4.3 Dr Coull indicates that Mr Cowan was not ready for discharge on 15 August 2019 and further evaluation was required. He states clearly that, "The complexity of that evaluation and potential interventions cannot be underestimated given the clinical context. All these interventions would have required careful consideration and discussion with Mr Cowan and his partner. Any tests and treatment for Mr Cowan would require to be completed under the Adults with Incapacity legislation." Dr Kelman indicated that if Mr Cowan had remained in hospital after 15 August 2019 he would have been treated with intravenous rehydration and antibiotics.

[74] In paragraph 4.4 of his report Dr Coull refers to the rising sodium levels and worsening kidney function on 13 and 14 August 2019. This should have led to consideration of rehydration by different means other than oral means. He goes on to say that Mr Cowan had been resistant to various interventions but importantly states that Mr Cowan had tolerated intravenous therapy earlier in his admission. Again, discussion with Mr Cowan and his partner would have been required and a potential trial of such therapy undertaken to see if it could be tolerated. Other interventions may have identified other issues. At paragraph 4.5 Dr Coull states that Mr Cowan "may have declined or not tolerated" such interventions and if so, this would have led to further discussions between Mr Cowan, his partner and the clinical team as to potential IV antibiotics. If he had not tolerated these treatments or his condition had deteriorated then further conversations would consider how Mr Cowan's symptom control should be prioritised over further invasive treatments such as intravenous therapy.

[75] It is clear from these parts of Dr Coull's report that Dr Coull has taken into account the fact that certain interventions had not been previously tolerated by Mr Cowan, but from my reading of what he says, that did not mean that there should be no attempt to discuss and potentially try further interventions again.

[76] Ultimately, however, it is Dr Coull's opinion that even if treatment had been tolerated and successful, it is likely that Mr Cowan's life would only have been extended by a few weeks or a small number of months at most. There was no contradictory evidence led.

7. Proposed findings agreed by parties

[77] All parties were agreed that formal findings were appropriate in relation to Section 26(2)(a) – (d).

8. Section 26(2)(e) reasonable precautions which might have avoided death

[78] Mr Morrison on behalf of the Crown invited me to make findings under this provision. The wording of the provision does not require reasonable precautions whereby the death **would** be avoided but rather it provides for reasonable precautions whereby the death **might** have been avoided. With reference to the Explanatory Notes to the Act, Mr Morrison highlighted that "A precaution might realistically have prevented a death if there is a real or likely possibility, rather than a remote chance, that it might have done so. No certainty as to the avoidance of death is required. He therefore proposed a finding that a reasonable precaution would have been for Mr Cowan to remain in hospital for ongoing care and treatment and not to have been discharged on 15 August 2019. In support of that submission, he referred to Dr Coull's report at paragraph 5.1 where he states that:

> "Mr Cowan was not ready for discharge [on 15 August 2019] and he is likely to have survived longer than 23 August 2019 if he had remained in hospital and tolerated interventions such as rehydration and antibiotics."

Whilst Dr Coull offers his opinion as to Mr Cowan's longevity had the discharge not gone ahead, Mr Morrison submitted that this issue is not a matter for this court to address. Dr Coull opines that Mr Cowan would likely have survived beyond the date of his death had he remained in hospital for on-going care and treatment rather than being discharged. This aligns with the evidence of Dr Kelman. This means that Mr Cowan's death at the time on that date and in the circumstances in which it occurred could have been avoided. but for the discharge and therefore the continuing intervention and treatment.

[79] Mr Morrison referred to two cases in which it was clear that the period for which a person may have survived if certain steps had been taken was not a matter for such an inquiry as this. (Determination of Sheriff Kenneth Ross re: John Aitken dated 16 August 2011 at paragraph [29] and Determination of Sheriff Douglas Keir re: John Smith dated 6 September 2021 at paragraph [64]). The submissions for the other parties involved in this inquiry seemed to suggest that because Dr Coull said that Mr Cowan was going to die at some point from the illnesses from which he was suffering then this precluded a finding that the death was avoidable. This is a preclusive approach and not one that the court should take.

[80] Addressing the issue of Mr Cowan's tolerance and consent to ongoing treatment, Dr Coull indicates at paragraph 4.7 that if he had not tolerated or consented to further interventions then this would have led to further discussions about what might be appropriate by way of further interventions. Mr Cowan had tolerated treatments and interventions during his time in Victoria Hospital as spoken to by Dr Kelman and Dr Coull. There is a possibility that he would have done so again. Mr Morrison invited me to find, on the basis of Dr Coull's report and Dr Kelman's evidence that there was a "real or likely possibility, rather than a remote chance" that ongoing treatment might have prevented death. The court could find that the death of Mr Cowan was avoidable in the circumstances in which it occurred.

[81] The court also has to address whether the precaution that could have been taken to avoid death was a reasonable one. The Crown submit that the discharge was inappropriate. Dr Kelman outlined her criteria-led discharge in the ward round noted on 14 August 2019 (Crown Production #3 at pages 104-105). Dr Kelman confirmed that Mr Cowan's blood results from 14 August 2019 were such that he should not have been discharged. There was no evidence before the court that any of the clinicians involved in Mr Cowan's discharge checked these results before his discharge. There was no evidence that Mr Cowan's bloods analysis was improving which was one of the criteria set out by Dr Kelman. In fact, the evidence points to the opposite in that the blood results indicated on-going infection and dehydration. Had those results been checked and properly analysed then it would have been reasonable for Mr Cowan to remain in hospital for ongoing care and treatment. To have followed the plan put in place by Dr Kelman can be determined to be a reasonable course of action.

[82] On behalf of NHS Fife, Mr Paterson submitted that no determination ought to be made relative to section 26(2)(e) – (g). NHS Fife accept that Mr Cowan should not have been discharged from hospital on 15 August 2019 but this did not cause Mr Cowan's death. As indicated by Dr Coull, Mr Cowan's clinical condition placed him at a high risk of death and he was highly likely to succumb to the illness for which he was admitted to hospital on 7 August 2019.

[83] Mr Paterson reminded the court that the determination must be based on the evidence led at the inquiry and speculation was to be avoided. The court has to determine whether there existed a real or likely possibility, rather than a remote chance, of the death being avoided by

the precaution. He referred to the Policy Memorandum relating to the Act at paragraph 178 where it states:

> "The Scottish Government does not believe that it was the intention that the interpretation of the word "might" should be construed as "any chance no matter how slim".

Also at paragraph 179 it states:

> "The use of the word "realistically" is intended to imply an actual rather than fanciful possibility that the recommendation might have prevented the death."

[84] In relation to the discharge, the principal issue between NHS Fife and the Crown was whether the court should find that by not discharging Mr Cowan, his death could have been avoided. The evidence for this is the agreed testimony of Dr Coull. That being the case, the Crown accept that when Mr Cowan was admitted to hospital he was moribund. He was in terminal decline and yet the Crown argue that if he had not been discharged then this would have prevented his death. That submission is illogical according to Mr Paterson. The Crown downplay Dr Coull's starting point that Mr Cowan would only have survived beyond 23 August 2019 had a number of interventions been tolerated and the evidence does not allow the court to come to that conclusion. Mr Paterson submitted that the Crown's interpretation of section 26 was too technical. It is not as simple as asking whether, at the time of the death, what happened could have been avoided. The evidence of Dr Coull was that Mr Cowan's death would have occurred weeks or months after 23 August 2019 and the cause of that would have been the reasons for which he was admitted on 7 August 2019. So realistically his death could not have been avoided.

[85] As far as the conflict between the evidence of Dr Baldwin and Dr Adrees is concerned, it would be difficult to resolve that conflict especially where Dr Baldwin was not available to be cross-examined. However, in Mr Paterson's submission it was not necessary for the court to resolve the conflict. The decision to discharge a patient is a medical one. It cannot be taken by a doctor as junior as Dr Baldwin. The investigations included in Dr Kelman's criteria led discharge plan were not carried out. It is unlikely that Dr Baldwin would not have sought guidance from a senior colleague. However, it is equally unlikely that Dr Adrees would have instructed Mr Cowan's discharge knowing that Dr Kelman's criteria were not met. Mr Paterson therefore submitted that there was most likely a breakdown in communication between the junior and senior doctors. That could be readily inferred. That is not likely to recur under the present system now in place and spoken to by Dr Kelman.

[86] Mr Paterson also referred to the conflict in the evidence between Ms Watson, the Care Home manager and Ms Young, the nurse who Ms Watson spoke to about whether Mr Cowan was fit to return to the Care Home. Mr Paterson suggested that Ms Young's evidence should be preferred because it was supported by what was in fact recorded in the medical notes. Also, Ms Coleman said in her evidence that she was expecting Mr Cowan back at the Care Home. Mr Paterson accepted that this conflict was of little moment but he addressed the matter for the sake of completeness.

[87] On behalf of Dr Gattazzo, Ms MacNeill started by highlighting the fact that the function of the sheriff in a Fatal Accident Inquiry does not include making any finding of fault or apportioning blame between any persons who might have contributed to the accident. She then went through the evidence of Dr Gattazzo which was mainly uncontroversial. The area of conflict surrounds the issue of the phone call made by Dr Baldwin to Dr Gattazzo on 15 August 2019. Dr Gattazzo did not recall the conversation referred to by Dr Baldwin but accepted that it would be common for junior doctors to call those more senior to them for advice or support if needed. She submitted that the evidence before the inquiry around the decision making process for discharge is unclear particularly in relation to the discussions between the medical team caring for Mr Cowan on 15 August 2019.

[88] In Ms Harrison's submission there was no evidence before the inquiry that Dr Gattazzo could have taken any precautions in terms of this section that could have resulted in the death of Mr Cowan being avoided.

[89] On behalf of Dr Baldwin, Ms Harrison invited me to accept the evidence of Dr Baldwin in relation to what happened on 15 August 2019. She said that she was asked by Dr Adrees to review the border patients alone. Dr Adrees said that this decision would not have been his but rather that of the rota coordinator. Dr Kelman disagreed with that proposition and she confirmed that a junior doctor is allocated to a ward by the rota coordinator. The question of which doctor on the ward sees which patients on a particular day is a decision made within the clinician team. Dr Kelman was also clear that it should be a senior doctor who reviewed the border patients and this suggests that Dr Baldwin's evidence that Dr Gattazzo offered to accompany Dr Baldwin that day was indeed in line with the common practice at that time. Dr Baldwin said that she had been told by a nurse when she came to ward 13 that Mr Cowan was due for discharge. She reviewed his notes and clearly recalls making a telephone call to Dr Gattazzo to discuss the discharge given that Dr Kelman's plan had not been implemented. Ms Harrison highlighted the tension in the evidence about the phone call and invited me to consider whether this phone call was made and if so, the nature of the conversation. The evidence would seem to point to Dr Baldwin having made the call. With regard to the telephone conversation it is possible that there was a miscommunication among the doctors involved in that three way conversation.

[90] Dr Baldwin of course was not able to make the decision to discharge Mr Cowan being a junior doctor and having been in the job for only eight days. She did all that was required of her. She made enquiries of senior colleagues in accordance with usual practice and she genuinely believed that the decision was that Mr Cowan was ready for discharge. She acknowledges and regrets her failure to record the conversation that she says she had with Dr Gattazzo and Dr Adrees. She has made certain changes to her practice following upon that error. Even if she had made such a note however, this would not have had any bearing on Mr Cowan's outcome in Ms Harrison's submission. The decision to discharge Mr Cowan was not one Dr Baldwin could make and she merely completed the administrative task of preparing the discharge letter.

[91] With reference to Dr Coull's report, Ms Harrison reiterated that in Dr Coull's opinion, at its highest, Mr Cowan's discharge on 15 August 2019 accelerated his death and did not avoid it. Therefore the court may conclude that no findings ought to be made under section 26(2)(e).

[92] On behalf of Dr Adrees, Mr Higgins accepted that Mr Cowan was discharged inappropriately on the basis that it was not known if his bloods were improving at that time and the planned x-ray and ultrasound had not taken place. Mr Higgins submitted that it was, however, not clear how Mr Cowan came to be discharged.

[93] Mr Higgins highlighted the conflicting evidence about whether or not the Care Home were happy to accept Mr Cowan back into their care. There was the evidence about the actual discharge itself. The evidence of Dr Baldwin was that she was told by a senior nurse that Mr Cowan was to be discharged. Ms Young, a senior nurse on the ward that day said that she was advised on handover between the night shift and day shift that Mr Cowan was to be discharged. There was no documentation to confirm that.

[94] Dr Adrees' evidence was that he did not recall the telephone call made by Dr Baldwin. He thought that it was highly unlikely that the call was made as there was no record of it. Mr Higgins said that Dr Adrees did not accept that he was the consultant in charge on 15 August 2019. It is not clear, if that is the case, who Dr Adrees suggests was in charge. The evidence was that two consultants were responsible for the ward, Dr Adrees and Dr Kelman. They were not on the ward together at any time so if one was there, then the other was not. Therefore, if Dr Adrees was there, then it follows that Dr Kelman was not there and Dr Adrees was in charge of the ward.

[95] It is not possible for the court to determine how Mr Cowan came to be discharged on the evidence before it according to Mr Higgins. He suggested that there were a number of reasons or explanations and it would be wrong to hypothesise about which is the most likely. The purpose of the inquiry is not to find fault or blame but to fact find and consider what steps might be taken to prevent other deaths in similar circumstances.

[96] Mr Higgins invited me to prefer the evidence of Dr Adrees where it differed from the other evidence in the case. He invited me to attach little weight to Dr Baldwin's affidavit. It was not possible to assess her credibility and reliability. The fact that Dr Kelman's name was on the Immediate Discharge document (Crown Production #15) would imply that Dr Adrees did not agree to the discharge as suggested by Dr Baldwin but there was no opportunity to question Dr Baldwin about that. There was insufficient evidence before the inquiry to make a finding under section 26(2)(e) that a reasonable precaution which might have prevented Mr Cowan's death was that he should not have been discharged from Victoria Hospital. Mr Higgins did suggest that if the court considered it necessary to make a finding in respect of the discharge being inappropriate then this should be under section 26(2)(g).

[97] Mr Higgins highlighted the evidence from Dr Kelman and Dr Coull about the treatment that Mr Cowan could have had if he had remained in hospital. The inquiry did not hear from Dr Kelman that even if he had received and tolerated further treatment that this would have led to an improvement or that he would not have succumbed to the conditions from which he was suffering. Reference was made again to Dr Coull's report.

[98] In Mr Higgins' submission, the evidence plainly indicated that it was unlikely that Mr Cowan would have consented to and tolerated further investigations and treatment. In his submission the evidence does not support a finding that not discharging Mr Cowan might realistically have resulted in the death being avoided and therefore no finding should be made under section 26(2)(e).

Decision

[99] In Carmichael's textbook Sudden Deaths and Fatal Accident Inquiries (3rd edition) at paragraph 5-75, the author sets out what is considered to be the correct approach to section (6)(1)(c) of the 1976 Act which was the predecessor to section 26(2)(e) of the 2016 Act. He states:

> "What is required is not a finding as to reasonable precautions whereby the death or accident resulting in death 'would' have been avoided, but whereby the death or accident resulting in death 'might' have been avoided…..Certainty that the accident or death would have been avoided by the reasonable precaution is not what is required. What is envisaged is not a 'probability' but a real or lively possibility that the death might have been avoided by the reasonable precaution."

[100] The Explanatory Notes to the 2016 Act clearly envisage a similar approach being taken to section 26(2)(e) of the 2016 Act. At paragraph 72 it states:

> "Subsection (2)(e) requires the determination to set out any precautions which were not taken before the death which is the subject of the FAI, but that could reasonably have been taken and might realistically have prevented the death. The precautions that the sheriff identifies at this point relate to the death which is the subject of the FAI and might not be the same as those recommended to prevent other deaths in the future under subsection (4)(a). In subsection (2)(e)(i), 'reasonably' relates to the reasonableness of taking the precautions rather than the foreseeability of the death or the accident. A precaution might realistically have prevented a death if there is a real or likely possibility, rather than a remote chance, that it might have so done."

[101] This means that no certainty as to avoidance of death is required. Dr Coull states that but for the discharge and therefore continuing intervention and treatment, Mr Cowan's death could have been avoided. He goes on to say that Mr Cowan is likely to have survived longer than 23 August 2019. The question of how long he would have survived having received such treatment or not is not a matter for this inquiry. Dr Coull's position is that the death could have been avoided had Mr Cowan not been discharged. I accept that Dr Coull then goes on to give an opinion as to how long Mr Cowan might have lived thereafter had he not accepted interventions and treatments but Dr Kelman spoke of treatments that she would have attempted had Mr Cowan not been discharged. There was evidence that if certain treatments and interventions were not tolerated then further attempts would be made to discuss options with Mr Cowan and Ms Ballingall. However, the discharge did go ahead and there was no opportunity to put those treatments in place so that had a direct impact on hastening Mr Cowan's death. This is the evidence of Dr Coull (paragraph 5.2). If those treatments and interventions had been tolerated there was a possibility that they could have been successful and death might have been avoided at least beyond 23 August 2019 (paragraph 4.7).

[102] I do not accept Mr Paterson's interpretation of Dr Coull's report. In Dr Coull's conclusion at paragraph 5 he makes it clear that Mr Cowan "is likely to have survived longer than 23 August 2019 had he remained in hospital on 15 August 2019 and tolerated interventions and treatment.". There was evidence from Dr Kelman as to what that treatment might have been and there was evidence that although he had not tolerated some interventions, Mr Cowan had tolerated some interventions. I do not accept that his intolerance in relation to some interventions was sufficient evidence to conclude that he would not tolerate further treatments had he remained in hospital. There was ample evidence to show that he had tolerated certain interventions and treatments.

[103] I accept that Dr Coull places Mr Cowan at a high risk of dying from his illness and ultimately his life may have been extended by only a few weeks or months had he not been discharged and he had the necessary interventions. He would have been highly likely to succumb to the illness for which he was admitted on 7 August 2019. The term "highly likely" is not a certainty and that raises the spectre of Mr Cowan's death being avoided. Even if death is "highly likely", is a patient not entitled to a level of care and treatment that would make that avoidable? As Mr Morrison pointed out, if a patient is suffering from an end stage disease, for example cancer, then such a preclusive approach would mean that there could never be findings in relation to precautions on the basis that death is inevitable. That cannot be correct and I reject that submission.

[104] The court has to address whether the precaution not to discharge Mr Cowan would have been a reasonable one. It is clear from the evidence that Mr Cowan should not have been discharged. It was plainly wrong. Would the precaution not to discharge him have been a reasonable one in the circumstances? Mr Cowan was clearly not fit for discharge on 15 August 2019. Both Dr Kelman and Dr Coull agree on this. I hardly think I need to go further other than to highlight the evidence that Dr Kelman's criteria led discharge plan was not implemented. Mr Cowan's blood tests were not properly analysed on 15 August 2019 and had they been they would have revealed on-going infection and dehydration that would and should have ruled out discharge. He had not had the x-ray requested by Dr Kelman and no referral was made to the Hospital@Home Service. A reasonable precaution would have been to delay Mr Cowan's discharge to allow Dr Kelman's plan to be implemented.

9. Section 26(2)(f) any defects in any system of working which contributed to the death

[105] Mr Morrison submitted that a finding would be merited under this subsection. The wording of the provision is broad and he proposed that there was a defect in the process involved in the discharge of Mr Cowan and in particular, there was a lack of scrutiny or review in the process of authorisation of his discharge.

[106] Mr Cowan was not medically fit for discharge and the criteria detailed in Dr Kelman's plan were not met. He was discharged with no referral to Hospital@Home. If this had been in place, Mr Cowan would have had his blood samples monitored and IV fluids or antibiotics administered as required.

[107] The fact that the exact circumstances of his discharge are unclear is in itself further evidence of the defect asserted by the Crown. The four clinicians were unable to give a comprehensive or cohesive account of who was ultimately responsible for Mr Cowan's care or who was

ultimately responsible for authorising his discharge. All of the evidence around the discharge process points to a process which lacked checks and balances, accountability and formality. This contributed to the discharge of a patient who was not fit for discharge and which ultimately led to his untimely death.

[108] Mr Morrison highlighted the evidence of Dr Kelman and Norma Beveridge about the changes that have been made to the discharge process since Mr Cowan's death. These include a routine and consistent Multi-Disciplinary team meeting to discuss patient discharges and the use of a prominent nursing checklist. These changes show that the previous system was not working effectively and was indeed defective.

[109] NHS Fife's position in relation to this provision is that there must exist evidence that the defect in question did in fact cause or contribute to the death. Just because Mr Cowan was inappropriately discharged did not necessarily arise from a defect in the system. A communication breakdown is not a system defect. Mr Paterson highlighted the fact that the only expert evidence before the court relative to the cause of Mr Cowan's death was Dr Coull's report. Although Dr Kelman had indicated in her evidence that had she been made aware of Mr Cowan's blood results taken on 14 August 2019, she would have considered starting IV fluids and stopping his furosemide prescription. Mr Paterson said that there was no evidence before the inquiry as to when that would have taken place or what would have happened had Mr Cowan not been discharged.

[110] Dr Coull's evidence was that Mr Cowan was likely to have survived beyond 23 August 2019 had he not been discharged and he had consented to, tolerated and received adequate hydration, further radiological investigation and antibiotics. Dr Coull's opinion about Mr Cowan's survival beyond 23 August 2019 was predicated on that factual hypothesis. Mr Paterson's submission was that Mr Cowan was not prepared to consent to treatment and investigations. He bases this assertion on the evidence that on 14 August 2019, Mr Cowan had refused an x-ray, was too agitated to attend for an ultrasound and refused blood tests. He refused blood tests on 15 August 2019, the day of his discharge. There were examples of previous non-cooperation as well. On this basis, it was unlikely that Mr Cowan would have consented to, tolerated and received adequate rehydration, further radiological investigation and antibiotics. Therefore, he would not have survived after 23 August 2019, according to Dr Coull. If he had then it would only have been for a matter of weeks or a small number of months. Therefore, the court has no evidence before it that any intervention on 15 August 2019 or in the days that followed might have prevented Mr Cowan's death, far less that the absence of such intervention caused or contributed to it. On that basis there should be no finding in relation to this provision.

[111] On behalf of Dr Gattazzo, Ms MacNeill also submitted that there must exist evidence that the defect in question did in fact cause or contribute to the death. There was no deficiency in Mr Cowan's medical care prior to his discharge or in Dr Gattazzo's professional conduct as part of the medical team. Although the conclusion of Dr Coull's report was significant in that he states that Mr Cowan should not have been discharged, there was no clear evidence about the discharge process and therefore it would not be appropriate to make a finding that the particular system of working was lacking.

[112] No submissions were made on behalf of Dr Baldwin in respect of this provision.

[113] Mr Higgins on behalf of Dr Adrees submitted that there were no defects in the system of working which contributed to the death from his perspective and accordingly, proposed no findings under this provision.

Decision

[114] The fact that Mr Cowan was wrongly discharged on 15 August 2019 is the starting point for any discussion on this provision. The evidence about the lack of proper communication and a proper, robust system in place for the discharge of Mr Cowan is pretty overwhelming. There were so many areas of confusion that it is not surprising the system failed. There was the confusion about who was actually the consultant in charge of Mr Cowan. There was confusion as to who was responsible for his care on 15 August 2019. There was confusion as to who told Dr Baldwin to review the patients in ward 13 alone. There was confusion as to who told Rona Young that Mr Cowan was ready for discharge other than it was at the handover from the night shift to the day shift. There was confusion as to who authorised Dr Baldwin to actually discharge Mr Cowan. It was agreed that someone in a more senior role to her had to have authorised the discharge. I have to say that I find it quite alarming that an FY1 doctor with only two weeks experience in the job was being tasked with the discharge process at all. Then there was the issue of the phone call. I have already indicated that on the balance of probabilities I believe Dr Baldwin made the phone call. However, the confusion about what might have been said or not said or how that might have been interpreted or not interpreted in my opinion highlights a further defect in the process. In addition, there is the evidence of Dr Kelman and Norma Beveridge that since Mr Cowan's death certain more robust procedures have been put in place including a daily Multi-Disciplinary Team meeting where daily discharges are discussed. Dr Kelman's evidence was that in her opinion Mr Cowan's discharge would not have gone ahead had this new, more robust system been in place.

[115] Having determined that not discharging Mr Cowan on 15 August 2019 was a precaution that could have reasonably avoided his death, I have no difficulty in finding that these defects in the discharge process contributed to that wrongful discharge and therefore contributed to his death. Whilst I accept that Dr Coull predicated his opinion about Mr Cowan's survival on Mr Cowan consenting to continuing treatment and

interventions, I did not agree with the position that the evidence was that Mr Cowan would not have been prepared to consent to ongoing treatment. That was not the evidence before the inquiry. He had not consented to or tolerated certain investigations but that was not the whole picture. He had tolerated other treatments and investigations so it is wrong to suggest that he would not have tolerated further treatment or investigations in the future. That would be speculation. I therefore conclude that the precaution not to discharge him could have avoided his death on 23 August 2019.

10. Section 26(2)(g) any other facts which are relevant to the circumstances of the death

[116] On behalf of the Crown, Mr Morrison submitted that findings under this provision do not require any causative link to the death. He invited findings under this provision that there was a breakdown in understanding between the hospital and the Care Home at the time of Mr Cowan's discharge; that aspects of Mr Cowan's care whilst in hospital were substandard; and that no referral was made to the Hospital@Home service as had been planned by Dr Kelman.

[117] On behalf of NHS Fife, Mr Paterson made no submissions in relation to this provision.

[118] On behalf of Dr Gattazzo, Ms MacNeill made no submissions in relation to this provision.

[119] On behalf of Dr Baldwin, Ms Harris made no submissions in relation to this provision.

[120] On behalf of Dr Adrees, Mr Higgins submitted that I could make a finding that a fact relevant to the circumstances of the death is that Mr Cowan's discharge from hospital was inappropriate.

Decision

[121] I agree with the submissions made by the Crown on this section. The evidence before the court regarding communications between the hospital and the Care Home presents a contradictory picture and a breakdown in understanding about Mr Cowan's discharge. This was a fact relevant to the circumstances of Mr Cowan's death.

[122] The standard of Mr Cowan's care has been highlighted by Ms Ballingall and the subsequent NHS response to her complaint (Crown Production #12). Norma Beveridge was tasked to investigate the complaint and confirmed that it was upheld. This was a fact relevant to the circumstances of Mr Cowan's death.

[123] The lack of referral to the Hospital@Home Service may be considered to have been a reasonable precaution which may have avoided Mr Cowan's death. Mr Morrison accepted that it might be considered speculative to suggest that such a referral would have had any bearing on the outcome. However, the failure to make the referral shows a lack of planned through care and monitoring which had been envisaged by Dr Kelman in her discharge plan. Again, I have no difficulty finding that this was a fact relevant to Mr Cowan's death.

11. System improvements

[124] The changes in practice that have been implemented since the discharge of Mr Cowan have been highlighted above. Dr Kelman told the inquiry that there is now a Multi-Disciplinary Team meeting every day at 9am and 1pm. These meetings bring together representatives from various specialties and the issue of a patient's discharge is discussed. Norma Beveridge confirmed the changes that have been made since the death of Mr Cowan. There have been improvements made to processes that were already in place. The decision to discharge a patient is made at the Multi-Disciplinary Team meeting. The meeting is a fundamental part of the daily work of the ward and the discharge plan is part of that meeting. Ms Beveridge spoke about the discharge checklist and how changes were identified to make that a more robust and visible part of the discharge process. The discharge checklist is used by nursing staff to assist in ensuring all relevant matters are covered prior to discharge (Productions for NHS Fife #2).

[125] In addition to these changes a Care Home Liaison Working Group has been established to improve communication and build relationships between the hospital and Care Homes.

12. Recommendations

[125] I have not made any recommendations in terms of section 26(1)(b) as positive changes have been made to the discharge process since Mr Cowan's discharge. There is also a Care Home Liaison Working group that aims to improve communication and build relationships between care homes and the hospital. Whilst I have identified significant shortcomings in the discharge process at the time of Mr Cowan's death, I accept that there have been proactive and significant changes to that process that have and will hopefully continue to ensure that such an issue does not arise again.

13. Conclusion

[126] Finally, I would like to offer my most sincere condolences to Ms Ballingall and Mr Cowan's wider family and friends. Ms Ballingall sat through the inquiry listening to the evidence with dignity and fortitude and I commend her for that.

Appendix

Witnesses to the Inquiry

1. Ms Linda Ballingall, Mr Cowan's partner (by affidavit)
2. Sharon Watson, Manager at Balfarg Care Home, Glenrothes
3. Gillian Harris, Senior Social Care Worker, Balfarg Care Home, Glenrothes
4. Michelle Coleman, Nursing Assistant at Balfarg Care Home, Glenrothes
5. Dr Nives Gattazzo, ST4 Specialty Registrar, Victoria Hospital, Kirkcaldy
6. Dr Muhammed Adrees, Locum Consultant Physician, Victoria Hospital
7. Rona Young, Patient Flow Co-ordinator, Victoria Hospital, Kirkcaldy
8. Dr Craig Morris, GP at North Glen Medical Practice, Glenrothes
9. Dr Morag Patterson, Consultant Geriatrician, Victoria Hospital, Kirkcaldy
10. Norma Beveridge, Head of Nursing for the Emergency Care Directorate, Victoria Hospital, Kirkcaldy
11. Dr Aylene Kelman, Consultant Geriatrician, Victoria Hospital, Kirkcaldy
12. Dr Sophie Baldwin, FY1, Victoria Hospital, Kirkcaldy (by affidavit)

Witnesses are designed with reference to the post they held in 2019.

Report

13. Dr Andrew Coull, Consultant Physician, Liberton Hospital/Royal Infirmary of Edinburgh

Appendix 2: Draft Response Letter to Fatal Accident Enquiry

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

Date: 5 May 2023
Your ref: CP| Our ref: Court Ref KKD-B156-22
Enquiries to: Valerie Muir
Direct line: 01592 648080 | Extension: 28080 | Email: valerie.muir@nhs.scot

Scottish Courts and Tribunal Service
By email: FAInotices@scotcourts.gov.uk

Dear Sheriff Elizabeth McFarlane

I write to provide NHS Fife's formal response to the recent Fatal Accident Inquiry into the death of Mr. Derek Cowan published in April 2023. My sympathies remain with the family of Mr. Cowan.

As part of your determination having considered the information presented at the inquiry and the changes already implemented by Victoria Hospital, Kirkcaldy since the discharge of Mr. Cowan from Victoria Hospital, Kirkcaldy there were no recommendations made.

I am grateful to the Scottish Courts and Tribunal Service for their work on this important Fatal Accident Inquiry and for publication of this report.

Yours sincerely

Carol Potter
Chief Executive, NHS Fife

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**5 May 2023**
Title:	**Patient Experience and Feedback Report**
Responsible Executive:	**Janette Owens, 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 is presented for:

- Assurance

This report relates to a:

- Emerging issue
- Government policy/directive
- Local policy

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

- Person Centred

2 Report summary

2.1 Situation

Patient complaints are reported on a monthly basis 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 50% by 31st March 2023)

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 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

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 particular 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

With the stage 2 complaints there is now a level of detail which clarifies where each complaint is in the process. Delays in the process remain with receiving statements (44%) and final response out for comment or approvals (39%).

STAGE 2	20/03/2023		27/03/2023	
Number of new Stage 2's received	5		6	
Total Number	**143**	%	**142**	%
Awaiting Statements	64	45	63	44
Returned to Service insufficient statement	0	0	0	0
Requires PET Action / Follow Up	5	3	8	6
Ready to draft	5	3	5	4
Part Drafted (added 6/3/23)	2	1	1	1
Drafting in Progress	7	5	7	5
FR out for comment	9	6	9	6
FR out for approval	42	29	47	33
FR with Director H&SCP	4	3	0	0
FR with GM for sign off	0	0	0	0
FR with Head of Service for sign off	1	1	0	0
FR sent to CEO	4	3	2	1
Signed Final Response (within target)	11 (1)			
	143	100	142	100

In the last week of March 2023, there were 142 stage 2 complaints in the system, with 13 in total sitting within the Patient Experience Team ready to draft or being drafted (9%).

NB As of 14 April 2023 there are 154 stage 2 complaints, however only 36 of these complaints are within the 20-day target, with 4 ready to draft, 1 part drafted and 2 with the final draft out for approval. Twenty-five (69%) of these complaints are “awaiting statements” and a further 4 requiring further PET action. Therefore, figures over the next quarter for compliance with responding to a complaint within the national 20-day target are predicted to remain extremely low.

Work with services continue to review new ways of working and understand challenges. Clinical pressures continue to impact performance with obtaining statements and approval of final responses. An MSForms questionnaire has been created to gather information and to try to understand the barriers staff

are experiencing with providing statements. This will be tested before widespread dissemination over the next month.

A "complaints escalation" standard operating procedure (SOP) is being drafted. This will highlight and support with processing complaints within the agreed national timescales, in line with the model handling complaint procedure.

The complaint “complexity scoring” tool to triage complaints and categorise them as low, moderate, or high complexity continues to be tested. The complexity categorisation score will provide insight into the volume of complex complaints that NHS Fife receives and handles.

A Recovery and Improvement Plan (Appendix 1) has been developed to guide the redesign of the Patient Experience service, focussing on patient experience and feedback.

A quarterly report (Appendix 2) has been developed for the Clinical Governance Committee which captures information on ‘Measuring the Experience’ and ‘Improving the Experience’. The report provides information on different methods of gathering feedback and, as we emerge from the pandemic, will report on work being taken forward to understand and improve the patient experience.

The report also captures performance data which is required as part of the Model Complaints Handling Procedure.

Importantly, in line with the Organisational Learning Group, emerging themes, lessons learned, and quality improvement initiatives will be highlighted in future reports.

2.3.1 Quality/ Patient Care

Analysing data will lay the foundation for quality improvement work. The Organisational Learning Group will review themes, trends and lessons learned from complaints and adverse events which can be triangulated with activity and staffing resource.

2.3.2 Workforce

Workforce planning

The Patient Experience Team establishment has been 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 consists of 1.0 WTE Band 7 team leader; 3.4 WTE Band 6 Patient Experience Officers; 1.8 WTE Band 4 Patient Experience Support Officers; 2.07 WTE Band 3 Patient Experience Administrators.

Additional team support consists of 1.0 WTE Band 6 Bank Patient Experience Officer. A 9-month fixed term 0.69 WTE Band 4 Patient Experience Support

Officer. A 1.0 WTE Band 4 Administrator post will be implemented to support administrative and coordination aspects of the complaints handling process. This will release more time for Officers and help streamline systems and processes.

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

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 Other impact

n/a

2.3.7 Communication, involvement, engagement and consultation

NMAHP leadership group has been involved in discussions and improvement action planning.

2.3.8 Route to the Meeting

Update from Patient Experience Team
Executive Directors Group 20 April 2023

2.4 Recommendation

Clinical Governance Committee is asked to take **assurance** from the report.

Report Contact

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Patient Experience and Feedback

Recovery and Improvement Plan

March 2023

Published Month Year

www.nhsfife.org

CONTENTS

ISSUE: 1	RECOVERY
OBJECTIVE	**Backlog of 'ready to draft' complaints responses is addressed**. 40 responses to be drafted by PR officers as at 01/02/22. This number will inevitably increase as more statements from services are received. Aim is to have no backlog, to allow PR officers to focus on managing new complaints within the Model CHP timescales, and support services to provide statements.

No	ACTIONS	LEAD	DATE	PROGRESS	STATUS
1.1	Provide weekly report on complaints in system to share with operational teams: ECD, PCD, W&CS, CCS, PPCS, C&CS, corporate services	PRT Admin	31/03/22	Weekly report produced providing information on number of complaints within 15 days (green); 15 – 20 days (amber); >20 days (red); status (awaiting statements, for approval etc).	complete
1.2	Prepare complaint information, statements to draft	PRT Admin	31/03/22	Packs prepared for weekend drafting	complete
1.3	Identify staff, experienced in complaints management, to support focused drive on drafting responses	ADoN	31/03/22	Senior nurses working additional hours at weekends to reduce backlog, supporting PRT	complete
1.4	Focus on 'ready to draft' responses by PROs	PR Lead	31/03/22	PROs prioritised drafting backlog of responses	complete
1.5	Highlight 'ready to draft' responses: number, complexity	PRT Admin	31/03/22	Backlog of 'ready to draft' responses cleared	complete

OBJECTIVE	**Define timeline / trajectory for improvement in complaints response times**

No	ACTIONS	LEAD	DATE	PROGRESS	STATUS
1.6	Re-establish weekly meetings with service SPOC	PR Lead	8/4/22	Weekly /bi-weekly meetings re-established	Complete
1.7	Reduce backlog of statements from services and expedite Final Responses awaiting approval	PR Lead / SPOC	31/12/22	14/04/23 - An MSForms questionnaire has been created to gather information and to try to understand the barriers staff are experiencing with providing statements. This will be tested before widespread dissemination. 13/04/23 – HoPE met with Business Analyst to again discuss digital solutions to support statements and final response sign off	In progress

				Challenges remain with receiving statements within timescales. ECD postponed the complaints process within their services PRD officers workforce remains challenged, mainly due to sickness absence. Accommodating phased returns. As of 36/09/22, 71 (42%) stage 2 complaints are outstanding awaiting statement returns. Reviewing statement memo with aim to reduce duplication, streamlining process and improving quality March 2023 - MSForms questionnaire has been created to gather information and to try to understand the barriers staff are experiencing with providing statements. This will be tested before widespread dissemination.	
1.8	Analyse data from process mapping exercises and agree improvement trajectory with services	PR Lead / HoPE	31/12/22	Process mapping complete. Initial SharePoint solution for gathering data is not viable. As an alternative solution, new fields have been added to Datix. This has allowed more meaningful data to be entered and exported direct to excel for interpretation. Improvement trajectory not yet discussed with services. New weekly reports are being sent to the services from Datix. March 2023 - The digital & information team has created a preliminary summary page for the PET Dashboard. This will be reviewed over the next month to agree on data metrics and reporting priorities.	In progress
1.9	Establish focus groups to discuss complaints management with services	PR Lead / HoPE	31/12/22	Initial induction meetings have taken place with HoPE and several HoN and ADoN's.	Complete

ISSUE: 2	'MEASURING THE EXPERIENCE': ANALYSIS AND REPORTING				
OBJECTIVE	Provide clear analysis of patient experience and feedback data, designing effective format for reports which promotes discussion and learning				
No	**ACTIONS**	**LEAD**	**DATE**	**PROGRESS**	**STATUS**
2.1	Collaborate with Risk Management Coordinator to broaden use of DATIX in Complaints Management, coding themes, capturing lessons learned, actions planned	ADoN	31/12/22	Initial meeting took place to identify potential 'addition' to DATIX system. Additional data fields have been added to Datix as a solution for extracting data. Further ongoing meetings planned to expand on this and to discuss Datix capabilities for extracting more detailed data. Ongoing literature search for coding and categorization of complaints. March 2023 - Explore and promote the use of "Action" module with Datix for complaints	In progress
2.2	Data collection and analysis systems to be developed to facilitate 'live' status of complaints, avoid duplication, and enable bottlenecks to be identified	ADoN / HoPE	31/12/22	SharePoint not a viable solution for data collection and analysis system. Additional data fields have been added to Datix and data extracted to excel. This negates the need to manually update data onto an excel spreadsheet. Additional fields are being added to Datix for multi-directorate complaints and this will allow us to identify more easily services involved and track the progression of the whole complaint.	Complete
2.3	Arrange meeting with Digital and Information Services to ensure systems are not being duplicated	DoN / ADoN	1/5/22	Solution identified and agreed.	Complete
2.4	Capture data required for 9 KPIs in the Model Complaints Handling Procedure	PR Lead	31/12/22	Data systems are currently in place to gather this data. Further work is to be done to enhance the quality of the data. Currently reviewing the feedback Questionnaire in relation to KPI-2 "Complaint Process Experience". A new feedback questionnaire is under design using MS Forms format and a draft copy will be distributed within the organisation and to the public for comments and review before being	Complete

				implemented. MS Forms will also capture response rates and data that can be used for future learning and quality improvement.	
2.5	Develop criteria against which quality of statements are assessed	PR Lead	31/12/22	March 2023 - MSForms questionnaire has been created to gather information and to try to understand the barriers staff are experiencing with providing statements. This will be tested before widespread dissemination.	In progress
2.6	Develop criteria against which quality of draft responses are assessed	PR Lead	31/12/22	Consideration is underway on the drafting of a process to capture this information and once completed will be tested with clinical services. March 2023 – PET Lead has created criteria and is reviewing quality of draft responses. This needs to be embedded within practice.	In progress
2.7	Develop criteria against which complaints are assessed as being upheld, not upheld or partially upheld	PR Lead	31/12/22	Consideration is underway on the drafting of a process to capture this information and once completed will be tested with clinical services.	Not started
2.8	Design template for EDG and CGC SBARs reporting	DoN	8/6/22		Complete
2.9	Design quarterly report template for CGC, including MCHP which will inform Annual Report	DoN	8/6/22		Complete
2.10	Complete Annual Report for SG	DoN	30/9/22		Complete

ISSUE: 3	COMPLAINTS HANDLING SERVICE MODEL
OBJECTIVE	Review and redesign service model to improve effectiveness and efficiency of processes

No	ACTIONS	LEAD	DATE	PROGRESS	STATUS
3.1	Carry out detailed process map of PRO work	PR Lead	31/12/22	Process mapping to be arranged	Complete
3.2	Carry out detailed process map of PR administrators' work	PR Lead	22/4/22	Process mapping undertaken	Complete
3.3	Review outcomes and implement recommendations from process mapping sessions	HoPE	31/12/22	Outcomes being reviewed and recommendations considered	Complete

3.4	Benchmark complaints management teams / processes across other Boards and public sector agencies	PR Lead	31/12/22	Ongoing contact to be made with all Boards to review establishments, documentation and processes	Complete
3.5	Process mapping analysis to elicit gaps, duplication, more efficient way of working	PR Lead	31/12/22	Process mapping underway with Quality Improvement project manager	Complete
3.6	Proactively seek feedback from complainants re the complaints handling process (as per KPI) (will also support QI)	PR Lead	31/12/22	Questionnaire sent with all final response letter as of 1/4/2022. A new feedback questionnaire is under design using MS Forms format and a draft copy will be distributed within the organisation and to the public for comments and review before being implemented. MS Forms will also capture response rates and data that can be used for future learning and quality improvement. Feedback "opt in" box has been added to Datix which will allow us to run a report and identify complainants that wish to engage with the feedback process.	Complete
3.7	Poor uptake with feedback from complaints re the complaints handling process (as per KPI)	HoPE	30/11/22	Change format of Questionnaires sent with all final response letters, from PDF to a more user friendly word document. Exploring MS Forms for feedback questionnaires. Organisational Learning Group supporting this change as a Quality Improvement Project.	Complete
3.8	Sending email via Datix System	HoPE / PR Lead	30/09/22	Datix systems has been changed to allow the ability to send emails to recipients with NHS straight from the complaint file. This was not activated previously within the Complaints module. This allows direct emails from Datix rather than having to exit Datix, send from MS Mail, copy sent email and paste within the progress note in Datix complaint file. The ability to send emails from Datix has streamlined the process and is a more efficient way of working.	Completed

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	Link with Organisational Learning Group	ADoN / HoPE	06/10/22	OLG in early stages of development. ADoN co-Chair. Systems and processes being worked through	Completed
4.2	Identify small Tests of Change in department	ADoN	1/4/22	Blended approach to office working has been established, minimum 50% office-based	Complete
4.3	Identify small Tests of Change in Complaints Handling	PR Lead	31/12/22	Identify ToCs following review of outcomes and recommendations from process mapping	Complete
4.4	Review recorded answer phone message	HoPE / PR Lead		Review answer phone message – length, details Ensure information provide in answer phone message is accurate and update Consider allocated telephone extension for internal queries for NHS staff	Complete
4.5	Review complaint "Holding" Letter process	HoPE / PR Lead	30/09/22	Holding letters are issued every 20 days to complainants advising of delays in providing response letters. This has been changed to an email (where possible) which is a quicker process and releases time. The "Holding" letter/email has also been changed to reflect the feedback from patients who were unhappy with the content.	Complete
4.6	Review of the Complaints "Acknowledgement" process	HoPE / PR Lead	31/12/22	Current review of the delays with complainants receiving "Acknowledgement" letters within 3 working days. The current way the data is extracted from Datix is not always accurate and false breaches are occuring. Currently being reviewed by the Datix team and PR Lead. March 2023 – Data is sent to PET Lead and breaches reviewed to identify if they are true breaches and any learning. New administration process in place to ensure acknowledgement letters are processed within 3 day target.	Complete

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**
5.1	Support staff well-being	ADoN / HoPE	30/09/22	First 'Spaces for listening' session took place with Chaplain Service in July. Enquire about additional 'Spaces for listening' sessions. It is planned that these sessions will be provided every 3 months and staff are keen to continue with this. The second session took place 29/09/22.	Completed
5.2	Appoint additional PR officer via bank contract to focus on expediting draft responses	ADoN	1/5/22	Commences in post 31/5/22.	Complete
5.3	Leadership: recruit Head of Patient Experience (HoPE)	ADoN	7/4/22	Post appointed to	Complete
5.4	Ensure PDPs undertaken to support staff development	PR Lead	31/12/22	March 2023 – PDP's continue to be undertaken HoPE to confirm progress with PR Lead Email sent to staff to populate TURAS PDP prior to arranging one to one to discuss	In progress
5.5	Source training opportunities for PRT	PR Lead	31/12/22	March 2023 – ongoing training opportunities undertaken, focus on mandatory training completion also HoPE to confirm progress with PR Lead Exploring training in relation to complaints that relate to Information Governance	In progress
5.6	Develop system to categorise complaints from 'simple' to 'complex' to provide approximate time to draft response	HoPE / PR Lead	31/12/22	March 2023 – Scoring Matrix created and being currently tested before adding to Datix. Ongoing literature search for coding and categorization of complaints	In progress
5.7	Measure workload to support workforce planning	PR Lead	31/12/22	HoPE to confirm progress with PR Lead Ongoing review of caseloads, roles and responsibilities	Complete
5.8	Review of PR team roles and responsibilities	HoPE / PR Lead	30/11/22	March 2023 – additional 0.69 WTE Band 4 Support Officer and 1.0 WTE PET Administration Officer, will continue to review role	In progress

				Ongoing review of systems and process along with tasks, roles and responsibilities. Test of change commenced 09/08/22 with additional admin support for Senior Complaints Officer Test of change to commence 11/08/22 with PR Support Officer reviewing incoming mail to PR department, releasing PR officers to draft complex complaints	
5.9	Establishment and budget	HoPE / PR Lead	30/11/22	Benchmarking and reviewing current establishment, banding and roles within PR department Review of current budget Review of current vacancies within establishment Fixed term 0.69 WTE Band 4 PR Support Officers post has been advertised and an Administrator 1.0 WTE Band 4 post is currently being reviewed.	Completed
5.10	Rebranding of Team	HoPE / PR Lead	31/12/22	March 2023 – Department successfully rebranded to the Patient Experience Team in December 2022. Communications have provided 3 design options for Rebranding of Patient Relations Team to Patient Experience Team. This is currently with a small group within the public for their review and comments.	Completed

Patient Experience and Feedback

PEaF Quarterly Report (Q4) for Clinical Governance Committee

January - March 2023

CONTENTS

Introduction

Person-centred Care

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

'Patient experience and feedback' is captured by a number of different methods, including:

- Care Opinion
- Compliments and comments
- Complaints
- Care Assurance processes, e.g: Shadowing / observation; Walkarounds; 15 step Challenge
- *Surveys (2022/23)*
- *Post discharge phone calls (2022/23)*

Improving the experience

It is important to analyse the data, identifying themes and any particular issues:

- Develop and share goals and targets based on data
- Lessons learned, improvement actions developed, successes celebrated
- Create an enabling infrastructure: Framework; Leadership; Education and training
- Engage staff, patients, families and carers in improvement work
- *'Warm welcome / fond farewell' (2022/23)*
- 'You said… We did'
- *Focus groups (2022/23)*
- Initiatives, such as the Care Experience Improvement Model

Measuring the Experience

Care Opinion highlights the 25 organisations across the UK, with the highest number of staff listening, learning, and making changes. NHS Fife is the top performing NHS Scotland Board.

NHS Fife's **Care Opinion** highlights for Q4 include:

- **217** stories, viewed **19,312** times in all:
  - January 63 stories
  - February 58 stories
  - March 96 stories

In Q3, Care Opinion moderators rated the stories as:

- Not critical 82% (177)
- Minimally critical 3% (7)
- Mildly Critical 7% (15)
- Moderately critical 8% (18)

An important aspect of Care Opinion is the ability to feedback information to patients on changes which have been made.

Compliments:

'Compliments', another vital component of patient feedback, is not routinely reported on. There is a 'compliments' section in the Datix Complaints module which is not widely used, and the following table only provides a small glimpse of positive patient feedback.

It is hoped that the 'compliments' module will become more widely used as staff are encouraged to record compliments, celebrating and learning from success.

Compliments	22/23 Q1	22/23 Q2	22/23 Q3	23/24 Q4	Total
Compliment	287	266	400	222	1175
Learning from Excellence	22	4	0	0	26
Comments and Feedback	10	4	8	0	22
Total	319	274	408	222	1223

Compliments	22/23 Q1	22/23 Q2	22/23 Q3	22/23 Q4	Total
Acute Services Division - Planned Care & Surgery	177	134	216	91	618
Community Care Services	50	57	65	41	213
No value	32	29	27	25	113
Primary and Preventative Care Services	19	14	25	27	85
Acute Services Division - Women, Children and Clinical Services	32	29	6	11	78
Complex and Critical Care Services	25	16	15	6	62
Community Services (Fife-Wide)	N/A	N/A	N/A	N/A	0
Community Services (West)	N/A	N/A	N/A	N/A	0
Acute Services Division - Emergency Care & Medicine	3	1	9	22	35
Community Services (East)	N/A	N/A	N/A	N/A	0
Corporate Directorates	0	0	1	4	5
Total	338	280	364	227	1209

Comments:

Emergency Care & Medicine **-** I would like to compliment both the Victoria hospital, I think Ward 53 and St Andrews hospital Ward 1 for the excellent care and attention given to my husband during his lengthy stay there. Staff have been so kind to him and me and to my family by allowing us to sleep over at times, bringing us cups of tea and comforting me after my husband passed. No words can explain my thanks to them.

Community Care Services Older Peoples' Services – Just wanted to say, 'Thank You'. Thanks for being wonderful! To all the amazing staff at Balgonie Ward, thank you so much for your excellent care and support. You are all marvelous! I can't actually thank you enough

Woman and Children's – I wanted to pass on some feedback of PAU and Children's Ward. My little Giorgia was admitted septic recently requiring triple therapy. Thankfully on the mend now. I wanted to pass on how amazing the staff had been looking after her and how I genuinely could not fault the service and patient care we received. Some staff went above and beyond, two female doctors, Sonya and Ayla and Staff Nurse Catherine who was Giorgia's named nurse. The whole team are a credit to the service.

Complaints:

Trends

There are two stages to the NHS complaints procedure:

1. Early resolution
2. Investigation

Stage 1: Early resolution

The focus is on finding a solution quickly and locally if possible. If the complaint cannot be resolved at stage 1, or if the complainant is not happy with the outcome of stage 1, the complaint should be moved on to stage 2.

Most complaints should be resolved within five working days of the date the complaint is received. In some circumstances, this can be up to ten working days.

Stage 2: Investigation

Complaints might be handled at stage 2 because:

- They are complex, serious or high-risk issues and are not suitable for early resolution
- early resolution has failed
- the complainant was unhappy with the outcome of stage 1 and asked for an investigation.

The complainant should receive a written response within 20 working days.

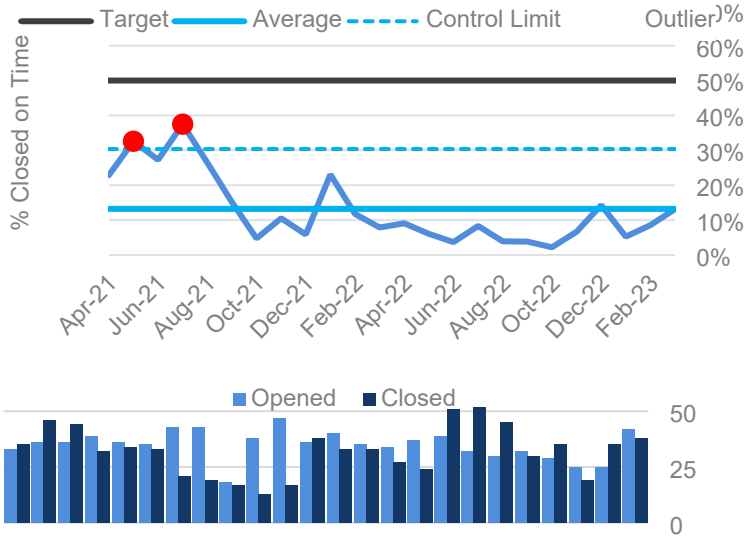
This table presents the total number of Enquiries, Concerns, Stage 1, and Stage 2 complaints received each quarter:

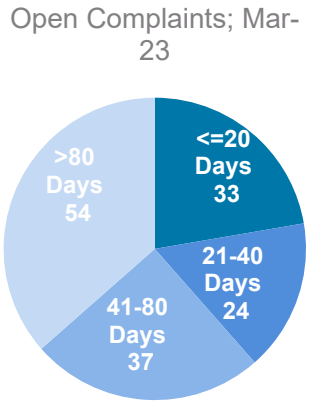
Records logged in Datix Complaints module – 01/04/2022-31/03/2023	22/23 Q1	22/23 Q2	22/23 Q3	23/24 Q4	Total
Stage 1 Complaint	109	151	122	133	515
Stage 2 Complaint	108	102	85	92	387
Concern	176	150	139	92	557
Enquiry	63	120	143	151	477
Total	456	523	489	468	1936

The pressures encountered in services because of the pandemic have led to difficulties in achieving the Model Complaints Handling Procedure timescales. Communication with complainants has been maintained by the Patient Experience Team over this difficult period. A Recovery and Improvement Plan has been developed to improve performance. The Model Complaints Handling Key Performance Indicators are appended to this report.

Stage 2 closed complaints and % closed within timescale

	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Closed Complaints	38	33	33	27	24	51	52	45	30	52	19	35	38
% closed within timescales	**7.9**	**9.1**	**6.1**	**3.7**	**8.3**	**3.9**	**3.8**	**2.2**	**6.7**	**14.3**	**5.3**	**8.6**	**13.2**





Themes

The quarterly ranking of each theme is highlighted in brackets.

Issue noted in Complaint		22/23 Q1	22/23 Q2	22/23 Q3	22/23 Q4
1	Disagreement with treatment / care plan	64 (1)	11 (1)	63 (1)	49 (1)
2	Co-ordination of clinical treatment	62 (2)	8 (2)	26 (4)	18 (3)
3	Staff attitude	46 (3)	5 (3)	25 (5)	22 (2)
4	Unacceptable time to wait for the appointment / admission	41 (4)	2 (7)		15 (4)
5	Lack of support	26 (5)	1 (9)		10 (7)
6	Telephone	24 (6)	3 (6)	18 (6)	11 (6)
7	Poor nursing care	18 (7)	5 (4)	35 (2)	9 (8)
8	Face to face	15 (8)	4 (5)	34 (3)	13 (5)
9	Lack of a clear explanation	15 (9)	2 (8)	15 (7)	5 (12)
10	Insensitive to patient needs		1 (10)		8 (9)
11	Poor medical treatment			12 (8)	6 (11)

The top 4 themes each quarter are:

- Disagreement with treatment / care plan
- Coordination of clinical treatment
- Staff attitude
- Unacceptable time to wait for the appointment / admission

These issues have been addressed at an individual level, but organisational learning must take place to improve practice and to improve the patient experience. The establishment of the Organisational Learning Group will support this endeavour.

Positive and Negative Themes

Positive themes (Care Opinion) Q4	Negative Themes (Care Opinion) Q4	Negative Themes (Complaints) Q4
Staff	Communication	Disagreement with treatment / care plan
Professional	Not being listened to	Staff attitude
Friendly	Waiting time/s	Co-ordination of clinical treatment
Nurses	Staff attitude	Unacceptable time to wait for the appointment
Communication	Appointments	Face to face
Caring	Access to services	Telephone
Level of care	Bedside manner	Lack of support

What was good?

What could be improved?

Locations receiving most complaints:

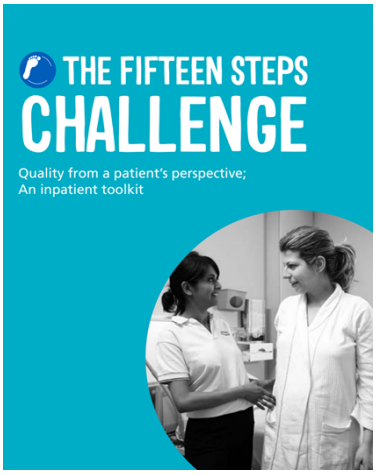
1. General Medicine (31)
2. Mental Health (27)
3. Emergency Department (24)

Improving the Experience

Surveys, Focus Groups, Care Assurance Processes

Each quarter, this section will include feedback from patient / family surveys, complainant survey, patient and staff focus groups, and care assurance processes, including leadership walkarounds; 15 steps challenge; shadowing / observation; 'warm welcome / fond farewell' initiative; care experience improvement model.

Again, the impact of the pandemic has delayed the structured introduction of these processes although they have been happening on an ad hoc basis.



"The 15 Steps Challenge" is a suite of toolkits that explore differen healthcare settings through the eyes of patients and relatives. With an easy to-use methodology and alignment to NHS strategic drivers, these resource support staff to listen to patients and carers and understand th improvements that we can make. The toolkits help to explore patien experience and are a way of involving patients, carers and families in qualit assurance processes.

The 15 steps challenge has been utilised in Glenrothes Hospital but, as we strive to improve patient experience, we will ask patients and their relatives to undertake the challenge.

The Model Complaints Handling procedure, KPI 2, relates to the Complaint Process Experience. Several methods to obtain feedback have been tested, but the results have been poor. Our feedback forms were sent out with the final response letter and often only returned when the complainant was dissatisfied with the complaint outcome, so we ceased to use these. These have been re-introduced, and again feedback has been poor.

A new Patient Experience Feedback questionnaire has been developed on Microsoft Forms to capture the experience of the person making the complaint in relation to the complaints handling process provided. Complainants will 'opt in' to provide feedback, this will be recorded on Datix, and the questionnaire will be sent out 2 -3 weeks after the complaint response letter. This will allow us to obtain feedback each month by contacting complainants who have opted in. Since January 2023 we have seen an improved response rate (24%).

'Warm Welcome… Fond Farewell' is an initiative to standardise admission information and ensure consistent discharge planning. It will help address some of the themes identified in complaints around communication, lack of clear explanation.

The Head of Patient Experience will take forward these examples of patient experience improvement and will report on them in future reports.

Scottish Public Services Ombudsman

The SPSO is the final stage for complaints about public service organisations in Scotland and offers an independent view on whether the Board has reasonably responded to a complaint. A complainant has the right to contact the SPSO if they are unhappy with the response received from the Board.

The number of SPSO cases, decisions and outcome by quarter:

	Apr to Jun 2021	Jul to Sep 2021	Oct to Dec 2021	Jan to Mar 2021	2021 / 2022	Apr to Jun 2022	Jul to Sep 2022	Oct to Dec 2022	Jan to Mar 2023	2022/ 2023
New SPSO cases	6	3	2	5	16	3	13	4	5	25
SPSO decisions	4	3	4	3	14	6	4	1	3	14
SPSO cases fully upheld	1	0	2	1	4	1	1	0	1	3
SPSO cases partly upheld	0	0	0	1	1	3	2	0	0	5
SPSO cases not upheld	2	3	2	1	8	2	1	1	2	6
Cases not taken forward	1	1	0	2	4	6	1	1	0	8

New SPSO cases this quarter

This quarter, 5 new information requests have been received. These relate to the following services:

- Planned Care: 2
- Community Services Palliative Care: 1
- Community Care Services: 1
- Community Care Services / Emergency Care: 1

New SPSO decisions this quarter

There was 3 new decision received from the SPSO this quarter.

- 1 Upheld
- 2 Not upheld

NHS Scotland Model Complaints Handling Procedure

Introduction

Empowering people to be at the centre of their care and listening to them, their carers' and families about what is, and is not, working well in healthcare services is a shared priority for everyone involved with healthcare in Scotland. Scottish Ministers want to facilitate cultural change and to create an environment that uses knowledge to inform continuous improvement to services in a culture of openness without censure. The NHS Scotland Model Complaints Handling Procedures (CHP) forms an integral part of that vision.

The CHP was introduced across Scotland from 1 April 2017. The key aims are:

- to take a consistently person-centred approach to complaints handling across NHS Scotland
- to implement a standard process
- to ensure that NHS staff and people using NHS services have confidence in complaints handling
- encourage NHS organisations to learn from complaints to continuously improve services.

Complaints Performance Indicators

The CHP introduced nine key performance indicators by which NHS Boards and their service providers should measure and report performance. These indicators, together with reports on actions taken to improve services as a result of feedback, comments and concerns will provide valuable performance information about the effectiveness of the process, the quality of decision-making, learning opportunities and continuous improvement.

Quarterly Reports

In accordance with THE PATIENT RIGHTS (FEEDBACK, COMMENTS, CONCERNS AND COMPLAINTS (SCOTLAND) DIRECTIONS 2017 (the 2017 Directions) relevant NHS bodies have a responsibility to gather and review information from their own services and their service providers on a quarterly basis in relation to complaints. Service providers (Primary Care) also have a duty to supply this information to their relevant NHS body as soon as is reasonably practicable after the end of the three month period to which it relates.

This quarterly report represents NHS Fife's response to the 2017 Directions and will form part of the Feedback and Complaints Annual Report for the Scottish Government. This section of the report is structured around the nine Key Performance Indicators.

Indicator One: Learning from complaints

A statement outlining changes or improvements to services or procedures as a result of consideration of complaints including matters arising under the duty of candour. This should be reported on quarterly to senior management and the appropriate sub-committees, and include:

- *Discussions taking place on how we proceed with this and the best way to capture this data.*
- *The Patient Experience Team is working collaboratively with the Organisation Learning Group and Clinical Governance to align learning from complaints and adverse events. This will ensure learning is shared and implemented across the wider organisation, to improve the quality of services that enhance the safety of the care system for everyone.*

Indicator Two: Complaint Process Experience

A statement to report the person making the complaint's experience in relation to the complaints service provided. NHS bodies should seek feedback from the person making the complaint of their experience of the process. Understandably, sometimes the person making the complaint will not wish to engage in such a process of feedback. However, a brief survey delivered in easy response formats, which take account of any reasonable adjustments, may elicit some response.

- *Complaints handling feedback forms were re-introduced in the first quarter with a poor response rate. The PDF form was changed to Microsoft Word to make it more user friendly however response rates remained poor.*
- *A new Patient Experience Feedback Questionnaire was created on MS Form and commenced testing in January 2023. The questionnaire is sent to the complainant 2-3 weeks after the response letter and not with the response letter which was the previous process. Response rate has improved and is 24%.*
- *An "opt in" option has been added to Datix which will be used to run a weekly report highlighting complainants that have given consent to participate in providing feedback.*

Indicator Three: Staff Awareness and Training

Subject Title		No. of staff			Notes
		NHS	SWFC	VOL	
Good conversations (Gc) (3 day course)	Q1	12	6	4	Figures provided for NHS, Social work / Fife Council, Voluntary Sector
	Q2	7	6	2	
	Q3	12	6	3	
	Q4	6	10	4	
Gc half- day intro course	Q1	0	0	0	
	Q2	3	7	2	
	Q3	8	7	5	
	Q4	1	17	4	
Gc Foundation Management		15			Good Conversations training is also provided as a half-day session on the 5-day Foundation Management programme
Human Factors		-			NES offer a range of training and information resources on this topic – Learning page sites, presentations, Guidance, webinars and posters. We are unable to report on engagement in these resources.
Duty of Candour Training	Q1	222			
	Q2	170			
	Q3	166			
	Q4	196			

Indicator Four: The total number of complaints received

	Q1	Q2	Q3	Q4	Total
4a. Number of complaints received by the NHS Fife Board	217	253	207	225	902
4b. Number of complaints received by NHS Primary Care Service Contractors	211	198	115	92	616
4c. Total number of complaints received in the NHS Board area	**428**	**451**	**322**	**317**	**1518**

Records logged in Datix Complaints module – 01/04/2022-31/03/2023	22/23 Q1	22/23 Q2	22/23 Q3	23/24 Q4	Total
Stage 1 Complaint	109	151	122	133	515
Stage 2 Complaint	108	102	85	92	387
Concern	176	150	139	92	557
Enquiry	63	120	143	151	477
Total	456	523	489	468	1936

NHS Fife Board - sub-groups of complaints received

	Q1	Q2	Q3	Q4	Total
4d. General Practitioner	81	11	11	7	110
4e. Dental	1	3	1	1	6
4f. Ophthalmic	0	0	0	0	0
4g. Pharmacy	27	0	0	0	27
Total - Board managed Primary Care services	**109**	**14**	**12**	**8**	**44**

	Q1	Q2	Q3	Q4	Total
4h. General Practitioner	128	77	65	47	317
4i. Dental	3	3	0	6	12
4j. Ophthalmic	0	2	0	0	2
4k. Pharmacy	80	121	50	39	290
Total – Independent Contractors	**211**	**198**	**115**	**92**	**616**
4l. Combined total of Primary Care Service complaints	**320**	**212**	**127**	**100**	**660**

Indicator Five: Complaints closed at each stage

	Number				**As a % of all NHS Fife complaints closed (not contractors)**			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Number of complaints closed by the NHS Board *(do not include contractor data, withdrawn cases or cases where consent not received).*	**132**	**264**	**235**	**223**				
5a. Stage One	107	136	123	131	81%	51%	52%	59%
5b. Stage two – non escalated	24	110	95	72	18%	42%	41%	32%
5c. Stage two - escalated	1	18	17	20	1%	7%	7%	9%
5d. Total complaints closed by NHS Board	**132**	**264**	**235**	**223**	**100%**	**100%**	**100%**	**100%**

Indicator Six: Complaints upheld, partially upheld, and not upheld

Stage one complaints	Number				As a % of all complaints closed by NHS Fife at stage one			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
6a. Number of complaints upheld at stage one	24	35	36	31	25%	29%	35%	37%
6b. Number of complaints not upheld at stage one	51	63	42	36	52%	52%	41%	42%
6c. Number of complaints partially upheld at stage one	23	23	24	18	23%	19%	24%	21%
6d. Total stage one complaints outcomes	**98**	**121**	**102**	**85**	**100%**	**100%**	**100%**	**100%**

Stage two complaints Non-escalated complaints	Number				As a % of all non-escalated complaints closed by NHS Fife at stage two			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
6e. Number of non-escalated complaints **upheld** at stage two	8	13	18	12	42%	25.5%	30%	30%
6f. Number of non-escalated complaints **not upheld** at stage two	9	25	23	14	47%	49%	38%	35%
6g. Number of non-escalated complaints **partially upheld** at stage two	2	13	19	14	11%	25.5%	32%	35%
6h. Total stage two, non-escalated complaints outcomes	**19**	**51**	**60**	**40**	**100%**	**100%**	**100%**	**100%**

Stage two escalated complaints Escalated complaints	Number				As a % of all escalated complaints closed by NHS Fife at stage two			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
6i. Number of escalated complaints **upheld** at stage two	0	2	1	1	0%	14%	7%	6%
6j. Number of escalated complaints **not upheld** at stage two	1	9	10	13	100%	65%	67%	81%
6k. Number of escalated complaints **partially upheld** at stage two	0	3	4	2	0%	21%	26%	13%
6l. Total stage two escalated complaints outcomes	**1**	**14**	**15**	**16**	**100%**	**100%**	**100%**	**100%**

Indicator Seven: Average times

	Q1	Q2	Q3	Q4
7a. the average time in working days to respond to complaints at stage one	5.9	14.2	14.1	11.5
7b. the average time in working days to respond to complaints at stage two	44.0	93.8	98.7	127.7
7c. the average time in working days to respond to complaints after escalation	33.0	102.4	66.4	51

Indicator Eight: Complaints closed in full within the timescales

	Number				As a % of complaints closed by NHS Fife at each stage			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
8a. Number of complaints closed at stage one within 5 working days.	75	83	60	65	94%	93%	87%	88%
8b. Number of non-escalated complaints closed at stage two within 20 working days	5	5	5	5	6%	6%	7%	7%
8c. Number of escalated complaints closed at stage two within 20 working days	0	1	4	4	0%	1%	6%	5%
8d. Total number of complaints closed within timescales	**80**	**89**	**69**	**74**	**100%**	**100%**	**100%**	**100%**

Indicator Nine: Number of cases where an extension is authorized

	Number				As a % of complaints closed by NHS Fife at each stage			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
9a. Number of complaints closed at stage one where extension was authorised	12	19	16	16	38%	35%	27%	62%
9b. Number of complaints closed at stage two where extension was authorised (this includes both escalated and non-escalated complaints)	20	36	44	10	62%	65%	73%	38%
9c. Total number of extensions authorised	**32**	**55**	**60**	**26**	**100%**	**100%**	**100%**	**100%**

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Meeting:	**Clinical Governance Committee**
Meeting date:	**5 May 2023**
Title:	**Adult Support and Protection Biennial Report 2020-22**
Responsible Executive:	**Janette Keenan, Executive Director of Nursing**
Report author	**Rona Laskowski, Head of Service, Complex and Critical Care, Fife HSCP**

1 Purpose

The purpose of this paper is to present the Fife Adult Support and Protection (ASP) Biennial Report 2020-22, and to provide an update on recent activity, including feedback from the Joint Inspection of Adult Support and Protection Measures in Fife in 2021.

This is presented for:

- Assurance

This report relates to a:

- Government policy/directive
- Local policy

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

- Person Centred
- Safe

2 Report summary

2.1 Situation

Fife Adult Support and Protection Biennial Report 2020 – 22 provides an analysis of Adult Support and Protection activity, including reports of harm, types of harm investigated and the profile of adults at risk for whom an investigation took place. It summarises local activity over the 2020-22 period and the key actions that have been taken under statutory functions as laid down in Adult Support and Protection (Scotland) Act 2007. There is a consideration of the impact of ASP work, current challenges and our response to these, and sets out the focus for development and improvement.

2.2 Background

The Biennial Report (appendix 1):
The Adult Support and Protection Committee received detailed statistical summary reports following the submission of the Scottish Government data return.

Reports provide trend analysis, information on types of harm being investigated, demographic details of adults at risk and has helped to inform the local improvement planning discussions for 2023-24. In addition, it has prompted a number of interagency self-evaluation activities to provide context to emerging trends.

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

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

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

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

2.3 Assessment

Reports of Harm:
The number of Reports of harm has continued to increase in Fife on an annual basis. Police and NHS remain the largest single organisations who report harm.

The most significant was a 30.2% rise in ASP referrals from the NHS (+104, from 344 to 448) from 2020-21 to 2021-22 with this biennial reporting period. A working hypothesis is that these numbers could have been affected by remobilisation of NHS appointments leading to increased contact with clients in 2021/22. During the previous year, Covid-19 restrictions and subsequent pressures on the service had led to more routine surgeries and treatments being put on hold.

Furthermore, the ASP team has reported a greater volume of referrals from NHS 24, with analysis evidencing a notable jump this period and a rise year-on-year from 2019/20 (16 referrals to 23 in 2020/21 to 55 in 2021/22). The second most significant rise for the source of ASP referrals was the Care Inspectorate, with figures almost tripling from 11 in 2020/21 to 42 during 2021/22 (+31).

Increases in ASP referrals was also observed for the Scottish Ambulance Service (+9, from 29 to 38) from 2020-21 to 2021-22. Reports of harm from SAS

also rose from 3 to 29 respectively). Further increases this year show this rise has been not only sustained but exceeded during the return for 2021/22.

This pattern has been reflected nationally, UK wide, across all types of harm and domestic abuse and is understood to be directly related to the impact of the pandemic.

In addition to this, it is considered that the impact of the focus, and visibility of Adult Support and Protection activity associated with the join inspection has resulted in a greater awareness of responsibilities across the partners agencies, facilitating a higher level of reporting.

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

5717 reports of harm were received between 2020-22, representing a percentage increase of 0.70% since the previous 2018-20 Biennial report (5677).

2.3.1 Quality/ Patient Care

Types of harm:
In Fife, 835 Investigations were undertaken in the reporting period 2020-22, which is an increase of 15% compared to the 2018-20 Biennial Report (724).

Reflecting data in previous years, the 2020-22 reporting period demonstrated that the most likely location of harm investigated continues to be an individual's own home (59%), followed by Not known (10%) and Care home (5%).

In comparison, 2018-20 data shows the main locations of harm were the individual's own home (63%), Not Known (12%) and Care Home (10%).

In particular, Fife's Care home statistics are of note. Not only have these numbers halved between the two reporting periods, they are also significantly lower than the 22% national average recorded in 2020. There are actions already in place to investigate reasons for this, including the addition of presentations by the Adult Support and Protection Team to care homes to provide further information on harm and the processes for reporting this.

However, again, related to the pandemic, through a national initiative in Scotland, the requirement to review every resident across all care homes in 2021 resulted in a significantly increased presence of both social work and nursing, fulfilling the required duties in relation to COVID, infection, prevention and control and the clinical and care governance requirements introduced at that time. This inflated visibility may have indirectly increased quality of care and management of resident situations, accordingly, reducing the level of Adult Support and Protection activity.

The available data is reflective of a number of similar trends to that of previous years and identifies a number of areas which may have been impacted upon by Covid-19. A hypothesis for the perhaps smaller than expected increase in reports of harm is the reduction in face-to-face contact and engagement with

members of the community due to lockdown restrictions at this time in 2020-21 in particular. The ASPC has developed a Stakeholder Engagement Strategy which is particularly relevant and raised the awareness of the continued need of practitioners to remain vigilant to identifying and reporting harm whilst we gradually came out of restrictions. It is not surprising that the most likely location of harm remains a person's own home given the restrictions that were in place for a large part of 2020-2021, however, there remain questions about the low level of investigations being progressed for adults in care homes. A mixed methods review was taken forward in 2022 and will continue into 2023 to provide exploration and assurances as to the reasons behind this and any supportive action required following.

Psychological and emotional harm

Many people experience psychological and emotional harm as a result of threats of harm, being left alone, humiliation, intimidation, causing distress, verbal abuse, bullying, blaming, constant criticism, controlling, depriving contact with others. **19%** of investigations carried out within the last reporting period related to an individual at risk of psychological or emotional harm. This is a 6% drop in comparison with the last reporting period (25% of investigations).

Financial harm

Financial harm covers theft, fraud, pressure to hand over or sign over property or money, misuse of property or welfare benefits, stopping someone getting their money or possessions, being scammed by rogue traders, online scams, by email or by post. Almost one in four investigations **(23%)** cites financial harm as the main type of harm reported.

Physical harm

Physical harm means any nonaccidental trauma, injury, or condition, including inadequate nourishment that, if left unattended, could result in death, disfigurement, illness, or temporary or permanent disability of any part or function of the body, including inadequate nourishment. Physical harm was the main type of harm investigated in **23%** of investigations.

Self-harm

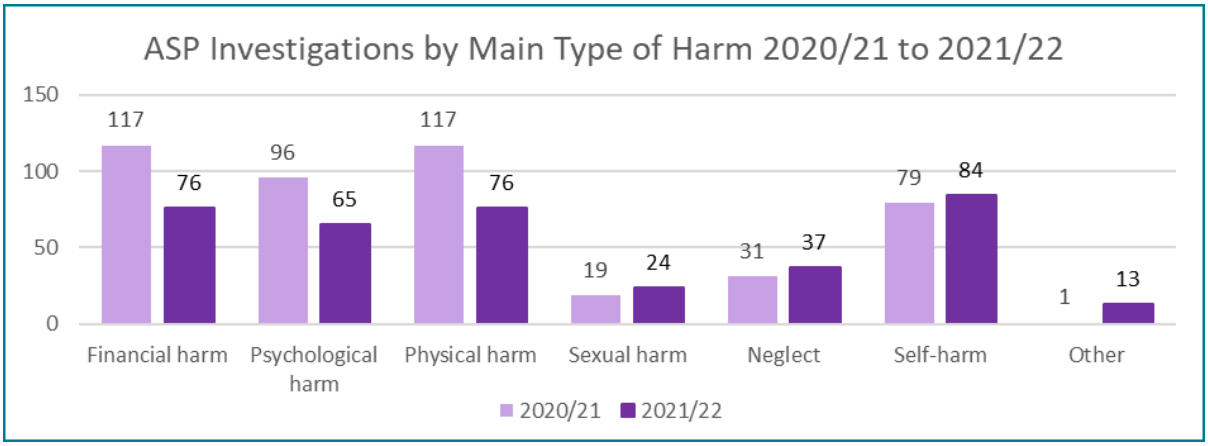
Self-harm is when somebody intentionally damages or injures their body. There has been a substantial increase in the number of investigations where self-harm is reported as the main type of harm. In 2016-18, 5% of investigations related to self-harm, which then rose to 18.6% of investigations in 2018-20 and further to **20%** in 2020-22.

Neglect

Neglect is a form of abuse where the perpetrator, who is responsible for caring for someone who is unable to care for themselves, fails to do so. It can be a result of carelessness, indifference, or unwillingness and abuse. 9.7% of investigations within the 2018-20 reporting period related to neglect and remained stable at **9%** in the 2020-22 reporting period.

Sexual harm
Any type of sexual activity without consent is considered sexual harm. Sexual harm involves imposing some form of sexual act on a person who doesn't want it. This means the person does not consent. Sometimes, a person is not legally capable of consenting, or refusing consent to a sexual act. The proportion of investigations where sexual harm is the main type of harm remains fairly low **(5%)** and is the same as the previous report (5%).

Biennial Report 2020-22 Harm Type Data



Feedback from the Joint inspection report of adult support and protection services in Fife
We received the following outstanding feedback from the Care Inspectorate.

Strengths
• Adults at risk of harm typically experienced improvements to their safety, health and wellbeing due to the collaborative efforts of social workers, health professionals, and police officers.

• The partnership's initial inquiry practice was highly effective, with well documented interagency referral discussions. Partners' participation in these discussions was consistent and purposeful.

• Adults at risk of harm benefitted from sound, well-documented investigative practice, and effective adult protection case conferences and review case conferences.

• Independent advocates ably supported adults at risk of harm throughout their adult protection journey.

• Partnership leaders promoted a collaborative ethos. It led to improved outcomes for adults at risk of harm.

• Adults at risk of harm played a key role on the adult support and protection committee. A third sector body effectively supported their meaningful participation.

• Partnership leaders exercised sound, collaborative leadership for adult support and protection. They initiated constructive quality assurance and self-evaluation work.

The inspection report did identify an area for improvement around chronologies which had already been identified by the ASPC and was under development.

Since the joint Inspection Reports was published the ASPC has worked with the Care Inspectorate around this area of improvement and chronologies are now embedded within the Adult Support and Protection process. The Care Inspectorate are satisfied that Fife ASPC have completed the improvement to the required standard. There is still work to be done to further embed the use of chronologies as a means of early identification of support need or harm and there is ongoing work with the Scottish Government to explore what this may look like. Fife's ASPC Inspection Improvement Plan was completed in September 2022, ahead of the scheduled October 2022 timescale and signed off by the Care Inspectorate in November 2022 prior to the last quarter's ASPC.

Reducing Harm

Actions taken to reduce harm

Priority areas:

- Service user engagement
- How to support people at risk of harm who are resistant or refuse any intervention
- Adults living at home and receiving care
- Adults living in care settings

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

- Undertaken changes to procedures and practices, including a review of the large scale investigation procedure and an audit of all large scale investigation activity within Fife from 2021-22. The findings from this audit are currently being considered and will form the basis of a future report to ASPC, and an associated practice improvement plan as required.
- Provided information and Advice: the Committee acknowledges the importance of continually raising understanding and awareness of how to identify and report harm
- Improving skills and knowledge: Comprehensive learning and development opportunities have been made available through the ASPC's suite of Adult Support and Protection training.
- Developed a Communication and Stakeholder strategy in 2022 to develop a framework for more effective and deeper engagement with service users.

2.3.2 Workforce

The importance of multi-agency working is key.

Analysis of training records across NHS Fife staff indicated that 1962 staff have completed the on line Level 1 Adult Support & Protection training throughout the period January 1st – October 31st 2022.

Capacity to build on this with attendance at face to face, more in depth training has been limited and is a feature of the 2023 workplan for the NHS Adult Support and Protection Oversight Group

Work is also underway within the NHS Adult Support and Protection Oversight Group, supported by the Executive Director of Nursing to consider the recently published NHS Public Protection Accountability and Assurance Framework and undertake a gap analysis of current capacity/ delivery and governance.

A formal tool to support self evaluation is anticipated, but not yet available.

2.3.3 Financial

There are no financial implications formally associated with this report.

2.3.4 Risk Assessment/Management

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

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

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

Work is well advanced with the DATIX team within NHS Fife to improve recording of outcomes from ASP investigations initiated by a referral from an NHS Colleague.

2.3.5 Equality and Diversity, including health inequalities

It has been identified that it would be helpful to ensure future analysis should interrogate the data of reports of harm and ASP investigations by locality to ensure a more robust understanding and triangulation of data, issues of deprivation and community characteristics.

2.3.6 Other impact

2.3.7 Communication, involvement, engagement and consultation

There has been no specific communication, involvement, engagement or consultation in relation to the preparation of this report.

2.3.8 Route to the Meeting

The bi- annual report has been signed off by the ASP Committee, HSCP Quality and Communities Committee and Chief Officers Public Safety group meeting.

The paper was considered at the Executive Directors Group on 20 April 2023.

2.4 Recommendation

The Report is for assurance.

Appendices:

- Biennial Report

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14 04 2023

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

Fife Adult Support & Protection Committee

Biennial Report 2020-2022

October 2022

Author: Ronan Burke, Quality & Assurance Officer

Contents

Foreword

As Independent Chair of Fife Adult Support and Protection Committee I am delighted to introduce this Biennial Report for 2020-2022. The last 24 months has been challenging for people within our community, practitioners, and services.

As a result of the Covid-19 restrictions many people have experienced a range of personal and professional challenges and despite the restrictions on our daily lives, many of us will still know people who became seriously unwell or sadly died during this period.

Within Fife there is a real strength to have so many individuals, practitioners, organisations, and agencies focussed on supporting the wellbeing of others. In these unprecedented times we have seen an extraordinary commitment to support and protect people from across our communities.

The Adult Support and Protection Committee has worked hard to fulfil its functions, as outlined by the Adult Support and Protection (Scotland) Act 2007. Throughout the reporting period, Fife Adult Support and Protection Committee adapted to the pandemic by identifying new ways of working and identifying risks and challenges with new approaches and a renewed dedication to making a difference even in the most difficult of circumstances. Through strong partnership working, commitment and resilience the Committee and Working Group members have; ensured training and development opportunities were delivered virtually to enable the confident application of Adult Support and Protection (Scotland) 2007 legislation across our frontline workers; developed a Committee Covid-19 Recovery Plan ensuring any risks and trends were identified and acted upon at the earliest opportunity; updated and developed policy and procedure including the Interagency Engagement and Escalation protocol and the Herbert Protocol; successfully raised awareness of Financial Harm and strengthened partnership working to identify and report this and initiated a short life working group focussing on hoarding and self-neglect.

Over the course of this reporting period our priorities have been driven and guided by our Strategic Improvement Plan 2019/ 2020 and 2021/2023. The Adult Support and Protection Team work to ensure the effective alignment of local work and priorities with that of the National forum.

The committee continues to work alongside colleagues in the Child Protection Committee, Fife Violence Against Women's Partnership, Fife Alcohol and Drug Partnership, and MAPPA (Multi-agency Public Protection Arrangements) to ensure there are shared learning opportunities and a mutual understanding of protection, harm and responsibility across all partners throughout the life span.

The Adult Support and Protection Committee has continued to drive forward improvement actions despite unprecedented times throughout 2020 – 2022. The contribution of all agencies represented on the Adult Support and Protection Committee who have given their on-going support, dedication, resilience, and creativity has been greatly appreciated.

I would like to offer my sincere thanks and appreciation to all those who have worked tirelessly with resilience and dedication to keep members of our community safe from harm.

Alan Small, Fife Adult Support and Protection Committee Chair

Introduction

The Adult Support and Protection Committee (ASPC) is a statutory body established under section 42 of the Adult Support and Protection (Scotland) Act 2007 (the 2007 Act) within each council area. The committee is chaired by an independent convenor who is neither a member nor an employee of the Council.

The ASPC is the primary strategic planning mechanism for inter-agency adult support and protection work in Fife. To operate effectively, all office holders and public bodies collaborate on the exercise of functions which relate to the safeguarding of adults at risk in Fife.

The ASPC is made up of senior representatives of key agencies who work together to effectively discharge its obligations in respect of policy and practice in adult support and protection matters. Fife's ASPC reports on its work and progress and is accountable to the Chief Officer of Public Safety (COPS).

The key functions of the ASPC as defined in the 2007 Act are:

- To keep under review the procedures and practices of the public bodies and office holders relating to the safeguarding of adults at risk;
- To give information or advice, or make proposals on the exercise of functions which relate to the safeguarding of adults at risk;
- To make, assist in, or encourage the making of, arrangements for improving the skills and knowledge of officers or employees who have responsibilities relating to the safeguarding of adults at risk; and
- Any other function relating to the safeguarding of adults at risk as the Scottish Ministers may specify.

In performing these functions, the ASPC must have particular regard to improving co-operation between and across each of the public bodies and office holders.

Fife's ASPC has continued to meet on a regular basis throughout the Covid-19 pandemic, moving to 'virtual' online meetings via Microsoft Teams. This has ensured and enabled a continued focus on adults at risk of harm and the timely oversight and identification of any themes and/or trends as they arose. This Biennial Report 2020-22 offers an oversight of how this focus was maintained during this time and shares the resulting outcomes.

Impact of the COVID-19 Pandemic

At the end of March 2020 Fife Adult Support and Protection Committee, alongside all ASPC's across Scotland, required to quickly adapt to the unknown and regularly changing circumstances surrounding Covid-19. The restrictions and implications linked to COVID-19 meant we had to develop new ways of working. Fife Public Protection Group was set up in order to ensure oversight of the safe and effective delivery of service across the Public Protections. Senior representatives from statutory partners (Social Work, Health and Police) met virtually on a weekly basis to ensure that all partners were supported, that risks or spikes in COVID-19 were identified early and addressed, trends monitored through relevant data analysis, and implications for staff welfare were considered.

All representatives of the ASPC received briefing and awareness raising materials throughout both periods of lockdown to support the continued importance of reporting Adult Protection concerns. Council Officers continued carrying out adult protection related work and visits with the aid of PPE and staff were provided with the appropriate technology and access to virtual meeting systems to allow virtual IRD and Case Conferences to continue.

It is also important to note that despite these unprecedented changes to our ways of working, the strategic work of the sub-committee groups continued, with many of the strategic outcomes being delivered from 2020-22, which the Biennial Report will illustrate.

Finally, it is vitally important to note that the commitment, dedication, creativity and flexibility of our ASPC members were critical in ensuring the support to our service users, patients, communities and workforce continued throughout this period. An integral part of this was the Partnership's Covid Recovery Plan which was first developed in June 2020. This kept, and continues to keep, all processes under review in light of Covid-19 and helps to identify and act on any practice issues raised. The Covid Recovery Plan takes into account ASPC functions, the working groups, learning and development, communication, national networks, working arrangements, service user contact/engagement, data, human rights and identifying harm and hidden harm as a result of the pandemic. This plan has helped ensure that harm continues to be identified and reported and that services and supports are able to reach all those who need it.

What our data tells us

For the past two years the Committee has been provided with detailed statistical summary reports following the submission of the Scottish Government data return. Reports provide trend analysis, information on types of harm being investigated and demographic details of adults at risk, all of which has helped to inform our local improvement planning discussions for the next reporting period. In addition, it has prompted a number of interagency self-evaluation activities to provide context to emerging trends, for example the annual Adult Support and Protection case file audit, a Mixed Methods Review in relation to care home statistics and future audit of all Large Scale Investigation activity over the last reporting period. A summary of the data is provided below.

Key Statistics

- 5717 reports of harm were received between 2020-22, representing a percentage increase of 0.70% since the 2018-20 report (5677).

- 835 Investigations were undertaken in the reporting period 2020-22, which is an increase of 15% compared to the 2018-20 Biennial Report (724).

- 223 initial and review case conferences were convened in 2020-22, an increase of 48 in comparison with the previous 2 years. This is a 27% increase in total.

- 17 Large Scale Investigations (LSI) were commenced 2020-22, compared with 4 across 2018-20. This is an overall increase of 325%. This is clearly a notable increase within the reporting period, with audit activity planned within the next reporting period to investigate this further.

- Continuing the trend from previous years, within 2020-2022 the majority of investigations relate to individuals aged 16-65 (64%), compared to 59% for 2018-2020.

- In terms of gender demographics, those identifying as female counted for 59% of total investigations from 2020-22, rising from 56% during the 2018-20 reporting period. For those identifying as male, we see a drop from 44% of total investigations in 2018-20 down to 41% from 2020-22.

- We see an increase from 14% in 2018-20, to 19% in 2020-2022 of total investigations where the adult's client category was recorded as adults with mental ill health. Interestingly, we see a drop of 2% for investigations where the adult's client category was recorded as physical disability (28% in 2018-20, 26% for 2020-22), and a drop of 1% for where it was identified the client category was infirmity due to old age (14% for 2018-20, 13% for 2020-22).

- The main types of harm recorded for cases at Investigation stage for the 2020-22 reporting period were Financial harm (23%), Physical harm (23%) or Self-harm (20%). In comparison, from 2018-20, the main types of harm recorded for cases at investigation stage were Psychological harm (25%), Financial harm (21%) and Physical harm (19%). We see a drop of 6% in reporting periods for Psychological harm. Self-harm statistics continue to rise which is something that has been noted across the adult's social work service for further development in terms of training offerings for frontline workers moving forward.

- Reflecting data in previous years, the 2020-22 reporting period demonstrated that the most likely location of harm investigated continues to be an individual's own home (59%), followed by Not known (10%) and Care home (5%). In comparison, 2018-20 data shows the main locations of harm

were the individual's own home (63%), Not Known (12%) and Care Home (10%). In particular, Fife's Care home statistics are of note. Not only have these numbers halved between the two reporting periods, they are also significantly lower than the 22% national average recorded in 2020. There are actions already in place to investigate reasons for this, including the addition of presentations by the Adult Support and Protection Team to care homes to provide further information on harm and the processes for reporting this.

The available data is reflective of a number of similar trends to that of previous years and identifies a number of areas which may have been impacted upon by Covid-19. The perhaps smaller than expected increase in reports of harm is likely to directly correlate with a reduction in face-to-face contact and engagement with members of the community due to lockdown restrictions at this time in 2020-21 in particular. The ASPC has developed a Stakeholder Engagement Strategy which is particularly relevant and raised the awareness of the continued need of practitioners to remain vigilant to identifying and reporting harm whilst we gradually came out of restrictions. It is not surprising that the most likely location of harm remains a person's own home given the restrictions that were in place for a large part of 2020-2021, however, there remain questions about the low level of investigations being progressed for adults in care homes. A mixed methods review has been taken forward in 2022 and will continue into 2023 to provide exploration and assurances as to the reasons behind this and any supportive action required following.

This report has highlighted that there is a growing number of investigations where the adult is experiencing mental ill health, and a growing number relating to self-harm. There is a possibility that this is reflective of the impact of lockdown restrictions on our individuals and communities. The volume and complexity of Adult Support and Protection work being undertaken across the service, particularly in relation to adults under the age of 65 is apparent. There are a high number of individuals whereby multiple reports of harm are received, and a number of individuals subject to repeat investigations. Existing audit processes will be used to identify learning and ensure that our processes in relation to multiple reports of harm and engagement escalation are sufficiently robust and to ensure that as an ASPC we are finding effective ways to keep people safe from harm.

Outcomes, achievements and service improvements

A number of different actions have been taken forward across the ASPC within the reporting period for the purpose of improving Adult Support and Protection related services, reducing the risk of harm and improving outcomes for adults at risk of harm.

Within the first 4 weeks of lockdown in March/April 2020, an extensive amount of shielding related work was carried out by Adult and Older Adult Social Work. Within Fife, over 10,000 people had been asked to shield and within this time frame 8,800 of them had been contacted by social work to carry out welfare checks. The remainder were contacted by letter and if this did not trigger contact, then these people were visited. Given the potential for social isolation and loneliness, these actions aimed to reduce the risk of harm for those forced to shield.

An Adult Support and Protection staff survey tool was developed in July 2020 to gather data regarding front-line worker's views on the ASP activity they were carrying out on a day-to-day basis. This included questions regarding confidence in the application of Adult Support and Protection

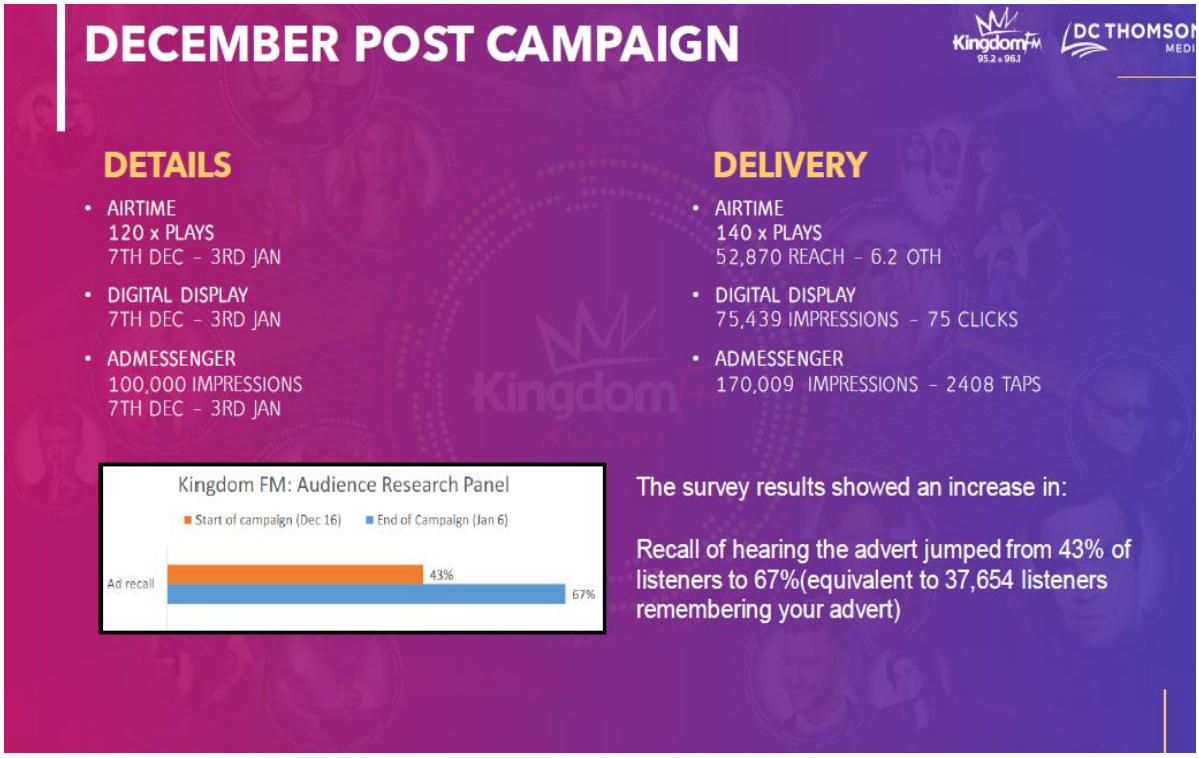
policy and procedures, as well as access to training, support and supervision to ensure ongoing learning and development.

At the same time, a service user feedback tool began development in July 2020 to gain information about how people with lived experience feel about the effectiveness of adult support and protection interventions. It was noted by the Adult Support and Protection Team that previous data focused on the number of investigations, IRDS, Case Conferences for example, but not on the views of those actually involved in these interventions. The aim of this tool was to have a greater understanding of these experiences and to identify gaps and routes for improvement. An initial 6 month review of the tool's effectiveness is planned for December 2022.

In addition, the Adult Support and Protection staff survey tool underwent extensive multi-agency discussion and consultation within the relevant ASPC sub-committee groups throughout the reporting period with first drafts produced. This will be launched within the next reporting period.

Inter-agency Adult Protection policies, procedures and practice guidance have continued to underpin work relating to the support and protection of adults at risk of harm. The overarching Fife Interagency Procedures have been reviewed during the period, to reflect changes and improvements and promote best practice. This has also included individual guidance in relation to important matters such as Financial Harm, Hoarding and Self-Neglect, Domestic Abuse, Multiple Report of Harm, Engagement Escalation protocols and Large Scale Investigation guidance. Each of these updates have been approved by the Committee and went live in June 2022, with reviews due to be carried out within the next reporting period. Also crucial to this has been the development of an inter-agency chronology process which has been an integral service improvement carried out within the reporting period.

Resultant to the identification of an increase in Financial Harm in the previous year, the Financial Harm Working Group continued their campaign to raise awareness of identifying and reporting harm throughout 2020-22. With a concern that Financial Harm may rise due to increased use of technology within homes and loneliness and isolation, the Financial Harm Working Group, supported by the ASPC and The Adult Support and Protection Team, launched its first radio campaign in December 2020 in partnership with Kingdom FM. This campaign aimed to raise awareness of Financial Harm, how to spot it and identify it. Feedback from Kingdom FM analytics identified a very successful campaign with significant reach across the community.



Positively, adverts in relation to the chosen category of harm were played approximately 6 times per day in December and reached a total of 52,870 listeners across the month. Given the population of Fife is approximately 370,000, this means the campaign reached 14% of this population across the month.

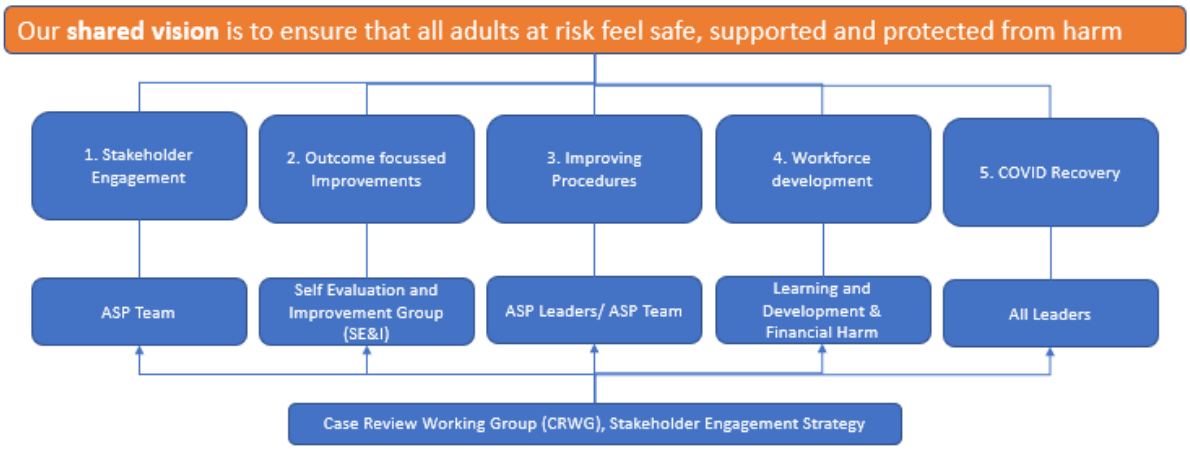
As a result of this, the campaign was run for a second time in February 2021, to align with National Adult Support and Protection Day. January 2021 saw the roll out of 'A Year of Financial Harm Awareness Raising' in the form of monthly SWAY documents, each raising the profile of a different type of scam or finance related harm. This campaign was hugely well received and continued throughout the full year. Linked to this, a pilot project commenced within the same period between Police and Trading Standards, which involved an information-sharing process whereby vulnerable person's database entries related to Financial Harm would be shared with Trading Standards in order to ensure support and preventative action to ensure adults were empowered and supported to remain safe from further harm. This innovative piece of improvement work is now established practice due to the success of the pilot.

We have continued running quarterly radio campaigns throughout the 2021 and 2022 reporting period, both to align with this year's Adult Support and Protection Day but also with different themes each quarter with the goal of raising Adult Support and Protection awareness. These have included Adult Support and Protection and Fire Safety, Adult Support and Protection and Social Media and alcohol and drug awareness. Analytics for each campaign have indicated positive engagement and reach for our topics, evidencing that our innovative strategy for reaching Fife residents has been successful.

In terms of quality assurance and audit activity analysis, this reporting period saw the addition of the Quarterly statistical data report added to the ASPC agenda. Specific indicators were identified to enhance discussion of the major adult support and protection themes affecting Fife and for all

agencies involved to understand more effectively what the data means. This in turn can better identify areas of improvement which are required and ultimately reduce the risk of harm for adults.

The reporting period also saw the introduction and work towards completion of Fife ASPC's Strategic Improvement Plan for 2021-23. The Strategic Improvement Plan set out Fife's vision for ASP and principles, five priority areas for development and subsequent aims and objectives for each. To ensure alignment and shared understanding of our vision, each priority has been driven forward by one of the ASPC sub-groups, the Adult Support and Protection Team or by Adult Support and Protection leads across partner agencies, who are tasked with developing and delivering a strategy or workplan to achieve the aims set out for each priority. The objectives within these plans have been specific, measurable, achievable, relevant and time-bound (SMART). The diagram below shows who has led the delivery of each of the five priorities with the Case Review Working Group (CRWG) feeding into all workplans as appropriate. Similarly, the Stakeholder Engagement Strategy and Performance Framework, which will be discussed later in this report, has actions linked to all priorities. From our vision and principles through to our workplans, this approach aims to be person centred and outcome focused.



Given the pandemic, the introduction of the above tools and methodologies has allowed the Partnership to further adapt to new ways of working which has proved to be a significant achievement.

Finally, a crucial aspect of our Adult Support and Protection outcomes, achievements and service improvements during this reporting period was the Fife Adult Support and Protection Inspection carried out by the Care Inspectorate. The focus of this inspection was on whether adults at risk of harm in the Fife area were safe, protected and supported. The joint inspection of the Fife partnership took place between May 2021 and August 2021.

The methodology for this inspection included four proportionate scrutiny activities. These were the following:

-Analysis of supporting documentary evidence and a position statement submitted by the partnership.

-A staff survey, where staff from across the partnership (738) responded to the Care Inspectorate's adult support and protection staff survey. This was issued to a range of health, police, social work and third sector provider organisations. It sought staff views on adult support and protection outcomes for adults at risk of harm, key processes, staff support and training and strategic leadership. The survey was structured to take account of the fact that some staff have more regular and intensive involvement in adult support and protection work than others.

-The scrutiny of the health, police, and social work records of adults of risk of harm, which involved the records of 50 adults at risk of harm where their adult protection journey progressed to at least the investigation stage. It also involved the scrutiny of recordings of 40 adult protection initial inquiry episodes where the partnership had taken no further action, in respect of further adult protection activity, beyond the duty to inquire stage.

-Finally, staff focus groups. The Care Inspectorate carried out two focus groups and met with 16 members of staff from across the partnership to discuss the impact of the Covid-19 pandemic on adult support and protection and adults at risk of harm. This also provided them with an opportunity to discuss how well the partnership had implemented the Covid-19 national adult support and protection guidance.

Positively, Fife received the following outstanding feedback from the Care Inspectorate.

Strengths

• Adults at risk of harm typically experienced improvements to their safety, health and wellbeing due to the collaborative efforts of social workers, health professionals, and police officers.

• The partnership's initial inquiry practice was highly effective, with well documented interagency referral discussions. Partners' participation in these discussions was consistent and purposeful.

• Adults at risk of harm benefitted from sound, well-documented investigative practice, and effective adult protection case conferences and review case conferences.

• Independent advocates ably supported adults at risk of harm throughout their adult protection journey.

• Partnership leaders promoted a collaborative ethos. It led to improved outcomes for adults at risk of harm.

• Adults at risk of harm played a key role on the adult support and protection committee. A third sector body effectively supported their meaningful participation.

• Partnership leaders exercised sound, collaborative leadership for adult support and protection. They initiated constructive quality assurance and self-evaluation work.

In terms of areas of improvement, Fife received the following:

Priority areas for improvement

• The partnership should develop standardised templates for adult protection chronologies, risk assessments, and protection plans, and use them consistently.

• The partnership should adopt the policy that all adults at risk of harm, who require them, should have a chronology, a risk assessment and an accompanying protection plan, whether they have been subject to a case conference or not.

These areas have been addressed by Fife's Inspection Improvement Plan, devised by the Adult Support and Protection Team, again throughout this reporting period. The route for the use of standardised adult protection chronology, risk assessment and protection plan earlier in the ASP journey than previously has been reviewed and agreed at Committee, with clear guidance given to practitioners as part of the overarching updated inter-agency Adult Support and Protection procedures which went live from June 2022 onwards. This will again by reviewed during the next reporting period to assess its effectiveness and ensure these are being used appropriately. To assist with this, Fife's inter-agency case file audit methodology has been reviewed and updated to ensure a focus on the above moving forward.

Training, learning and development

For a number of months following the initial period of lockdown, there was no Adult Support and Protection Training available. To ensure that there were enough Council Officers available to progress statutory Adult Support and Protection activity, an interim guidance was put in place. By December 2020 all ASPC Training, including Council Officer Training, was launched on Microsoft Teams which allowed practitioners an alternative way of receiving Adult Support and Protection learning and guidance. This focus was necessary given lockdown measures prevented any in-person training taking place. As a result, important Adult Support and Protection training was able to continue in extremely challenging circumstances, positively impacting on both adults at risk of harm and the continued learning and development of Council Officers and practitioners across all services.

We have continued to develop training and learning opportunities for front line staff since then, throughout the reporting period. Priority 4 of Fife's Adult Support and Protection Committee's Strategic Improvement Plan 2021-23 states that the Learning and Development sub-group "will continue to support our workforce, ensuring staff across all agencies are confident, knowledgeable and supported". This has included the development of training opportunities for our Adult Support and Protection training facilitators as well as Adult Support and Protection Senior Manager sessions.

Other essential aspects have included making sure that "training is supported and sustained through active implementation, supervision and coaching and a continued focus on staff wellbeing. This means building in enough time and resources where staff can talk, reflect, and be listened to". The overall aim for priority 4 of the Strategic Improvement Plan has been for all staff across partner agencies to feel supported and confident in identifying and responding to harm and in providing an integrated response to reduce harm. To help achieve this priority the Self Evaluation and Improvement Group launched an Adult Support and Protection post-training questionnaire in September 2021. Another purpose of the questionnaire is to gather data to allow assessment of the effectiveness of the current Adult Support and Protection training offerings across the Partnership.

Training evaluation reports have been completed quarterly and provided to the Learning and Development sub-group to allow discussion to take place at their quarterly Group meetings moving forward, as well as at the wider Committee meetings, also on a quarterly basis. Over 95% of all feedback received across all the Adult Support and Protection training courses since the questionnaire went live has either agreed or strongly agreed that these have resulted in increased Adult Support and Protection knowledge as well as increased confidence in carrying out the Adult

Support and Protection role across the frontline. This is a significant achievement considering the sudden unexpected change to learning via Microsoft Teams as a result of the pandemic at extremely short notice, which emphasises the strength of our Adult Support and Protection training facilitators within the Partnership.

Linked to the above has been the introduction of the frontline Adult Support and Protection Practitioner's Forum. It was a challenge progressing this due to the pandemic. Initially, within the reporting period, the Learning and Development sub-group spent time considering alternative ways in which this could be progressed, including a proposal that this would be held virtually, on a Fife-wide basis. It was proposed that initially the forum would include a representative from each partner agency with the aim of the group identifying themes for the forum for the remainder of 2022. This has allowed representatives of the forum to collate views and questions from colleagues and allowed continued feedback of Adult Support and Protection related information to front-line teams and meant that those front-line workers views could continue to be heard, which was crucial during the pandemic period.

An aide memoir was developed in 2020 by the Learning and Development Group for the accompanying officers (second officers) supporting the progress of Adult Support and Protection investigations. This brought about greater understanding of the role of accompanying officer within Adult Support and Protection interviews/visits and supported staff's confidence to take on this role. This role can be progressed by any appropriate partner, alongside the Council Officer (social worker).

Finally, crucial to the Partnership's ongoing Adult Support and Protection learning and development has been a revamp of our Adult Support and Protection Competency Framework. This is used to focus specifically on ensuring that relevant workers have the competencies, knowledge and skills they need to carry out their roles in supporting and protecting adults at risk of harm. It can also be used to review what the workforce already know and understand, support 'Learning and Development Needs Analysis' and identify ongoing opportunities for this. It should inform and enhance practice for those who need a particular set of skills and can be used as a tool when writing job descriptions.

Adult Support and Protection and workforce development should be seen as an essential part of continuous improvement, and the Framework is designed for use as part of agencies' continued professional learning. The individual learning and development needs of each worker should be considered and reviewed, including Adult Support and Protection where relevant, in how workers and managers will meet the Continued Professional Learning (CPL) requirements of particular roles. The competencies, knowledge and skills can be 'mapped' at an individual level (to any other forms of learning and development that workers take part in).

Each staff member will now read the table above and identify which Group describes their current role. Once this has been established they will be aware of which competencies they need to be able to demonstrate within their own work environment and be able to use this framework in order to evidence them appropriately. See appendix 2 for a full copy of the new framework. The purpose of changing the existing ASP Competency Framework was to simplify the process and provide a document which can be used clearly within frontline worker's supervision sessions with their line manager. It is clear what specific competencies are required for specific roles, prompting a good conversation within supervision as to how gaps of knowledge can be filled to ensure adults continue to be as safe from harm as possible.

Engagement, involvement, and communication

Continuing to engage with and involve people with lived experience has proved to be challenging within this period due to the lack of face-to-face meeting opportunities caused by lockdown measures. Despite this, the ASPC's Engagement and Participation Coordinators endeavoured to adapt to these changed circumstances as much as possible.

As lockdown measures commenced, a wide range of easy read resources were distributed around the ASPC so these could be shared with a wide range of service users.

The ASPC newsletter continued to be released on a monthly basis with links to sources of support and advice, and updates in relation to legislation. Fife Council's Deaf Communication Service was

involved in making material available in British Sign Language (BSL) to ensure members of our deaf community had access to all of the information needed to confidently identify and report harm.

A hugely important piece of work carried out during this period was the "Staying Safe, Keeping Well" booklet. This was created as a paper resource for those who do not get their information online or from social media. The leaflet contained numbers for emergency support, Council Covid Community helpline, general council numbers related to types of harm including domestic abuse, advice regarding scams, and general hints and tips for getting through the lockdown period. 13,500 were printed and distributed through Fife Voluntary Action Helping Hands volunteers – to people self-isolating, and vulnerable people who may not have had family/friend/neighbour support. Additional distribution was done through Meals on Wheels, Home Care and Community Learning and Development Teams. This demonstrates the effective engagement and joint working across our 3rd sector groups within ASP work and again showed an innovative communication method in challenging times.

Another example of engagement with the community was the ASPC's supermarket campaign carried out in May 2020. All Fife supermarkets were contacted (see appendix 3 for the covering letter which was distributed) and asked to display posters with the Fife Council Contact Centre telephone number and information as to how to make a referral. This was done in response to adults at risk of harm potentially being out of sight at the time due to lockdown measures. Please see below for the poster itself which was displayed.

Fife Adult Support & Protection
www.fife.gov.uk/adultprotection

Fife Child Protection Committee

Adult and Child Protection means protecting the most vulnerable from harm and neglect.

Harm and neglect can be perpetrated by anyone.
Harm can be a crime.

If you see something, are told something or something doesn't feel right you need to report it.

Adult Protection: 01383 602200

Child Protection: 03451 55 15 03

If someone is in immediate danger call **999**

www.fife.gov.uk/adultprotection

www.fifechildprotection.org.uk

The ASPC Engagement and Participation Officers also engaged with community groups as part of Teams/Zoom meetings throughout 2020-21 to continue to better understand the experiences of service users and include them in the co-production of services, policy and procedures as well as offering awareness raising sessions and the space to ask questions. Part of this engagement also included working with the Partnership's Deaf Communication Team so that our ASP policy and procedures could be translated into British Sign Language before being uploaded to Fife Council's Adult Protection information website. This has helped us be as inclusive as possible when raising awareness of ASP within our area.

Finally, an integral part of the Partnership's drive to enhance engagement, involvement, and communication within the reporting period has been the creation of our Communication and Stakeholder Engagement Strategy for 2022.

Section 42 of the Adult Support and Protection (Scotland) Act 2007 states that:

• Any actions undertaken by an Adult Protection Committee must have regard to improving communication and cooperation amongst its members;

• Formal inquiries consistently identify effective communication, information sharing and co-ordination as critical in protecting adults at risk of harm; and

• Adult Protection Committee's will have an opportunity to provide a model of joint working by the way they themselves operate and will require to promote good working relations between agencies and staff working within them.

The overall aims of this Communication and Stakeholder Engagement Strategy, in seeking to ensure achievement of the above, are:

• to set out how appropriate and effective communication will support the achievement of the ASPC's key strategic objectives;

• to promote effective communication in all aspects of adult support and protection; and

• to ensure that key stakeholders are aware of, understand and are engaged in this work.

Communication is a continuous process and the benefits of good communication include:

• Establishing collaboratively, and based on evidence, local priorities and plans which meet local needs;

• Continuous striving to improve outcomes for stakeholders;

• Working together to manage risk at an appropriate level;

• Taking collective responsibility for the achievement of a shared vision; and

• Assisting in the planning and development of more effective services, effective professional practice and stakeholder satisfaction, developing a learning approach across all partner organisations.

Our ASPC has resolved to develop a strong focus on engagement and communication across key stakeholders, including with those at risk of harm and their carers, to ensure the effectiveness of local safeguarding practice.

The ASPC Communication and Stakeholder Engagement Strategy sits within the wider context of the ASPC's Strategic Improvement Plan 2021-23, which sets out the principles and approach to the engaging with individuals, groups and communities in service planning and development to ensure positive outcomes. This plan then evaluates the impact of our activities and allows The Partnership to gain greater insight of the quality of our response to reports of harm, and the lived experience of all stakeholders.

The Action Plan at Appendix 4 has been developed to support the ASPC's Communications and Stakeholder Engagement Strategy. It outlines the communications and engagement activity that will take place over the course of the Strategy to implement and improve the ways in which we communicate with our different audiences. These have taken place within the reporting period, but also cross over into the next. Ultimately, the action plan has detailed how we have and will continue to work together with partners, individuals and in our communities to raise awareness and support the safety of vulnerable people in Fife who may be at risk of harm. Value has been placed on eliciting the voices of people with lived experience of the ASP process to drive outcome focussed improvements to practice.

Progress on delivery of the action plan has and will continue to be reported to the Fife Adult Support and Protection Committee. The development and delivery of this plan is a major achievement for Fife when taking into account the ongoing pandemic and the difficulties in engaging with others on a face-to-face basis during this reporting period.

Areas for Improvement/Looking forward

The key areas of work and improvement will be driven forward within the next reporting period by the ASPC Strategic Improvement Plan 2023-25. This will be written in the last quarter of 2022 before being approved at committee in January 2023 for the two years to follow.

Our shared vision is to ensure that adults at risk feel safe, supported and protected from harm. This strategic Improvement Plan for Fife will set out the actions we will take over the next reporting period and next two years in total to work towards achieving this vision.

The plan will build on achievements to date, using the previous improvement plan (2021-23) as our foundation and drawing on learning from Single and Interagency Case File Audits, Activity and Performance Data, Stakeholder feedback, and Initial and Significant Case Reviews.

The plan will out the ASPC's vision and principles, priority areas for development and subsequent aims and objectives. We understand particular improvements will be required and contained within strategic planning moving forward. These include an audit of Large Scale Investigations carried out within Fife, annual Initial Case Review reporting, the roll out and embedding of Learning Review guidance, Hoarding and Self-Neglect related guidance work, the creation of a Friends of the

Committee group to further develop our community links within Fife and improve stakeholder engagement further, and also the roll out of the new Liquid Logic case management system.

We need to continue to think differently in how we measure outcomes and move away from a focus on numbers and performance indicators to a more qualitative, deeper understanding of the complexities of people's lives. Underpinning our approach is a focus on transforming the way that we collect and use data to evaluate the impact of our activities and gain greater insight of the quality of our response to reports of harm, and the lived experience of all stakeholders.

A range of outcome focused indicators will be developed to evaluate our success against a number of strategic outcomes.

These will be measured through an outcome focused performance framework which was a fundamental objective of the previous Strategic Improvement Plan. All actions throughout this plan will be linked to the achievement of these outcomes.

Chairs closing remarks

There has been considerable work undertaken by all partners throughout 2020 – 2022 under the auspices of the Committee. Throughout this time period we were impacted upon by an unprecedented local and national challenge resultant to the sudden impact of COVID-19. The Committee has evidenced dedication, commitment, adaptability, resilience and creativity during this time and has ensured its function has been fulfilled. A robust Strategic Improvement Plan has been created on a foundation of partnership working, continuous improvement and a strive for excellence, where we will endeavour to ensure that learning identified during this time is embedded into practice.

Once again, I would like to offer my sincere thanks and appreciation to individuals, families, carers, practitioners, organisations and agencies within Fife who are involved in preventing harm and supporting those who have been harmed.

This will be my last Fife Adult Support and Protection Biennial report as I intend to stand down as Independent Chair in March 2023. Whilst my time as chair will come to an end I very much look forward to learning of further successes and initiatives undertaken by the Committee to help keep adults safe.

Alan Small, Fife Adult Support and Protection Committee Chair

Appendix 1-Annual Data Reports, 2020-2022

www.fifehealthandsocialcare.org

Fife Health & Social Care Partnership

Adult Support & Protection Annual Return 2020-21

Summary Statistics

May 2021

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

Contents

Introduction:

This report summarises the data collated for the annual Scottish Government Adult Support & Protection (ASP) statistical return.

It provides a count of referrals, investigations, Case Conferences and Large-Scale Investigations (LSIs) undertaken between 1st April 2020 and 31st March 2021, an overview of the types and location of harm investigated, and the demographic profile of adults subject to ASP Investigation in the same time frame. Where appropriate, trend or further analysis of the data has been provided. Summary tables are presented in Appendix1which detail the data submitted to the Scottish Government over the past 5 years. It is expected that a new quarterly minimum dataset for ASP will be developed which is intended to replace this return in future years.

Analysis of the data has raised a number of key areas for further exploration and this report highlights a few areas for consideration at Self Evaluation and Improvement Group (SE&I) to agree if they should be integrated into relevant improvement plans.

Key Statistics

- 2798 reports of harm were received, representing a percentage decrease of 5.7% since the 2019-20 report. Of the 1876 individuals referred, 29% of individuals had multiple reports of harm recorded.

- 460 Investigations were undertaken in the year, whilst this is an increase from the data reported to the Scottish Government last year (385) it must be noted that following a number of data validation exercises in 2020-21, the number of investigations now recorded on the social work system for 2019-20 has risen to 459 therefore there is no significant change noted.

- 126 initial and review case conferences are reported this year, an increase from 2019-20, 73% of these were undertaken in adults teams.

- Two LSIs were started in Quarter 4 of 2020-21, this is a decrease from 3 last year.

- Continuing the trend from previous years, the majority of investigations relate to individuals aged 16-65 (63%), and those identifying as female (58%).

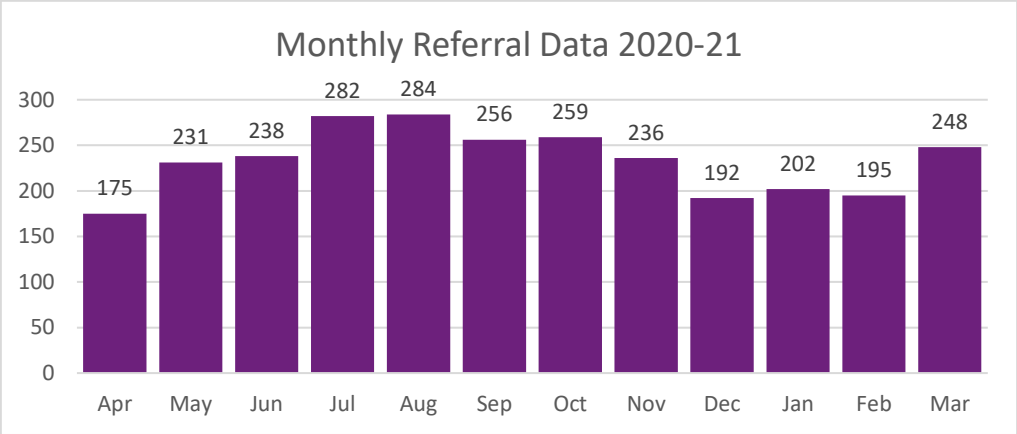
- There has been a 72% increase in investigations relating to adults with mental ill health from 58 last year to 100 in 2020-21.

- The main types of harm recorded for cases at Investigation stage were Financial harm (25%), Physical harm (25%) or Psychological/emotional harm (21%). There has been a notable increase in the number of Investigations relating to self-harm.

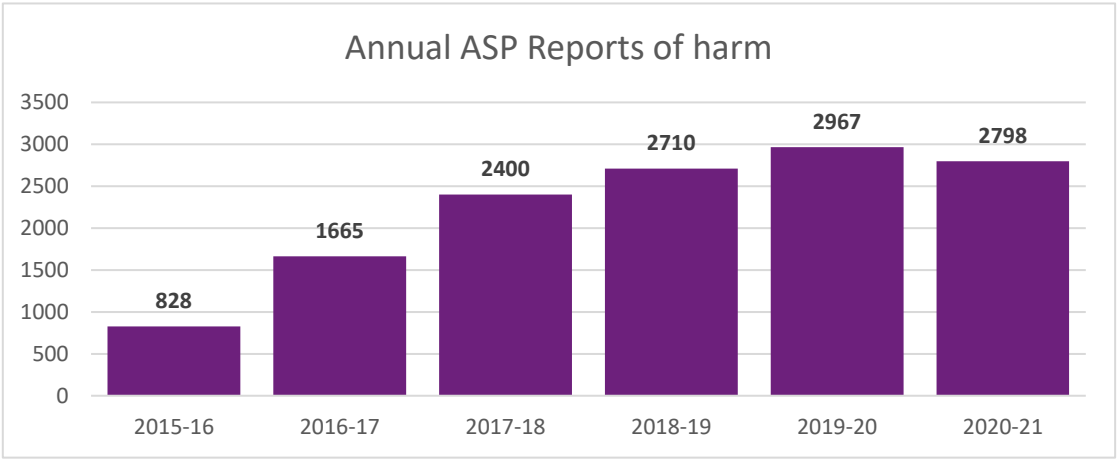
- Reflecting data in previous years, the most likely location of harm investigated was an individual's own home (62%), and very small numbers are recorded within care home settings (5%) when compared to the national average for last year (22%). There are actions already in place to investigate reasons for this.

Reports of Harm:

In 2020-21, 2798 reports of harm were received, representing a 5.7% decrease since the previous year and reversing the upward trend that we had seen since 2015[1]. It is suspected that this is partly due to the impact of Covid-19 restrictions which meant that some agencies did not have as much contact with individuals as would usually be the case. Monthly referral data shows that there were fewer reports of harm in months with the strictest lockdowns and would therefore support this theory.



In the counts below, an adult at risk of harm can be counted more than once where multiple referrals are made. In 2020-21 there were 2798 reports of harm for 1876 individuals, 551 individuals were referred more than once (29% of individuals had multiple referrals), with 45 people having 5 or more reports of harm recorded in the time period.



Base: SWIFT AIS- AP Contacts

Recommendations:

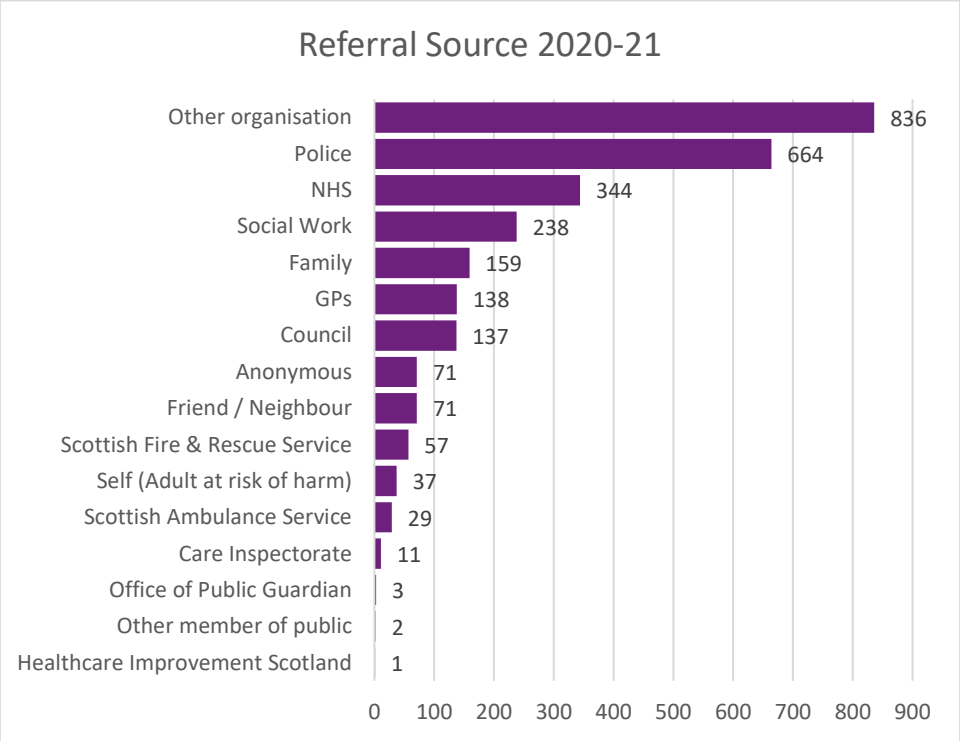
- *Adult Support & Protection Self Evaluation and Improvement Group (SE&I) to consider undertaking an audit of cases where there have been multiple reports of harm to evaluate the quality of the partnership's response to preventing harm and identify any learning or improvement actions.*
- *Social Work to audit 45 cases with 5 or more reports of harm to ensure that the multiple report of harm protocol is being correctly taken forward (and engagement escalation if appropriate), chronologies are in place and there is evidence of defensible decision-making in line with social work recording guidance.*

[1] In Fife, all contacts where 'Adult Protection' is recorded as 'contact reason' are counted as a referral. If reports of harm are later deemed as not appropriate these may be later 'reclassified' and therefore not included in the counts. This may not be the case in all partnership areas and therefore caution must be taken when comparing the data to National data.

- *ASP Leaders to consider audit findings, set up short life working group to review the multiple report of harm protocol and engagement escalation process, updates to coincide with annual interagency procedure review.*

Referral Source:

The chart below shows the referral source as reported to the Scottish Government for all 2798 reports of harm in 2020-21.

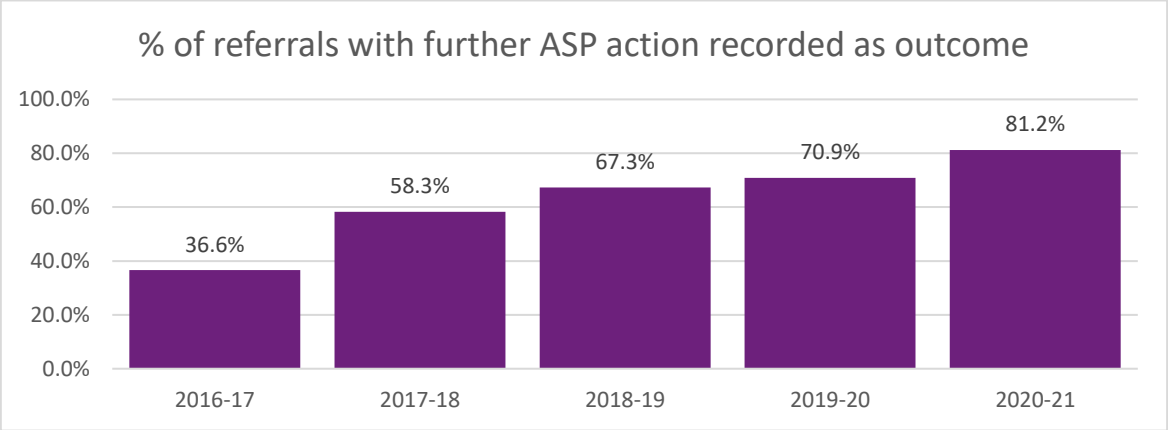


Whilst there has been an overall decrease in referrals this year, this is not consistent across all sources. There has been a significant increase in reports of harm from Police (664 compared to 377 in the previous year), and a notable increase in Scottish Ambulance Service (29 compared to 3 the previous year). Whilst there has been a significant decrease in reports of harm from 'other organisations' the number remains high, potentially indicating that a wide range of agencies are aware of what constitutes harm and how to report it. There has been a decrease in the number of self-referrals this year. As part of the ongoing 2021-23 workplan, the ASP Team will continue to strengthen links with all partners and raise awareness of our key messages throughout 2021-22 through the development and implementation of a stakeholder engagement plan.

The Summary Tables (Appendix1)show the referral source for all reports of harm over the past 5 years. SE& I will continue to monitor referral source on a quarterly basis through quarterly reports.

Outcome of referral:

In comparison to previous years, a higher proportion of referrals (81.2%) required further Adult Protection action. Whilst this could point to improved practice in relation to the correct identification and reporting of harm, this could also be attributed to an alteration in recording practice at the Social Work Contact Centre (SWCC). There are inconsistencies in how contact reason is currently recorded when a case is reclassified which would also impact on this number. This makes interpretation of referral data difficult. The development of a national minimum data set combined with the procurement of a new case management system (Liquidlogic) for social work brings with it an opportunity to review and clarify recording practices in relation to how reports of harm are captured and reported on in future.



The table below shows the count for each outcome of the report of harm over the last 5 years, the increase in work progressed and the decrease in reports of harm where other non-AP action was required could potentially indicate that practice has strengthened across the partnership with appropriate identification and reporting of harm.

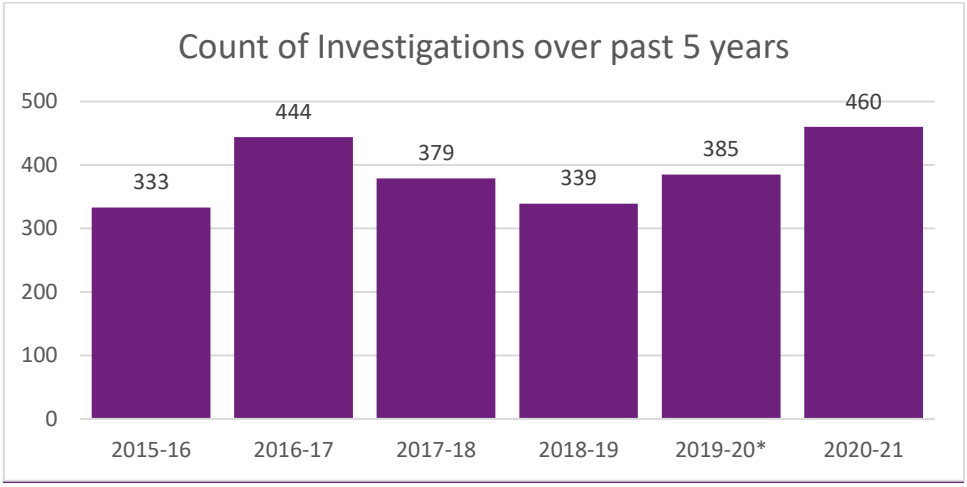
Outcome	2016-17	2017-18	2018-19	2019-20	2020-21
Further Adult Protection Action	610	1398	1825	2103	2272
Further Non-AP Action	301	332	242	256	130
No further action	713	610	560	518	342
Not recorded	41	60	83	90	54
Total	**1665**	**2400**	**2710**	**2967**	**2798**

Recommendation:

- *ASP Team, PIP Team, Social Work and Workforce Development to work with the SWIFT replacement team to ensure that the Liquidlogic system is able to effectively capture and report on count, source and outcome of all reports of harm.*

Investigations:

In 2020-21 there were 460 ASP Investigations undertaken, whilst this demonstrates an increase from the 385 Investigations reported in the Annual Statutory Return last year, much work has been done with respect to data quality this year which resultantly increased the number of Investigations recorded last year to 459, a similar number to this year. The graph below shows the number of Investigations reported to Scottish Government Annual Return over the past five years.



*This figure has been revised to 459 in the social work performance reports

The number of individuals for whom an investigation has taken place is 428, this is because 29 Individuals have had more than one ASP Investigation undertaken within the time period. A breakdown by age shows that 24 of the 29 individuals who had multiple investigations were aged under 65. Data shows that 9% of all adults aged under 65 are subject to multiple investigations, compared to 3% of those aged over 65.

Recommendations:

- *SE&I Interagency Audit to include a sample of cases where there have been multiple investigations with a view to evaluating if the partnership could strengthen its response to harm, particularly in relation to effectively supporting adults aged under 65.*

- *ASP Leaders to review cases and consider procedural implications (if any) where multiple investigations are taking place.*

Outcome of Investigations:

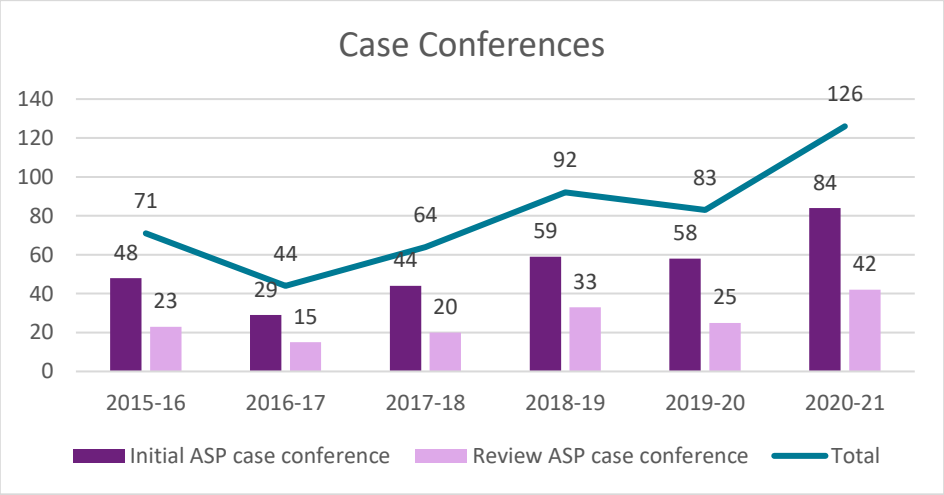
The proportion of cases progressed past investigation stage for further AP action remains similar to previous years.

Outcome	2016-17 (444)	2017-18 (379)	2018-19 (339)	2019-20 (385)	2020-21 (460)
Further AP action	16.9%	12.7%	10.0%	11.4%	12.8%
Further non-AP action	48.2%	43.8%	30.1%	34.0%	37.4%
No further action	30.9%	41.4%	48.7%	52.2%	49.3%
Not known	4.1%	2.1%	11.2%	2.3%	0.4%

Overall 12.8% of cases were progressed for further ASP action, however of the 59 cases progressed, 44 relate to adults under the age of 65. 15.2% of cases relating to adults under 65 were progressed for further ASP action compared to 8.8% of adults aged over 65. This again points to the complexity of the ASP work being taken forward by Adults teams.

Case Conferences:

There has been a 52% increase in the overall number of ASP case conferences taking place since last year, of the 126 initial and review case conferences, 92 were undertaken by Adults Teams (73%).



Recommendation:

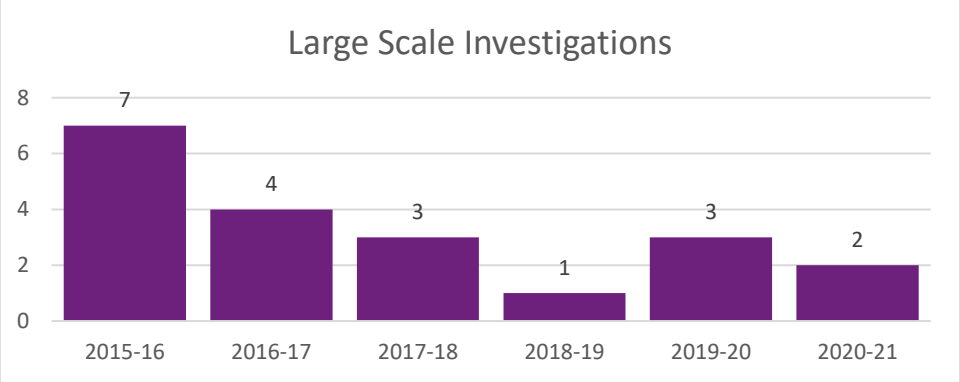
- *Social work service managers to continue to monitor through the Quarterly ASP Performance Process and consider resource implications, specifically as a result of the high number of case conferences undertaken within adults teams.*

Protection orders:

There were no protection orders granted in 2020-21

Large Scale Investigations:

There were two Large Scale Investigations undertaken in 2020-21, both commenced in Quarter 4 of the year.

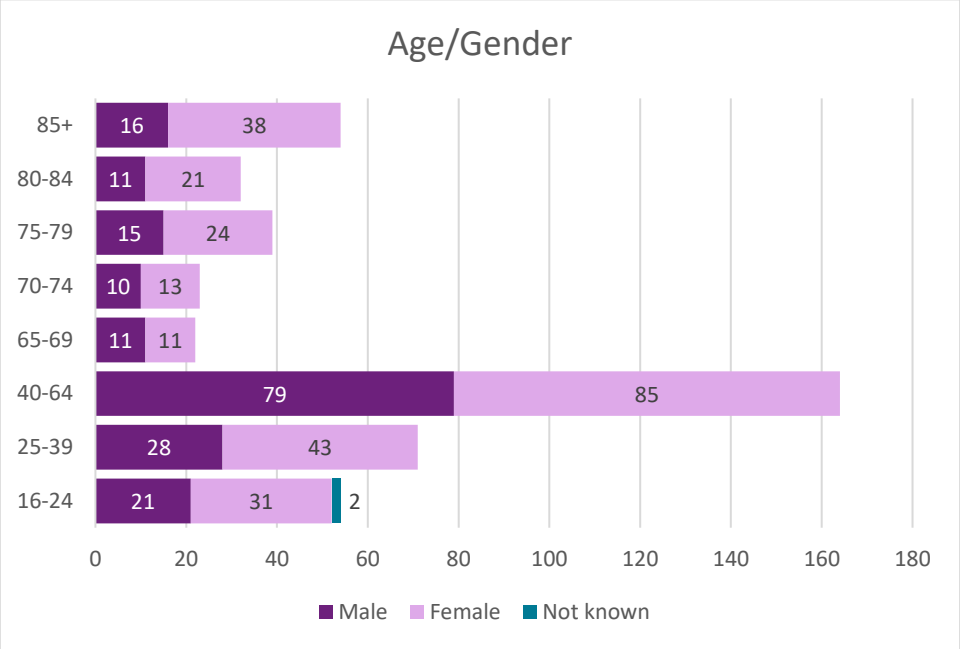


Demographic Information:

To plan and develop effective pathways and preventative support, it is essential to monitor who is at-risk, what type of harm they are experiencing and where this harm takes place. Nationally, this is reported on at Investigation Stage and this is what is reported on below. Please note an Adult at Risk of harm can be counted more than once in the below counts (where more than one investigation has occurred for an individual in the period). This data is reported to ASPC on a quarterly basis to enable continuous monitoring of any trends.

Age/Gender

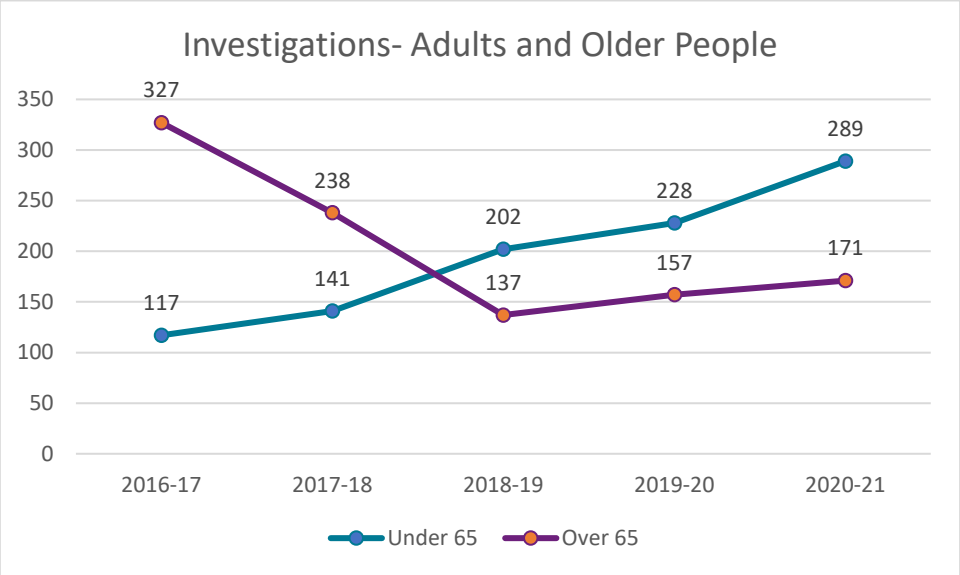
The graph below shows the count of investigations undertaken by gender and age group. Overall, more investigations relate to adults identifying as 'female' and this is the case across all age groups with the exception of the 65-69 group, where there is an equal number of male and female adults. Please note 'not known' relates to two individuals who have chosen not to identify as male or female as opposed to being not recorded.



In 2016-17 26.3% of all investigations related to an adult under 65, compared to 62.8% of investigations this year. A short paper has been produced to summarise the age profile of Adults subject to ASP investigation, the changes over the past 5 years, and to provide a context to this change. (Appendix 2).

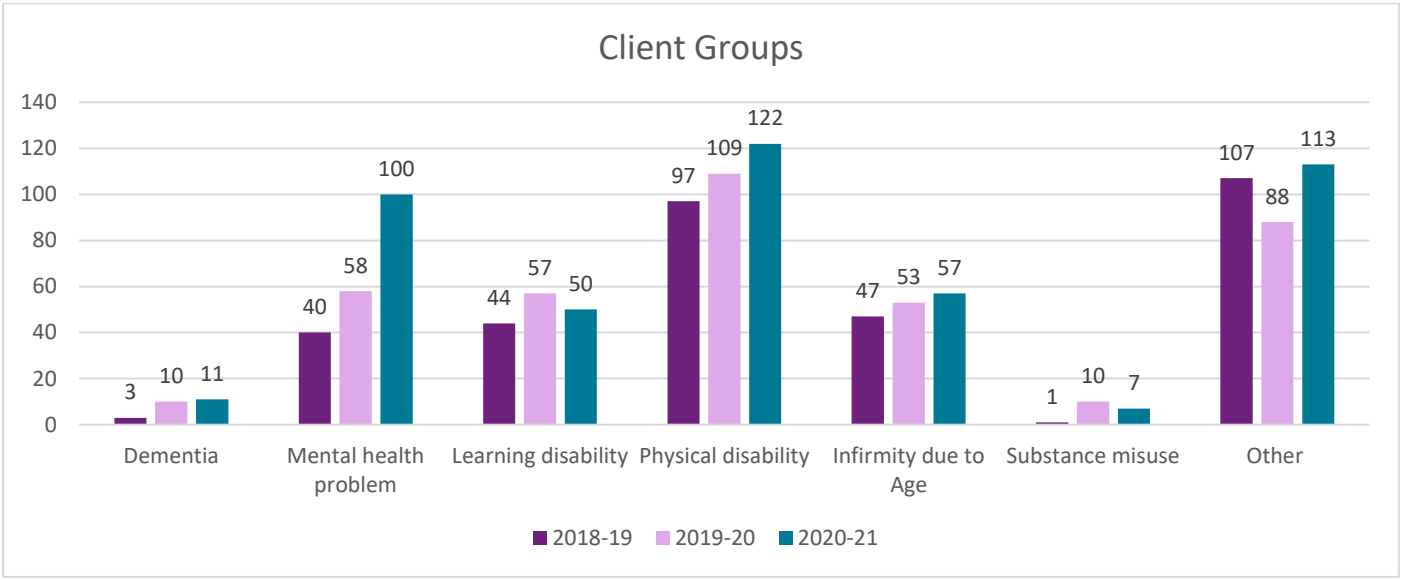
Investigations relating to adults aged under 65 has increased year on year, potentially this could be related to awareness raising and training across Fife to strengthen our approach to identifying and reporting harm. The reduction in reports of harm in older age groups is potentially related to work undertaken to ensure that practitioners are better able to differentiate between significant occurrences and harm and work to reduce the risk of harm occurring in care settings. The number of investigations relating to adults over 65 has been increasing for the past two years but at a slower rate than adults aged under 65.

The chart below shows the number of investigations relating to people under 65 and over 65 since the 2016 return.



Client Group

A high number of investigations relate to adults with a physical disability (26.5%) however in 2020-21 we have seen a substantial increase in the number of Investigations relating to adults with a mental health problem, with 21.7% of all investigations relating to an individual with mental ill health.



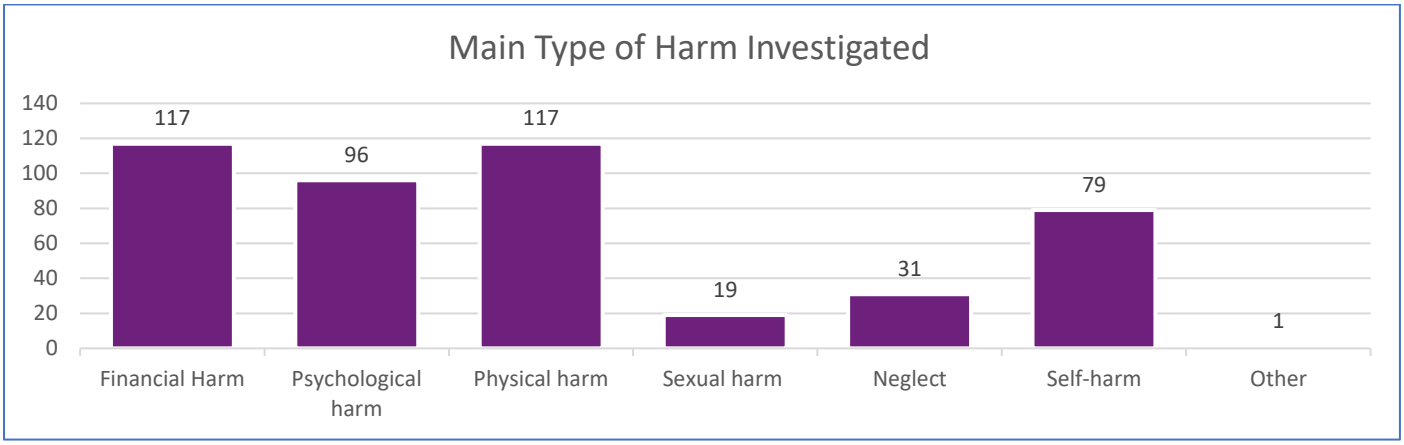
Recommendations:

- *Learning and Development to consider the increase in Investigations for adults with Mental ill health, staff confidence working across the acts and links with MH services. Review reach and effectiveness of Crossing the Acts training*

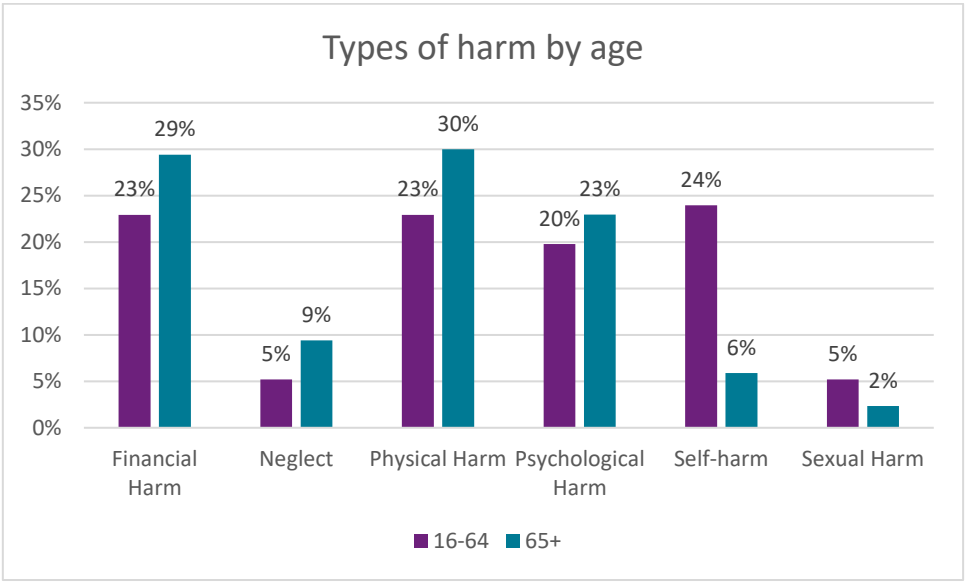
Incident Information:

Type of harm

In 2020-21, the most common types of principal harm recorded which resulted in an investigation was Financial (25%) and Physical (25%) harm. High numbers also related to psychological harm (21%) and self-harm (17%). The self-harm category has seen a substantial increase since last year (58% increase reported).



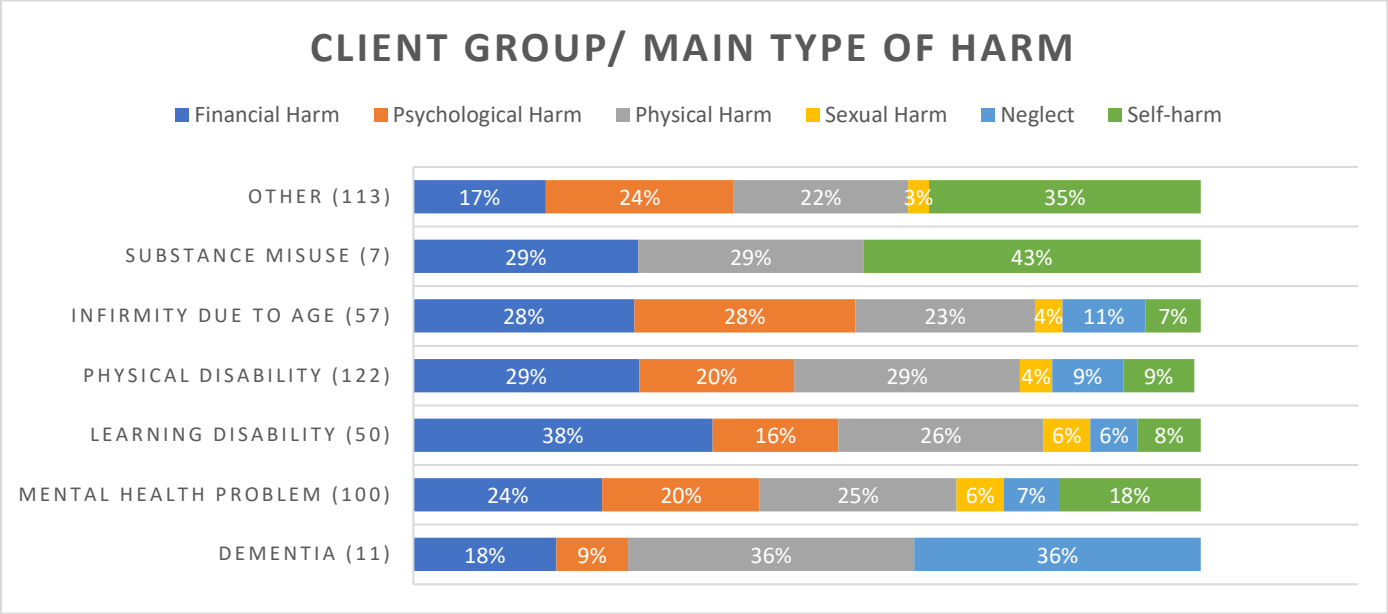
As in previous years, data shows that there is variance in types of harm experienced in different age groups, this is particularly the case with respect to investigations relating to self harm, with 87% of these investigations relating to individuals aged under 65, and accounting for 24% of all investigations where the adult was 16-64 (higher than any other harm type in this age range).



Recommendations:

- *Learning & Development to consider the increase in investigations relating to self harm, particularly in 16-65 age range, and the current training and resources in place to support staff to provide effective, timely support*

The type of harm investigated varies between client groups and although caution must be taken as counts broken into client group are small (shown in brackets below), it may be beneficial to consider this information as part of targeted communications campaigns.



Recommendations:

ASP Team to consider the breakdown of client group and types of harm with a view to developing more targeted communications campaigns. For example, looking at increasing information regarding the prevention of financial harm to people with learning disabilities.

Location of harm

Where the location of harm is known, the vast majority of harm investigated (62%) took place in an individual's own home. This is universal across age group, gender, primary client group and ethnicity and reflects the data from previous years.

The number of investigations where the location of harm was reported as 'care home' remains low (5.4% compared to 22% national average) and has further reduced in number since last year (25 compared to 37 last year). The planned self-evaluation activity to scrutinise and understand reasons for this is planned in 2021.

Concluding remarks:

As the data is largely reflective of previous years, the ASPC Strategic Improvement plan and supporting workplans already have a number of actions which are reinforced by the findings in this report, notably the development of a stakeholder engagement strategy which is particularly relevant given the reduction in referrals this year, and the mixed methods review to provide reassurance and explore the reasons behind the low number of Investigations in care homes which has continued this year.

However, this report has highlighted a number of new potential areas for further investigation, namely that there is a growing number of investigations where the adult has mental ill health, and a growing number relating to self-harm. The volume and complexity of ASP work being undertaken across the service, particularly in relation to adults under the age of 65 is apparent. There are a high number of individuals whereby multiple reports of harm are received, and a number of individuals subject to repeat investigations. Existing audit processes could be used to identify learning and ensure that our processes in relation to multiple reports of harm and engagement escalation are fit for purpose and to ensure that as a partnership we are finding effective ways to keep people safe from harm. In response to these findings a small number of actions have been identified to take forward, if agreed, these will be embedded to existing workplans for 2021-23 and are outlined below.

To demonstrate ongoing quality improvement and evidence the work undertaken to progress these identified actions, the ASPC will provide analysis and outcomes of the report recommendations below within the Annual Return 2021/2022.

2020-21 Key Findings	Report Recommendations for consideration	Lead	When
Significant number of individuals for whom multiple reports of harm are received	*Adult Support & Protection Self Evaluation and Improvement Group (SE&I) to consider including a sample of cases in the interagency audit where there have been multiple reports of harm to evaluate the quality of the partnership's response to preventing harm/ responding to reports of harm and identify any learning or improvement actions.* *Social Work ASP lead to consider audit of 45 cases with 5 or more reports of harm to ensure that the multiple report of harm protocol is being correctly taken forward (and engagement escalation if appropriate), chronologies are in place and there is evidence of defensible decision-making in line with social work recording guidance (include sample within existing case file audit process)* *ASP Leaders to consider audit findings, and review the multiple report of harm protocol and engagement escalation process, updates to coincide with annual interagency procedure review.*	SE&I ASP SW Lead QA Officer/ ASP Leaders	Dec 2021 Oct 2021 Jan 22
Difficulty interpreting data relating to the outcome of a report of harm	*ASP Team, PIP Team, Social Work and Workforce Development to work with the SWIFT replacement team to ensure that the Liquidlogic system is able to effectively capture and report on count, source and outcome of all reports of harm.*	SW ASP Lead	Jan 22
Individuals subject to multiple investigations are more likely to be aged under 65	*SE&I Interagency Audit to include a sample of cases where there have been multiple investigations with a view to evaluating if the partnership could strengthen its response to harm, particularly in relation to adults aged under 65.* *ASP Leaders to review cases and consider procedural implications (if any) where multiple investigations are taking place.*	SE&I	Dec 21

		ASP Leaders	Jan 22
High volume and complexity of ASP cases coming into adults teams	*Social work service managers to continue to monitor through the Quarterly ASP Performance Process and consider resource implications, specifically due to the high number of case conferences undertaken within adults teams.*	ASP SW Lead	Ongoing
Increase in investigations relating to adults with Mental ill health	*Learning and Development to consider the increase in Investigations for adults with Mental ill health, staff confidence working across the acts and links with MH services. Review reach and effectiveness of Crossing the Acts training*	L&D Group	Apr 22
58% increase in investigations relating to self harm	*Learning & Development to consider this trend (possibly through practitioner forum) and the current training and resources in place to support staff to provide effective, timely support*	L&D Group	Apr 22
Variance in the types of harm investigated by age and client group	*ASP Team to consider the breakdown of client group and types of harm with a view to developing more targeted communications campaigns as part of the stakeholder engagement strategy. For example, looking at increasing information regarding the prevention of financial harm to people with learning disabilities.*	ASP Team	Jan 22

Please contact Ronan Burke (Adult Support and Protection Team Quality Assurance and Development Officer) if you have any questions about the content of this report, or if you would like to request further analysis of the data from this return. Ronan.Burke@fife.gov.uk

Appendix 1

Summary Tables:

Section A: Data on referrals

Q1: Summary of Referrals over the past 5 years

	375	510	757	725	644
	427	502	659	757	822
	410	588	671	730	687
	453	800	623	755	645
	1665	**2400**	**2710**	**2967**	**2798**

Q2: Referrals by Source –over the last 5 years[2]

Source	2016-17	2017-18	2018-19	2019-20	2020-21
Mental Welfare Commission	0	0	0	0	0
Unpaid carer	0	0	0	0	0
Others	11	7	1	0	0
Healthcare Improvement Scotland	0	0	0	0	1
Other member of public	7	178	218	122	2
Office of Public Guardian	3	2	0	2	3
Care Inspectorate	15	31	0	7	11
Scottish Ambulance Service	3	3	0	3	29
Self (Adult at risk of harm)	38	40	49	50	37
Scottish Fire & Rescue Service	77	74	63	69	57
Friend / Neighbour	136	13	0	35	71
Anonymous	25	33	74	89	71
Council	272	343	194	193	137
GPs	45	64	131	180	138
Family	39	48	0	117	159
Social Work	216	258	293	310	238
NHS	229	365	322	411	344
Police	87	249	375	377	664
Other organisation	462	692	990	1002	836
Total	**1665**	**2400**	**2710**	**2967**	**2798**

Outcome of referral–over the last 5 years (Section E)

Outcome	2016-17	2017-18	2018-19	2019-20	2020-21
Further Adult Protection Action	610	1398	1825	2103	2272
Further Non-AP Action	301	332	242	256	130
No further action	713	610	560	518	342
Not recorded	41	60	83	90	54
Total	**1665**	**2400**	**2710**	**2967**	**2798**

Investigations – over the last 5 years (Section B)

	2015-16	2016-17	2017-18	2018-19	2019-20*	2020-21
Number of Investigations	333	444	379	339	385	460

* Following validations this number has been revised to 459 however the number here is what has been reported to SG in 2019-20

[2] Please note that Scottish Ambulance Service and Family are new dropdown categories to enable reports. The decline in 'other member of public' can be attributed to referrals being correctly classified into Friend/ Neighbour or Family in 2019-20

Investigations by client group - over the last 5 years (Section B)

Client groups	2016-17	2017 - 18	2018-19	2019-20	2020-21
Dementia	157	101	3	10	11
Mental health problem	37	54	40	58	100
Learning disability	63	70	44	57	50
Physical disability	54	46	97	109	122
Infirmity due to Age	49	48	47	53	57
Substance misuse	19	11	1	10	7
Other	65	49	107	88	113
Total	**444**	**379**	**339**	**385**	**460**

Investigations by type of harm - over the last 5 years (Section B)

Type of harm	2016-17	2017-18	2018-19	2019-20	2020-21
Financial Harm	68	91	52	97	117
Psychological harm	46	49	94	84	96
Physical harm	120	106	43	95	117
Sexual harm	20	19	29	17	19
Neglect	104	66	34	36	31
Self-harm	19	23	85	50	79
Other	67	25	2	6	1
Total	**444**	**379**	**339**	**385**	460

Investigation by location where principal harm took place - over the last 5 years (Section B)

Location of Harm	2016-17	2017-18	2018-19	2019-20	2020-21
Own home	264	246	226	227	285
Other private address	6	13	9	14	14
Care home	128	66	33	37	25
Sheltered housing or other supported accommodation	17	5	9	7	15
Independent Hospital	1	0	1	3	0
NHS	16	19	11	14	10
Day centre	1	5	0	1	0
Public place	9	20	27	16	16
Not known	2	5	23	66	95
Total	**444**	**379**	**339**	**385**	**460**

Outcome of Investigations - over the last 5 years (Section E)

Outcome	2016-17	2017-18	2018-19	2019-20	2020-21
Further AP action	75	48	34	44	59
Further non-AP action	214	166	102	131	172
No further action	137	157	165	201	227
Not known (ongoing)	18	8	38	9	2
Total	**444**	**379**	**339**	**385**	**460**

Number of Investigations by Age and Gender - over the last 3 years (Section B)

Number of investigations by age and gender												
Age Group	**2018-19**				**2019-20**				**2020-21**			
	Male	**Female**	**Not known**	**All adults**	**Male**	**Female**	**Not known**	**All adults**	**Male**	**Female**	**Not known**	**All adults**
16-24	17	15	0	**32**	16	22	2	**40**	21	31	2	**54**
25-39	28	26	0	**54**	37	29	0	**66**	28	43	0	**71**
40-64	56	60	0	**116**	55	67	0	**122**	79	85	0	**164**
65-69	6	9	0	**15**	10	8	0	**18**	11	11	0	**22**
70-74	9	10	0	**19**	6	11	0	**17**	10	13	0	**23**
75-79	9	13	0	**22**	9	16	0	**25**	15	24	0	**39**
80-84	10	20	0	**30**	17	27	0	**44**	11	21	0	**32**
85+	15	36	0	**51**	17	36	0	**53**	16	38	0	**54**
Not known	0	0	0	**0**	0	0	0	**0**	0	1	0	**1**
Total	150	189	0	**339**	167	216	2	**385**	191	267	2	**460**

Number of Investigations by Age and Ethnic Group - over the last 3 years (Section B)

	2018-19								2019-20								2020-21							
Age Group	White	Mixed or multiple ethnic groups	Asian, Asian Scottish or Asian British	African	Caribbean or Black	Other ethnic group	Not known	**All adults**	White	Mixed or multiple ethnic groups	Asian, Asian Scottish or Asian British	African	Caribbean or Black	Other ethnic group	Not known	**All adults**	White	Mixed or multiple ethnic groups	Asian, Asian Scottish or Asian British	African	Caribbean or Black	Other ethnic group	Not known	**All adults**
16-24	27	1	0	0	0	1	3	**32**	37	0	1	0	0	0	2	**40**	47	0	1	0	0	0	6	**54**
25-39	48	0	2	0	0	1	3	**54**	63	0	0	0	0	1	2	**66**	67	1	1	0	0	0	2	**71**
40-64	101	0	1	0	0	3	11	**116**	115	0	0	0	0	0	7	**122**	152	0	0	0	0	0	12	**164**
65-69	13	0	0	0	0	0	2	**15**	15	0	0	0	0	0	3	**18**	19	0	0	0	0	0	3	**22**
70-74	16	0	0	0	0	0	3	**19**	16	0	0	0	0	0	1	**17**	21	0	0	0	0	1	1	**23**
75-79	19	0	0	0	0	0	3	**22**	22	0	0	0	0	0	3	**25**	35	0	0	0	0	0	4	**39**
80-84	30	0	0	0	0	0	0	**30**	36	0	0	0	0	0	8	**44**	29	0	0	0	0	0	3	**32**
85+	47	0	0	0	0	0	4	**51**	48	0	1	0	0	0	4	**53**	52	0	1	0	0	0	1	**54**
Not known	0	0	0	0	0	0	0	**0**	0	0	0	0	0	0	0	**0**	0	0	0	0	0	0	1	**1**
Total	**301**	**1**	**3**	**0**	**0**	**5**	**29**	339	**352**	**0**	**2**	**0**	**0**	**1**	**30**	385	**422**	**1**	**3**	**0**	**0**	1	33	460

ASP Case Conferences - over the last 5 years (Section C)

Type of ASP Case Conference	2016-17	2017-18	2018-19	2019-20	2020-21
Initial ASP case conference	29	44	59	58	84
Review ASP case conference	15	20	33	25	42
ASP case conference*	0	0	0	0	0
Total	**44**	**64**	**92**	**83**	**126**

Number of LSI commenced - over the last 5 years (Section D)

	2016-17	2017-18	2018-19	2019-20	2020-21
Total number of LSI	4	3	1	3	2

Appendix 2
Fife Adult Support and Protection
Summary of age profile of adults subject to ASP Investigation 2020-21

Introduction:

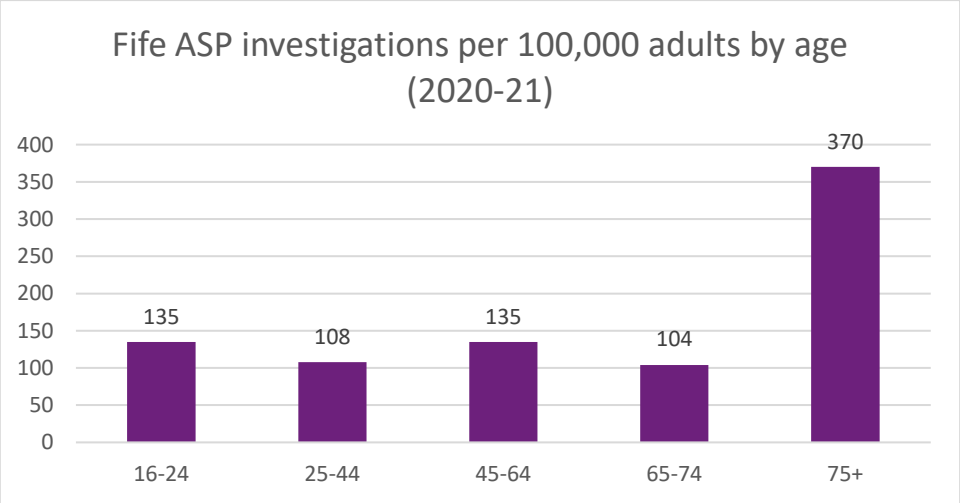
This analysis has been provided to give an overview of the age profile of adults in Fife subject to ASP Investigation. It should be read alongside the Annual Scottish Government Data report for 2020-21 which provides further detail of the data.

Data Overview:

Investigations per 100,000 population

In Fife, the breakdown per 100,000 adults by age group shows that people aged 65 and over are more likely to be subject to an ASP Investigation (225 adults per 100,000) than those of working age (124 adults per 100,000)[3].

When age categories are broken down further, adults aged 75+ are the most likely group to being subject to ASP Investigation (370 per 100,000) as shown in the chart below. This is thought to be broadly reflective of the national picture when compared to available benchmarking data.

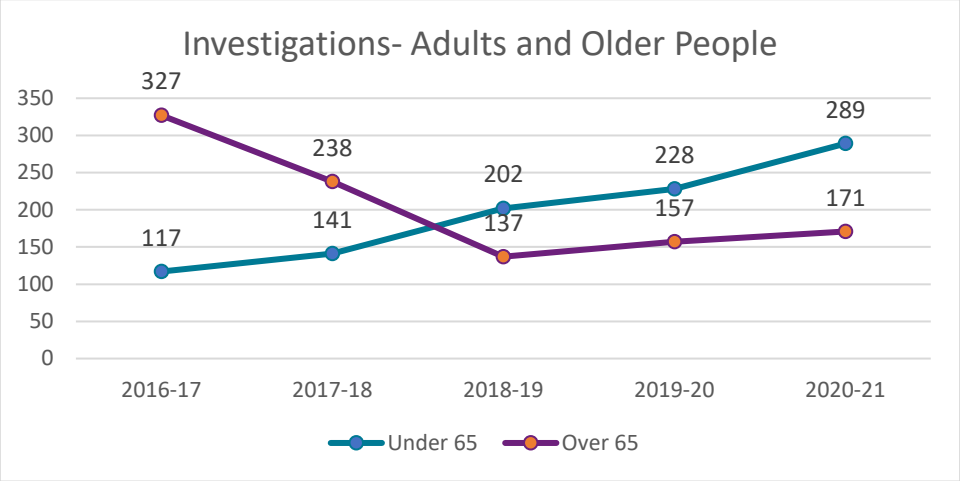


Count of Investigations:

Since 2016-17, the number of ASP Investigations relating to adults aged 16-64 has been increasing, 2020-21 data was no exception with figures showing a 27% increase in investigations in this age group since the previous year. Whilst the number of Investigations for Adults aged 65+ has also increased this year, this equates to a 9% increase.

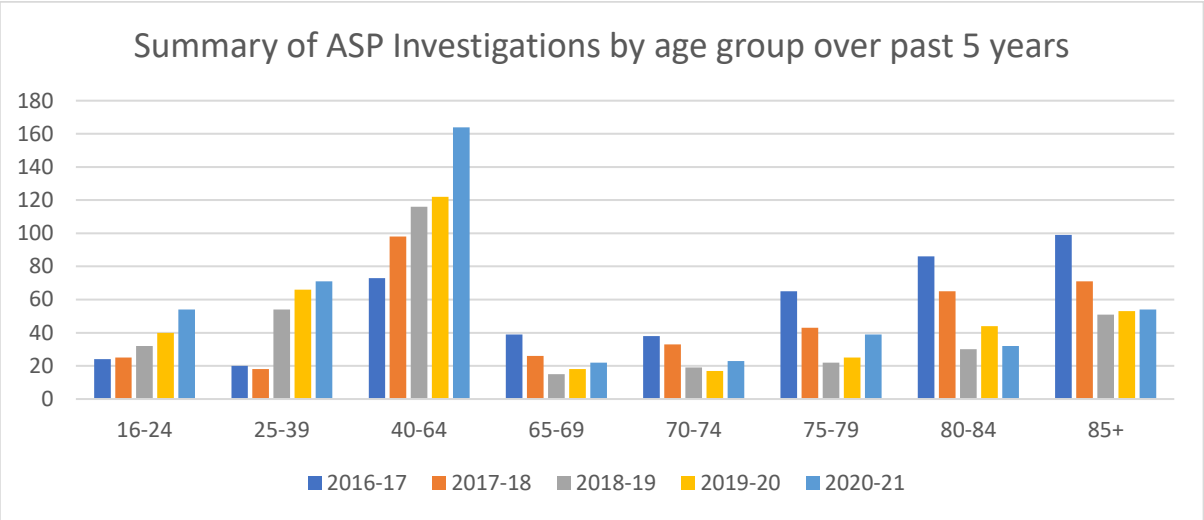
The number of investigations relating to adults aged 16-64 has been higher than those aged 65+ since 2018-19. For adults over 65, there was a sharp decline in Investigations between 2016-17 and 2018-19, followed by small increases over the past two years. The graph below shows the count of Investigations over the past five years by those aged under 65 and those over 65.

[3] For calculation of rates per 100,000, the population data was sourced from National Records of Scotland: https://www.nrscotland.gov.uk/files/statistics/council-area-data-sheets/fife-council-profile.html#table_pop_est_sex_age



Source: SG Annual Return Data

Breaking down the age category further shows that since 2017-18 there are consistently more investigations relating to Adults aged 40-64 when compared to any other age categories. All age categories in the under 65 age group note increases in numbers over the past five years, whilst all age categories over 65 group note a decline between 2016-19, with most categories seeing slight increases over the past two years.



Source: SG Annual Return Data

The reduction of Investigations in older age groups between 2016-19, particularly within Care Home settings has been highlighted in previous data reports. It is hypothesised that this decrease is primarily because our workforce is increasingly confident in correctly identifying and reporting harm, preventing harm in care settings and better able to differentiate between significant occurrences and ASP. The decrease may correspond to training launched in 2016 which primarily targeted managers and deputes in care homes, with a focus on 'early indicators' of harm and preventing harm in care settings. Subsequent training and reviews to procedure increasingly support our workforce to be confident in identifying and reporting harm and case file audits would support that improvements have been seen in relation to correct application of the three-point criteria.

It is anticipated that we will find further evidence to support this hypothesis through;

- A mixed methods review of the approach to responding to harm in care home settings (SE&I action)
- A review of the approach to contracts monitoring of Significant Occurrences (ASP Leaders action)
- An interagency staff survey to measure confidence in identifying and reporting harm which will be distributed to Care at home and Care home staff. (SE&I Action)
- Post training questionnaire to measure confidence in recognising and reporting harm following training (SE&I action).

Conclusions:

Based on the information available at the time of writing, our data reflects the national picture showing that adults over the age of 75 are more likely to be subject of ASP Investigation than those in younger age groups.

Whilst this is the case, in terms of operational management of ASP work it must be noted that the number of Investigations is far higher in Adults Services (16-64) than Older People (65+) and appears to be increasing at a faster rate. In addition, both the Social Work Performance reports and the analysis of the data return has highlighted the complexity of ASP work being undertaken for younger adults, pointing to the numbers progressed for further AP action following investigation, the number of individuals subject to multiple investigations and the different types of harm, specifically self-harm, predominantly experienced in younger age groups.

We are working within our communities to continuously raise awareness of what constitutes harm and how to report it. It is likely that we will continue to see further increases in the number of Investigations undertaken as more people become aware of the signs of harm and how to report it.

www.fifehealthandsocialcare.org

Fife Health & Social Care Partnership

Adult Support & Protection Annual Return 2021-22

Summary Statistics

Report Date: August 2022

Report Author: Katie Jones

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

Contents

1. Introduction

The following report is a summary of the data collected for the annual Scottish Government Adult Support and Protection (ASP) statistical return. The information gathered includes a count of referrals, IRDs, investigations, case conferences and large-scale investigations (LSIs) recorded between 1st April 2021 and 31st March 2022. An overview of the types and location of harm of investigations and the demographic profile of nominals subject of ASP investigations has also been provided. Summary tables are given in Appendix 1 which shows the data submitted to the Scottish Government for the most recent reporting period and the five previous financial years (2016/17 to 2021/22). Analysis of the 2021/22 data has highlighted key areas for future exploration and this report highlights points for consideration at the Self Evaluation and Improvement Group (SE&I) to agree if they should be integrated into relevant improvement plans. Concluding remarks and an overview of recommendations are provided from pages 16 to 20.

2. Key Statistics

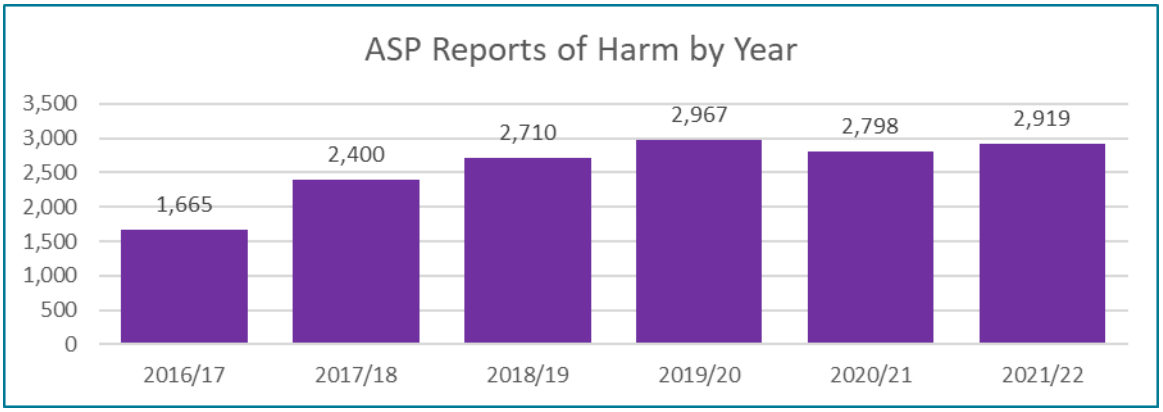
Data for the period 1st April 2021 to 31st March 2022 shows the following:

- There were 2,919 reports of harm received, a 4.3% increase on the 2020/21 report and a reversal of the decrease the previous year, with figures returning to similar levels observed pre-Covid.
- Of the 1,969 individuals referred, 27% had multiple reports of harm recorded (535), a small decrease on the 29% received the previous year but with a greater number of nominals with five or more referrals recorded (45 in 2020/21 and 50 in 2021/22).
- There were notable rises in ASP referrals from the NHS (+30.2%), possibly affected by remobilisation of NHS appointment leading to increased contact with clients in 2021/22. ASP referrals with further AP action continued to rise in 2021/22, marking the fifth consecutive year of increase.
- There were 375 investigations undertaken during 2021/22, which marks an 18.5% decrease on the previous year (460). Data validation exercises should be considered for the 2021/22 figures to ensure that the data is directly comparable.
- There were 97 case conferences reported this year, a 23% reduction on the 2020/21 report (126) and 76.2% of these were undertaken by the Adults team.
- There were 15 LSIs reported by team managers during 2021/22, a notable rise on the year before (2). An audit for LSIs 2020-2022 is currently being conducted to investigate possible reasons for this.
- Continuing the previous trend, the majority of ASP investigations related to nominals aged under the age of 65 (65.1%) and those identifying as female (60.3%).
- There was a notable decrease in investigations involving clients' mental health, which almost halved in 2021/22 (from 100 in 2020/21 to 57) following the rise observed the previous year (58 to 100).
- The main types of harm recorded at the ASP investigation stage were financial harm and psychological harm, consistent with previous trends and each accounting for 20.3% of total

investigations during 2021/22. Following the notable rise in investigations relating to self-harm last year (50 investigations to 79), this figure has increased further during 2021/22 (+5 to 84).

- As observed during previous years, the most likely location of harm investigated was the individual's own home (55.5%). Care home settings have decreased further (from 25 to 18) and remain very low (4.8%) as compared to the previous national average (22%). Actions are ongoing to investigate the reasons behind this.

3. ASP Reports of Harm

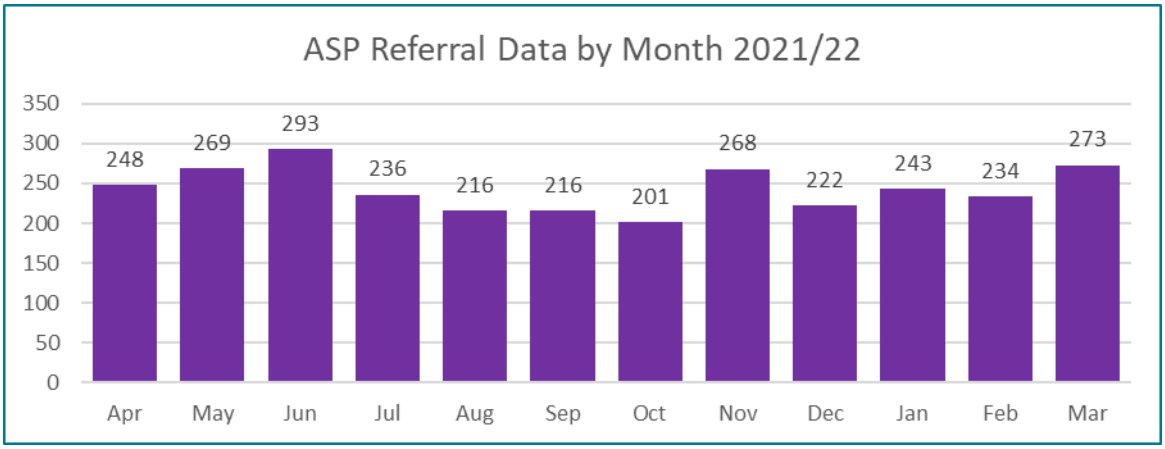


Source: SWIFT AIS.

The graph above shows that between 1st April 2021 and 31st March 2022, there were 2,919 ASP reports of harm recorded. This represents a 4.3% increase on 2020/21 (+121, from 2,798) and a return to the upward trend observed in previous years.

These figures reverse the 5.7% decrease observed during 2020/21, which was believed to be affected by Covid-19 restrictions reducing agencies' contact with individuals. This was supported by there being fewer reports of harm recorded in months with the strictest lockdowns (April 2020, December 2021, January 2021 and February 2021).

The graph below shows the number of referrals per month for 2021/22, with volumes ranging from 201 to 293. The total number of referrals in 2021/22 (2,919) have returned to similar levels to pre-Covid (2,967 in 2019/20) as restrictions have eased and services have remobilised.



Source: SWIFT AIS.

In relation to referrals, an adult at risk of harm can be counted more than once where multiple reports of harm have been received about the same individual. During 2021/22, there were 2,919 referrals recorded about 1,969 nominals. In total, 27% of individuals had multiple reports of harm (535 of 1,969), with 50 clients having five or more referrals recorded in the time period examined.

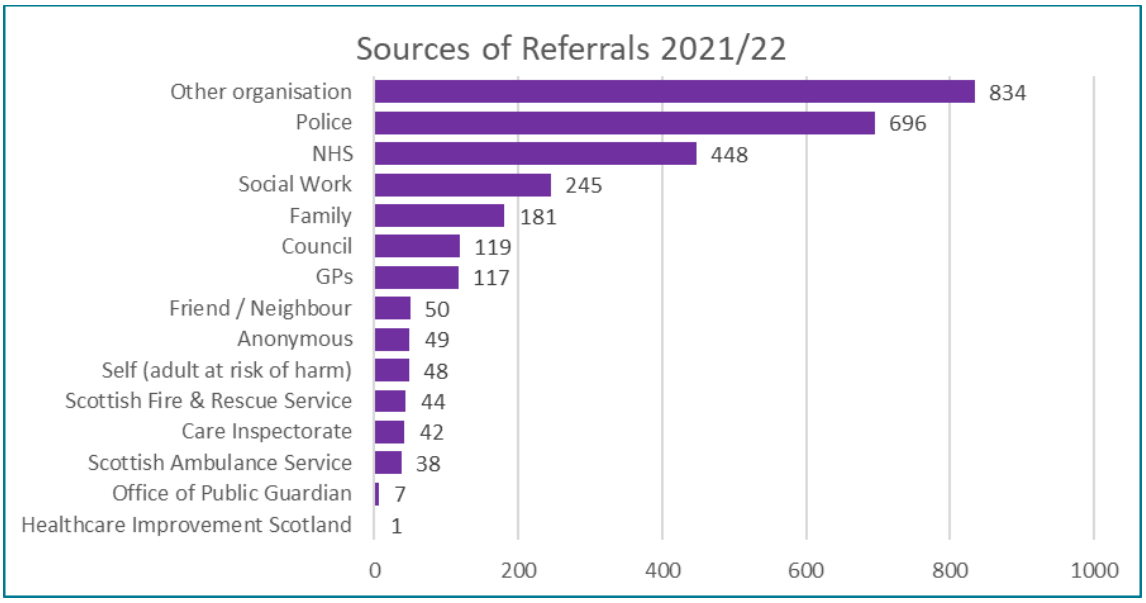
As compared to last year, this is a rise in relation to overall referrals (2,798 to 2,919) but a decrease in individuals with more than one reports of harm (from 29% or 551 to 27% or 535). During 2021/22, there were slightly more nominals with five or more reports of harm recorded (45 last year and 50 this year).

Recommendation 1: Adult Protection Self Evaluation and Improvement Group (SE&I) to consider undertaking an audit of cases where there have been multiple reports of harm (535) and / or an audit of cases with five or more reports of harm (50). This will help ensure that the multiple report of harm protocol is being correctly taken forward and that there is an escalation of engagement (where appropriate). It will also allow an evaluation of the quality of the partnership's response to preventing harm and help identify any learning points or further actions for improvement moving forward. In addition, this would assist with a review of chronologies which will be an action point for the overarching Adult Support and Protection Committee (ASPC) strategic improvement plan for 2023-25 and could be considered for the forthcoming annual ASP audit for 2023. Given the volume of cases involved (535 multiple reports of harm, 50 of which have 5+ referrals), it may be more appropriate to consider a dip sample from both categories to ensure any audit is manageable but as representative as possible of the broader data. The PIP team can provide further data on multiple reports of harm as required.

Recommendation 2: The service aims to complete 85% of inter-agency referral discussions (IRDs) within five working days. However, IRD snapshots may include multiple reports of harm IRDs (MRH) which can lead to delays in the timescale being met due to the time taken to co-ordinate the availability of participants to conduct the face-to-face meetings required. ASP team and PIP to examine the current scale and consider ways in which this can be addressed (such as reviewing MRHs separately, for example).

4. Source of ASP Referrals

The graph below illustrates the source of the ASP referral as reported to the Scottish Government for the 2,919 reports of harm recorded during 2021/22.



Source: SWIFT AIS.

Overall, there was a 4.3% increase in the total number of referrals recorded during this period (+121, from 2,798 in 2020/21).

The most significant was a 30.2% rise in ASP referrals from the NHS (+104, from 344 to 448). This is likely to have been affected by remobilisation of NHS appointments leading to increased contact with clients in 2021/22. During the previous year, Covid-19 restrictions and subsequent pressures on the service had led to more routine surgeries and treatments being put on hold. Furthermore, the ASP team has reported a greater volume of referrals from NHS24, with analysis evidencing a notable jump this period and a rise year-on-year from 2019/20 (16 referrals to 23 in 2020/21 to 55 in 2021/22). The second most significant rise for the source of ASP referrals was the care inspectorate, with figures almost tripling from 11 in 2020/21 to 42 during 2021/22 (+31).

Increases in ASP referrals were also observed for police (+32, from 664 to 696) and Scottish Ambulance Service (+9, from 29 to 38). Both experienced a notable rise during the last return (referrals from police rose from 377 in 2019/20 to 664 in 2020/21 and reports of harm from SAS from 3 to 29 respectively). Further increases this year show this rise has been not only sustained but exceeded during the return for 2021/22. Other rises of note were evident for the adult's family (+22, from 159 to 181) and self-reporting from the adult (+11, from 37 to 48).

Despite an overall increase in the volume of ASP referrals recorded during 2021/22, not all sources of referral experienced a rise during this period. One of the most significant decreases was in relation to GP referrals (-21, from 138 to 117). This may have been impacted, at least in part, to the reduction in face-to-face appointments in favour of telephone consultations due to Covid-19 restrictions experienced in 2021/22. Other decreases of note included referrals from friends and neighbours (-21, from 71 to 50) and the council (-18, from 137 to 119).

As was observed the previous year, the highest number of ASP reports of harm during 2021/22 were received from other organisations, which accounted for over a quarter (28.6%) of referrals (834 of 2,919). This is comparable with the figure observed during 2020/21 (836) and indicates that a wide range of agencies are aware of what constitutes harm and adults at risk and how to report it.

The summary tables provided in Appendix 1 show the referral source for all reports of harm reported to the Scottish Government during 2021/22 along with the previous five financial years for comparison purposes.

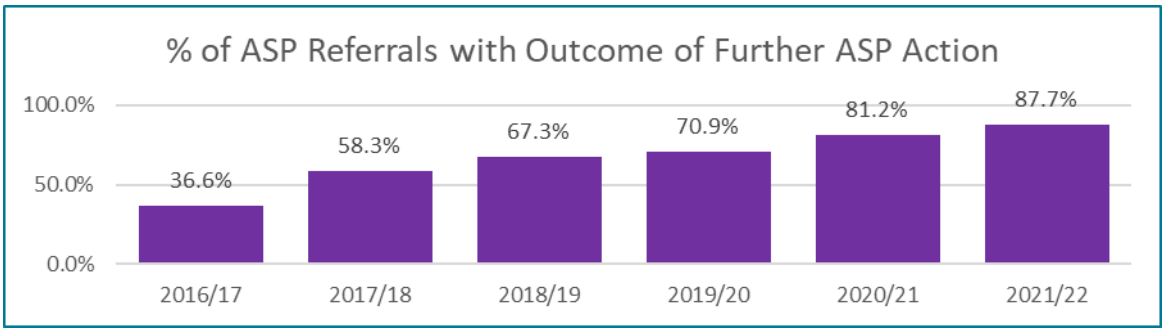
Recommendation 3: As per the ongoing 2021-23 ASP workplan, the ASP team will continue to strengthen links with all partners and raise awareness of the key ASP messages during the forthcoming year through development and implementation of a stakeholder engagement plan (planned in early 2023).

Recommendation 4: Audit and drug prevention activity from SAS were highlighted at ASPC in August 2022. Work is ongoing to further strengthen ASP links with SAS and reporting of harm moving forward.

Recommendation 5: SE&I group to continue to monitor the source of ASP referrals on a quarterly basis via analysis provided by the PIP team in the ASPC quarterly report.

5. Outcome of ASP Referrals

The graph below shows the outcome of the ASP referral as reported to the Scottish Government for the 2,919 reports of harm recorded during 2021/22.



Source: SWIFT AIS.

The proportion of referrals requiring further Adult Protection action rose by 6.5% during 2021/22 (from 81.2% to 87.7%). This continues the consistent increasing trend seen over six years examined (2016/17 to 2021/22). This may, in part, be a reflection of improved practice in the correct identification and reporting of harm, resulting from increased team knowledge, training opportunities and review at team level. A further contributory factor could be an alteration in recording practices at the Social Work Contact Centre (SWCC).

Further development and refinement of a national minimum dataset alongside the forthcoming new case management system for Social Work will enable review and clarification of recording practices on how reports of harm are collected and recorded. The launch of the new LiquidLogic system has now been rescheduled until mid-2023, allowing additional time for recording practices to be evaluated and refined to facilitate more consistent and robust performance reporting moving forward.

The table below shows the outcomes of ASP reports of harm from 2016/17 to 2021/22. The consistent increase in ASP referrals with further AP action since 2017/18 combined with a decrease in reports where non-AP action was required over the last three financial years indicates a further strengthening of practice across the partnership on the appropriate identification and reporting of harm in relation to adults at risk.

Referral Outcome	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Further Adult Protection action	610	1,398	1,825	2,103	2,272	2,560
Further non-AP action	301	332	242	256	130	90
No further action	713	610	560	518	342	206

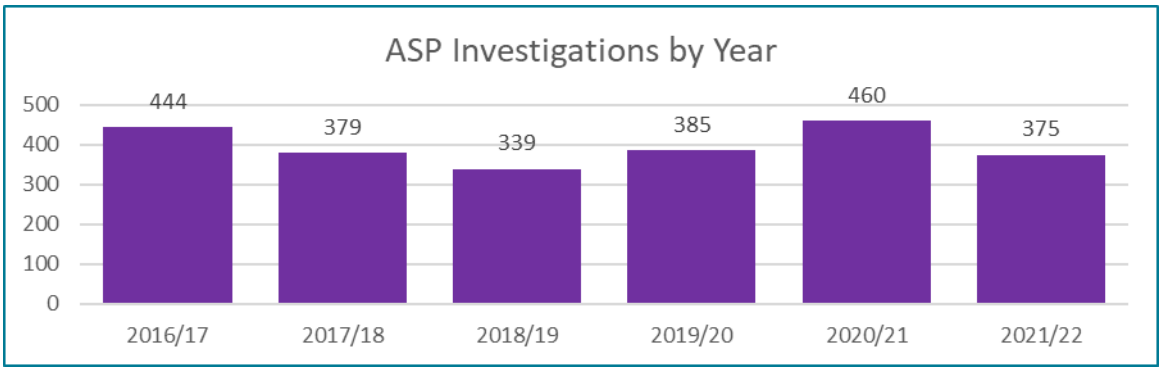
Not recorded	41	60	83	90	54	63
TOTAL	1,665	2,400	2,710	2,967	2,798	2,919

Source: SWIFT AIS.

Recommendation 6: Continuation of working group and regular meetings between ASP team, PIP team, Social Work, Workforce Development and SWIFT replacement team to ensure that the LiquidLogic system can effectively record and report on counts, source and outcomes of ASP referrals.

6. ASP Investigations

The graph below illustrates the number of ASP investigations as reported to the Scottish Government for the period 1st April 2021 to 31st March 2022.



Source: SWIFT AIS. Note: 385 recorded in 2019/20 rose to 459 following data validation exercises.

During 2021/22, the volume of ASP investigations conducted reduced by 18.5% as compared to the previous year (-85, from 460 to 375). The figures for 2021/22 (375) show a return to the levels observed during 2019/20 (385) and are generally consistent with the five-year average (401 per year based on figures from 2016/17 to 2020/21). However, it should be noted that data validations subsequently increased the 2019/20 figures from 385 to 459 (after this had been reported to Scottish Government). Similar actions should be considered for the 2021/22 figures in order to ensure that data is directly comparable.

Whilst 375 ASP investigations were conducted during 2021/22, this was in relation to 358 individuals. The majority of nominals were the subject of only one investigation (342), however 15 individuals had two ASP investigations undertaken and one nominal had three investigations conducted over the time period examined. It should be noted that this is a reduction in the number of individuals with multiple investigations as observed the previous year (29 in 2020/21).

Analysis by age group shows that 11 of the 16 nominals who were the subject of multiple ASP investigations were under 65 years, with five over the age of 65. Proportionally however, the figures are more

comparable, with 4.5% of adults aged under 65 years being the subject of more than one ASP investigation over the period examined (11 of 244) as compared to 3.8% of those aged 65 years and over (5 of 131).

Recommendation 7: ASP Team and PIP to investigate what data validation exercises were carried out during 2019/20 given the rise in investigations subsequently observed once this work had been carried out. Consider similar data validations for 2021/22. PIP team can provide data and analysis where appropriate.

Recommendation 8: SE&I interagency audit to consider including the 16 nominals who have been subject to multiple investigations during 2021/22 to evaluate if the partnership can strengthen its response to harm, particularly in relation to the support of adults under 65 years.

Recommendation 9: ASP team leaders to consider routine review of cases and any procedural implications where multiple investigations are being undertaken.

7. Outcome of ASP Investigations

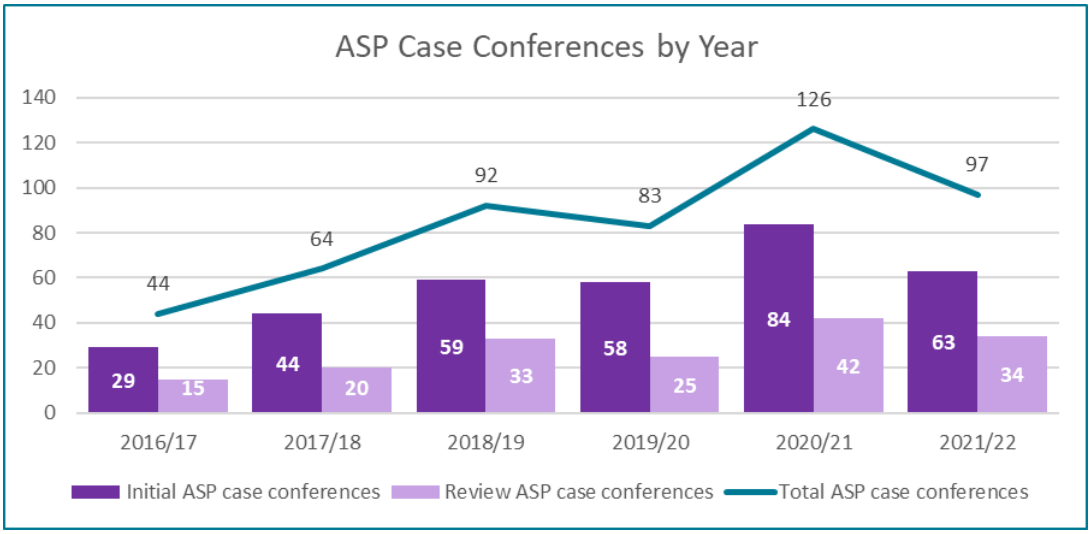
Investigation Outcome (%)	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Further Adult Protection action	16.9%	12.7%	10.0%	11.4%	12.8%	10.1%
Further non-AP action	48.2%	43.8%	30.1%	34.0%	37.4%	34.4%
No further action	30.9%	41.4%	48.7%	52.2%	49.3%	53.9%
Not recorded	4.1%	2.1%	11.2%	2.3%	0.4%	1.6%

Source: SWIFT AIS.

The table above provides the proportion of cases progressed past investigation stage for further ASP action. Overall, the figures observed for 2021/22 remain similar to previous years. Overall, 10.1% of cases were progressed for further AP action. This relates to 38 investigations, a notable reduction on the previous year (59 during 2020/21). Of the 38 cases progressed for further ASP action, 32 related to nominals under 65. Work is ongoing in relation to how this data will be captured on and extracted from LiquidLogic.

Recommendation 10: Continuation of working group and regular meetings between ASP team, PIP team, Social Work, Workforce Development and SWIFT replacement team to ensure that the LiquidLogic system can effectively record and report on counts, outcomes and nominal demographics from ASP investigations.

8. ASP Case Conferences



Source: Team managers.

The graph above shows the number of ASP case conferences undertaken during 2021/22 as compared to the previous five financial years. Overall, the volume of ASP case conferences conducted during 2021/22 decreased by 23% (-29, from 126 in 2020/21 to 97). This decrease was evident across both ASP case conference categories, with initial ASP case conferences reducing from 84 to 63 and review case conferences from 42 to 34. This also follows the notable 52% rise observed the previous year (from 83 in 2019/20 to 126 in 2020/21). Of the 97 total ASP case conferences during 2021/22, 76.2% were undertaken by the Adults teams (74). Proportionally, this is broadly comparable with the volume observed during the previous year (73% by Adults Teams).

Recommendation 11: Social work service managers to continue to monitor the distribution of ASP investigations and case conferences and consider the resource implications, particularly in relation to the volume of case conferences undertaken by the Adults teams during 2021/22 (76.2% of total).

Recommendation 12: Data on case conferences is currently gathered from team managers via Microsoft Forms due to difficulties in recording and extracting figures from SWIFT AIS. Ways to enable the consistent and accurate recording and extraction of case conferences on LiquidLogic should be considered as a priority to enable robust and timely data is easily available to facilitate regular performance monitoring and the collation of the statutory Scottish Government annual return.

Recommendation 13: ASP Team and PIP Team to compile concise guidance sheet for use by team managers about which information to record on case conferences for the Scottish Government return. This can be used for training, will facilitate consistency of approach across teams, ensure that data is directly comparable year-on-year and assist with future LiquidLogic discussions. This should be accompanied by a simple table / spreadsheet to capture all data required for internal performance and statutory reporting and saved in a centralised Sharepoint location to allow comparison between periods and facilitate regular updates from team managers. PIP team to compile timetable for completion and send reminders throughout the forthcoming year. Consider for use in the interim pending the launch of LiquidLogic.

9. ASP Protection Orders

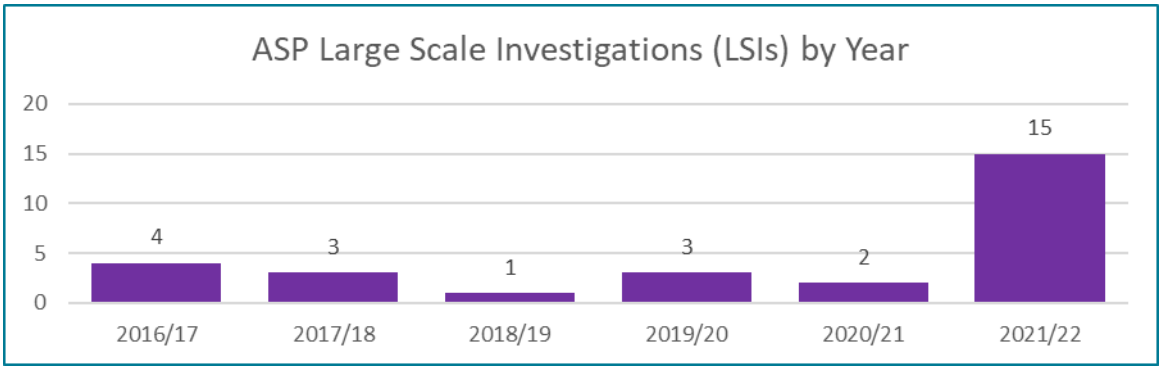
The Scottish Government return for 2021/22 requested information on protection orders granted, namely assessment orders, removal orders, temporary banning orders, banning orders, temporary banning orders with power of arrest and banning orders with power of arrest. There were no ASP protection orders granted in 2021/22 in Fife which is consistent with the previous year. Reporting of protection orders remains very low, and work is ongoing to investigate the reasons behind this. Consideration needs to be given to how information on protection orders will be recorded in and retrieved from the new LiquidLogic system and more streamlined and robust ways to capture the required information in the interim period.

Recommendation 14: Data on protection orders is currently gathered manually from team managers via Microsoft Forms due to difficulties extracting this information from SWIFT AIS (this data is currently recorded in profile notes which cannot easily be searched). Ways to enable the consistent and accurate recording and extraction of protection orders on LiquidLogic should be considered as a priority to enable robust and timely extraction to facilitate regular performance monitoring and statutory annual return.

Recommendation 15: ASP team and PIP team to compile concise guidance about what information to record on protection orders for the Scottish Government return along with a simple table / spreadsheet to capture all data required. This should be saved in a centralised Sharepoint location and used in the interim pending the launch of LiquidLogic (as per Recommendation 13).

Recommendation 16: ASP team to continue work on processes, information gathering and the recording procedure in relation to protection orders due to consistently low figures.

10. Large Scale Investigations (LSIs)



Source: Team managers.

The graph above shows the number of large-scale investigations (LSIs) reported to the Scottish Government. During 2021/22, there were 15 LSIs undertaken - a notable rise as compared to the previous five years, where the number of annual LSIs ranged from one to four annually. Three of the LSIs were undertaken by the Adults team, with the remaining 12 being conducted by the Older People teams. An LSI audit for the period 2020-2022 is currently being carried out by the ASP co-ordinator and the ASP quality assurance officer to examine reasons for the rise in LSIs experienced this year. LSI cannot be extracted from SWIFT AIS and as such, is currently gathered from team managers. Initial findings suggest that LSI IRD planning meetings may have been included in this year's figures (8) as well as formal full LSIs (6), however this would still constitute a rise in LSIs for 2021/22 as compared to the previous year (from 2 to 6).

Iriss, in partnership with the National Adult Protection Committee, have developed a free online learning resource explaining the role of LSIs within ASP practices in Scotland. This is split over four modules covering key principles, tasks / knowledge, potential practice dilemmas / errors, differences in singular investigations and an LSI and planning / structuring an LSI. The ASP team have been asked to consider this for delivery and training on a multi-agency basis. Iriss is also currently developing a national LSI framework to include learning, evidence and examples to encourage consistency in practice and ensure transparency of approach.

Recommendation 17: Social work service managers to continue to monitor distribution of LSIs and consider resource implications, particularly in relation to the number of LSIs undertaken by OP teams during 2021/22.

Recommendation 18: ASP team and PIP team to compile clear guidance on what LSI information is required for the Scottish Government and a table / spreadsheet to ensure consistency of approach across teams and on previous submissions (as per Recommendation 13). The lead should be taken from the Fife Interagency Guidance and Procedure for Large Scale Investigations of Adults at Risk of Harm (updated December 2021). The LSI review for 2020-22 is ongoing and has been added to the agenda of the next ASP managers meeting.

Recommendation 19: Ways to enable the consistent and accurate recording and extraction of LSIs on LiquidLogic should be considered as a priority to allow robust and timely extraction to facilitate regular performance monitoring and the statutory annual return to the Scottish Government.

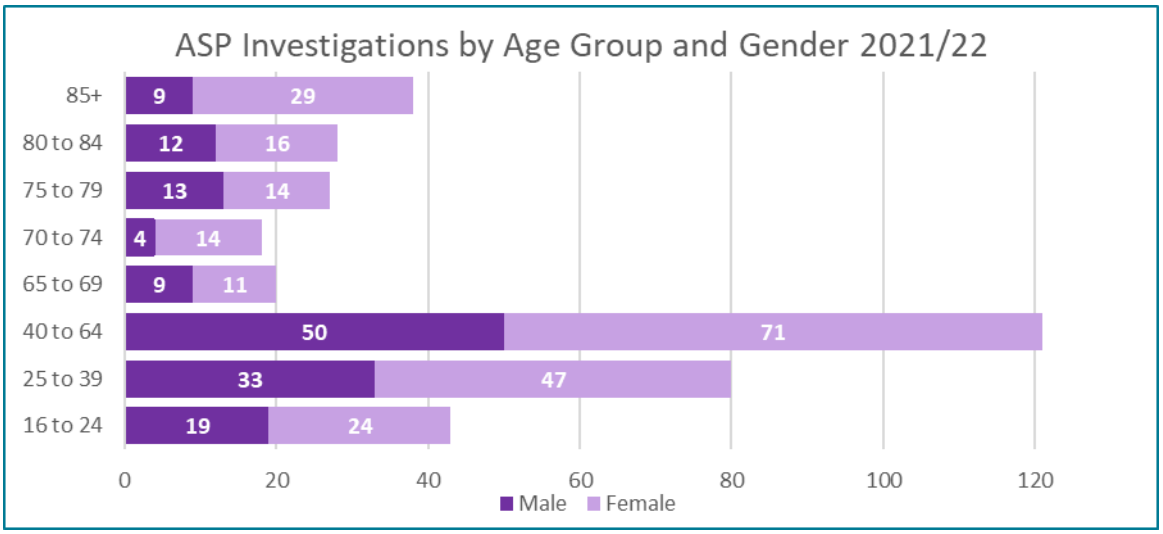
Recommendation 20: ASP are considering the LSI package from Iriss to compile a learning resource for delivery and training on a multi-agency basis.

11. Demographic Information

To facilitate planning and development of effective pathways and preventative support, it is essential to monitor details of adults of risk, the types of harm they are experiencing and where this is taking place. Nationally, this is reported on during the investigation stage of an ASP enquiry and analysis of this is

provided below. It should be noted that persons may be counted more than once within the following figures (where more than one investigation has been conducted for that nominal within the time period examined). Demographic data is reported to ASPC on a quarterly basis to enable continuous monitoring and early identification of trends or changes in data.

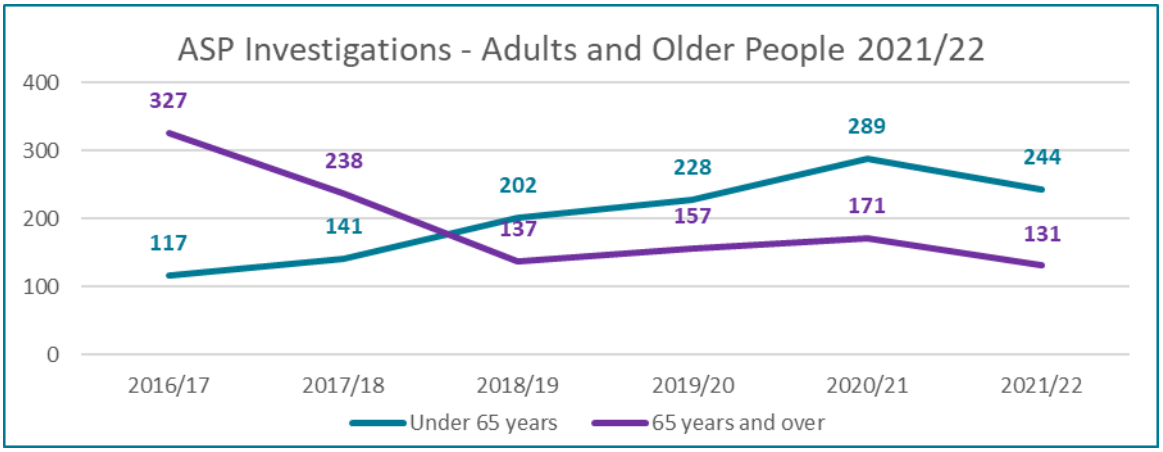
11.1. Age and Gender



Source: SWIFT AIS.

The graph above illustrates the count of investigations by gender and age group of the individual concerned.

Overall, a greater proportion (60.3%) of ASP investigations during 2021/22 related to adults identifying as female (226 of 375), which is the case across all age ranges considered. This trend was also observed consistently across all four quarters of the reporting period examined.



Source: SWIFT AIS.

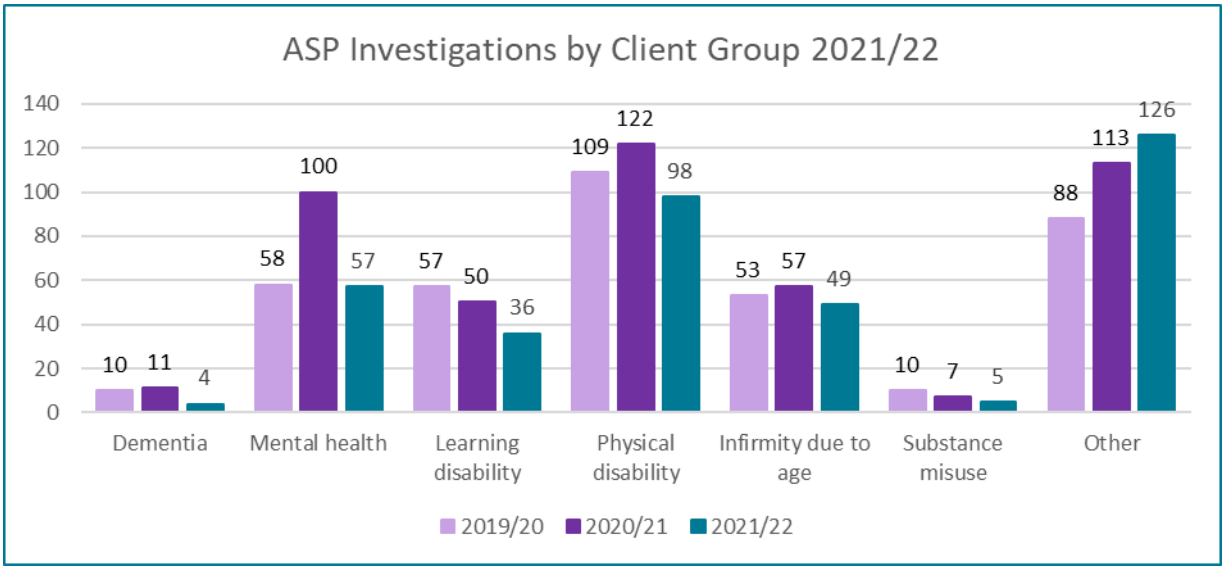
Age Group (%)	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Under 65 years	26.4%	37.2%	59.6%	59.2%	62.8%	65.1%
65 years and over	73.6%	62.8%	40.4%	40.8%	37.2%	34.9%

Source: SWIFT AIS.

During 2021/22, just under two thirds (65.1%) of investigations conducted involved persons under the age of 65 years (244 of 375). The proportion of investigations for this age group has shown a consistent upward trend since 2016/17 and a year-on-year increase since 2019/20, which may be reflective of awareness raising and training across Fife strengthening our approach to identifying and reporting harm.

The resulting reduction in the proportion of investigations involving older age groups (from 73.6% in 2016/17 to 34.9% in 2021/22) could be related to ongoing work to ensure that practitioners are better able to differentiate between significant occurrences and harm.

11.2. Client Group



Source: SWIFT AIS.

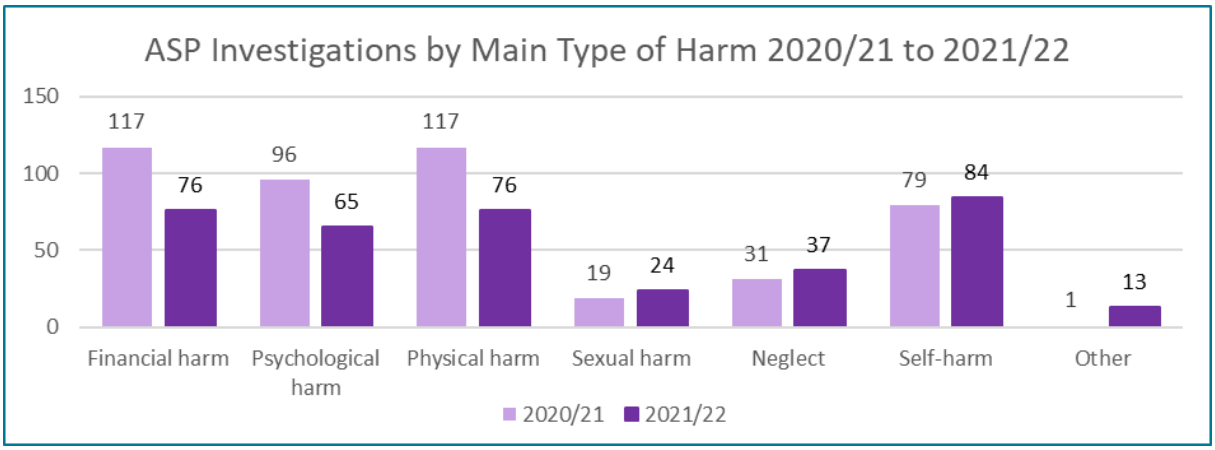
The graph above shows the number of investigations conducted for each client group category during 2021/22. Due to the overall decrease in the volume of investigations carried out over this period (from 460 in 2020/21 to 375 in 2021/22), there has been a resultant reduction in most of the client categories. The most notable is for mental health, which has almost halved in 2021/22 (from 100 to 57) following the rise observed the previous year (from 58 in 2019/20). One possible contributory factor to the rise seen in

2020/21 is the pandemic, with concerns over Covid-19, a reduction in available services and mandatory lockdowns likely to have had impact upon individual's mental health.

The only rise in client group during 2021/22 was in relation to the Other category (from 113 in 2020/21 to 126). The highest number of investigations were for Offenders (32) and Other Vulnerable People (30). It should be noted that for 19% of this category, the client group was listed as Not Recorded (24 of 126).

12. Incident Information

12.1. Type of Harm

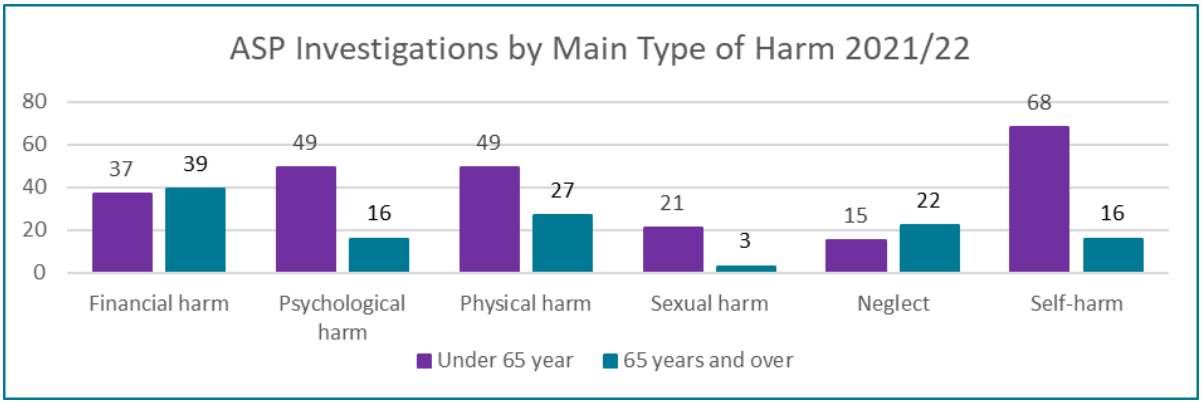


Source: SWIFT AIS.

The graph above shows the number of ASP investigations by main type of harm recorded. During 2021/22, the most common types of principal harm leading to an ASP investigation were financial harm and psychological harm, consistent with the previous year. Each accounted for 20.3% each of total investigations during 2021/22 (76 each of 375), a reduction in the proportions seen the year before (25% each in 2020/21).

Despite an overall decrease in the volume of ASP investigations carried out in 2021/22 (from 460 to 375), there were small rises in the volume and proportion of investigations involving sexual harm (+5, from 19 or 4.1% in 2020/21 to 24 or 6.4% in 2021/22; 18 nominals to 23), neglect (+6, from 31 or 6.7% to 37 or 9.9%; 31 nominals to 35) and self-harm (+5, from 79 or 17.2% to 84 or 22.4%; 75 nominals to 83). It is notable that the rise in investigations involving self-harm last year (from 50 to 79) has continued in 2021/22 (+5 to 84).

The graph below shows the main type of harm recorded in the ASP investigation by client age group for 2021/22. As in previous years, this demonstrates the variance in types of harm experienced over the different age groups. Consistent with the findings from 2020/21, the most notable is for investigations involving self-harm, with 80.9% of these involving under 65s (68 of 84) and accounting for 27.9% of all investigations involving adults aged 16 to 64 (68 of 244, higher than any other harm type for this age range).



Source: SWIFT AIS.

The type of harm investigated varies between client groups and it may be beneficial to consider this information to advise targeted communications campaigns. The highest count and percentage has been shown in red for each category in the table below for ease of reference. Caution must be taken when analysing the findings as counts for each can be small (given in the TOTAL column).

		Main Type of Harm							
Client Group		Financial harm	Psychological harm	Physical harm	Sexual harm	Neglect	Self-harm	Other	TOTAL
Dementia	Count	0	0	**2**	0	**2**	0	0	4
	%	0.0%	0.0%	**50.0%**	0.0%	**50.0%**	0.0%	0.0%	100.0%
Mental health	Count	**14**	**12**	7	5	3	**16**	0	57
	%	**24.6%**	**21.1%**	12.3%	8.8%	5.3%	**28.1%**	0.0%	100.0%
Learning disability	Count	7	7	**11**	3	2	5	1	36
	%	19.4%	19.4%	**30.6%**	8.3%	5.6%	13.9%	2.8%	100.0%
Physical disability	Count	**20**	12	**20**	5	19	18	4	98
	%	**20.4%**	12.2%	**20.4%**	5.1%	19.4%	18.4%	4.1%	100.0%
Infirmity due to age	Count	**17**	4	**14**	1	4	4	5	49
	%	**34.7%**	8.2%	**28.6%**	2.0%	8.2%	8.2%	10.2%	100.0%
Substance misuse	Count	**2**	**2**	1	0	0	0	0	5
	%	**40.0%**	**40.0%**	20.0%	0.0%	0.0%	0.0%	0.0%	100.0%
Other	Count	16	**27**	20	10	7	**41**	5	126
	%	12.7%	**21.4%**	15.9%	7.9%	5.6%	**32.5%**	4.0%	100.0%

Source: SWIFT AIS.

Recommendation 21: Learning and Development to consider the continued increase in investigations relating to self-harm and the current training and resources in place to support staff in providing effective and timely support.

Recommendation 22: ASP team to consider the breakdown of client group and types of harm with a view to developing more targeted communication campaigns based on the analysis above.

12.2. Location of Harm

The most frequent location of harm continues to be the individual's own home, accounting for over half (55.5%) of the ASP investigations during 2021/22 (208 of 375). This is a small decrease on the proportion observed the previous year (62%) but has remained universal across age group, gender, primary client group and ethnicity and is consistent with data from previous years. The number of investigations where the location of harm was reported as a care home has further decreased in 2021/22 (from 25 in 2020/21 to 18) and is very low (4.8%) as compared to the previous national average (22%).

Recommendation 23: Self-evaluation activity to scrutinise / investigate reasons for difference between number of investigations where location is a care home as compared to national average (ongoing).

13. Concluding Remarks

As has been observed previously, the data for 2021/22 is broadly consistent with the findings from past returns. As such, the ASPC Strategic Improvement Plan, updates and supporting workplans already contain ongoing actions which are further reinforced by the findings of this report. National statistics in relation to the Scottish Government returns for 2021/22 have not yet been published, but a comparison paper in relation to Fife statistics will be produced once this data becomes available.

Current work includes the development of a stakeholder engagement strategy and a mixed methods review to investigate the low number of investigations involving care homes as compared to the national average of 22% (volume in Fife decreased further in 2021/22, from 25 to 18 or from 5.4% to 4.8%).

Ongoing trends from previous years which have continued during 2021/22 include:

- Rising reports of harm from police (664 to 696) and Scottish Ambulance Service (29 to 38).
- Continued reduction in referrals from GPs (180 in 2019/20 to 138 in 2020/21 to 117 in 2021/22).
- Further increase in investigations involving self-harm, majority of which (80.9%) involve under 65's.

New potential areas for further investigation highlighted by the findings from this 2021/22 report include:

- Notable increase in referrals from NHS (from 344 to 448) – possibly due to greater service contact / involvement following easing of lockdown restrictions. Specific rise from NHS24 (from 23 to 55).
- Notable rise in ASP referrals from care inspectorate (from 11 to 42).
- Significant increase in the number of LSIs reported (from 2 to 15).

Overall, the volume and complexity of ASP work undertaken across the service, particularly in relation to those aged under 65 years, continues to increase. There has been a small reduction in the number of individuals for whom multiple reports of harm are received (551 to 535) but a rise in nominals with five or more referrals (from 45 to 50). The proportion of referrals requiring further adult protection action rose again 2021/22, marking the fifth consecutive year of increase. The proportion of ASP investigations involving those under 65 years of age has grown further (from 62.8% in 2020/21 to 65.1%).

Existing audit processes can be used to identify learning points and review and refine our processes regarding multiple reports of harm and escalation of involvement and engagement. This will help to ensure that we continue to move forward as a partnership in finding effective ways to keep people safe from harm. The tables overleaf provide an overview of the recommendations made from the findings in this report. If agreed to be taken forward, these can be embedded in the existing workplans for 2021-23 and the stakeholder engagement plans (as appropriate).

Recommendation 24: PIP team to produce a report on Fife ASP return for 2021/22 as compared to national statistics for Scotland once data becomes available from the Scottish Government (anticipated late 2022).

Please contact Katie Jones (Performance Improvement and Planning Officer) if you have any questions about the contents of this report or would like to request further analysis of the data from this return.

Email: Katie.Jones@fife.gov.uk

Key Finding and Report Section	Report Recommendation for Consideration	Lead	Required
Small decrease in nominals with multiple reports of harm (from 29% or 551 to 27% or 535) but a rise in the number of individuals with five or more referrals recorded (from 45 to 50). *(Section 3. ASP Reports of Harm)*	Recommendation 1: SE&I to consider undertaking an audit of cases where there have been multiple reports of harm (535) and / or an audit of cases with five or more reports of harm (50). This will help ensure that the multiple report of harm protocol is being correctly taken forward and that there is an escalation of engagement (where appropriate). It will also allow an evaluation of the quality of the partnership's response to preventing harm and help identify any learning points or further actions for improvement moving forward. In addition, this would assist with a review of chronologies which will be an action point for the overarching Adult Support and Protection Committee (ASPC) strategic improvement plan for 2023-25 and could be considered for the forthcoming annual ASP audit for 2023. Given the volume of cases involved (535 multiple reports of harm, 50 of which have 5+ referrals), it may be more appropriate to consider a dip sample from both categories to ensure any audit is manageable but as representative as possible of the broader data. The PIP team can provide further data on multiple reports of harm as required.	SE&I ASP team	2023
	Recommendation 2: The service aims to complete 85% of inter-agency referral discussions (IRDs) within five working days. However, IRD snapshots may include multiple reports of harm IRDs (MRH) which can lead to delays in the timescale being met due to the time taken to co-ordinate the availability of participants to conduct the face-to-face meetings required. ASP team and PIP to examine the current scale and consider ways in which this can be addressed (such as reviewing MRHs separately, for example).	SE&I ASP team	2023
Changes in referral trends in 2021/22 include a 30.2% rise in ASP referrals from NHS (+104), a notable increase from care inspectorate (+31) and continued rises from police and SAS. *(Section 4. Source of Referrals)*	Recommendation 3: As per ongoing 2021-23 ASP workplan, the ASP team will continue to strengthen links with all partners and raise awareness of the key ASP messages during the forthcoming year through development / implementation of a stakeholder engagement plan.	ASP team	Early 2023
	Recommendation 4: Audit and drug prevention activity from SAS were highlighted at ASPC in August 2022. Work is ongoing to further strengthen ASP links with SAS and reporting of harm.	ASP team SAS	2023

	Recommendation 5: SE&I group to continue to monitor the source of ASP referrals on a quarterly basis via analysis provided by the PIP team in the ASPC quarterly report.	SE&I PIP team	Quarterly
Later launch of LiquidLogic allows additional time for ROH recording practices to be evaluated / refined for more consistent / robust performance reporting moving forward. *(Section 5. Outcome of ASP Referrals)*	Recommendation 6: Continuation of working group and regular meetings between ASP team, PIP team, Social Work, Workforce Development and SWIFT replacement team to ensure that the LiquidLogic system can effectively record and report on counts, source and outcomes of ASP referrals.	ASP team PIP team SWIFT replacement team	As required

Key Finding and Report Section	Report Recommendation for Consideration	Lead	Required
Investigations reduced on last year to 375, similar to 2019/20 (385), which rose to 459 following data validation exercises. *(Section 6: ASP Investigations)*	Recommendation 7: ASP Team and PIP to investigate what data validation exercises were carried out during 2019/20 given the rise in investigations subsequently observed once this work had been carried out. Consider similar data validations for 2021/22. PIP team can provide data and analysis where appropriate.	ASP team PIP team	2023
16 nominals were the subject of multiple ASP investigations during 2021/22 (albeit decrease on last year). *(Section 6: ASP Investigations)*	Recommendation 8: SE&I interagency audit to consider including the 16 nominals who have been subject to multiple investigations during 2021/22 to evaluate if the partnership can strengthen its response to harm, particularly in relation to the support of adults under 65 years.	SE&I	2023
	Recommendation 9: ASP team leaders to consider routine review of cases and any procedural implications where multiple investigations are being undertaken.	ASP team	2023
The recording and extraction of ASP investigation data from LiquidLogic.	Recommendation 10: Continuation of working group and regular meetings between ASP team, PIP team, Social Work, Workforce Development and SWIFT replacement	ASP team PIP team	As required

(Section 7: Outcome of ASP Investigations)	team to ensure that the LiquidLogic system can effectively record and report on counts, outcomes and nominal demographics from ASP investigations.	SWIFT replacement team	
76.2% of case conferences completed by Adults teams in 2021/22 (74 of 97). *(Section 8: ASP Case Conferences)*	Recommendation 11: Social work service managers to continue to monitor the distribution of ASP investigations and case conferences and consider the resource implications, particularly in relation to the volume of case conferences undertaken by the Adults teams during 2021/22.	SW teams	2023
Recording of case conference information on Liquid Logic and for Scottish Government return and internal monitoring and reporting purposes. *(Section 8. ASP Case Conferences)*	Recommendation 12: Data on case conferences is currently gathered from team managers via Microsoft Forms due to difficulties in recording and extracting figures from SWIFT AIS. Ways to enable the consistent and accurate recording and extraction of case conferences on LiquidLogic should be considered as a priority to enable robust and timely data is easily available to facilitate regular performance monitoring and collation of statutory SG return.	ASP team PIP team SWIFT replacement team	2023
	Recommendation 13: ASP Team and PIP Team to compile concise guidance sheet for use by team managers about which information to record about case conferences for SG return. This can be used for training, will facilitate consistency of approach across teams, ensure data is directly comparable year-on-year and assist with LiquidLogic discussions. This should be accompanied by a simple table / spreadsheet to capture data required for internal performance and statutory reporting and saved in a centralised Sharepoint location to allow comparison between periods and facilitate regular updates from team managers. PIP team to compile timetable for completion and send reminders throughout the forthcoming year. Consider for use in the interim pending the launch of LiquidLogic.	ASP team PIP team	2023

Key Finding and Report Section	Report Recommendation for Consideration	Lead	Required
Recording of ASP Protection Orders. *(Section 9. ASP Protection Orders)*	Recommendation 14: Data on protection orders is currently gathered manually from team managers via Microsoft Forms due to difficulties extracting this information from SWIFT AIS (this data is currently recorded in profile notes which cannot easily be searched). Ways to enable the consistent and accurate recording and extraction of protection orders on LiquidLogic should be considered as a priority to enable robust and timely extraction to facilitate regular performance monitoring and statutory annual return.	ASP team PIP team SWIFT replacement team	2023
	Recommendation 15: ASP team and PIP team to compile concise guidance about what information to record on protection orders for the Scottish Government return along with a simple table / spreadsheet to capture all data required. This should be saved in a centralised Sharepoint location and used in the interim pending the launch of LiquidLogic (as per Recommendation 13).	ASP team PIP team	2023
	Recommendation 16: ASP team to continue work on processes, information gathering and the recording procedure in relation to protection orders due to consistently low figures.	ASP team	2023
Increase in volume of LSIs during 2021/22. *(Section 10. Large Scale Investigations (LSIs))*	Recommendation 17: Social work service managers to continue to monitor distribution of LSIs and consider resource implications, particularly in relation to the number of LSIs undertaken by OP teams during 2021/22.	ASP team	2023
Recording of LSIs. *(Section 10. Large Scale Investigations (LSIs))*	Recommendation 18: ASP team and PIP team to compile clear guidance on what LSI information is required for the Scottish Government and a table / spreadsheet to ensure consistency of approach across teams and on previous submissions (as per Recommendation 13). The lead should be taken from the Fife Interagency Guidance and Procedure for Large Scale Investigations of Adults at Risk of Harm (updated December 2021). The LSI review for 2020-22 is ongoing and has been added to the agenda of the next ASP managers meeting.	ASP team PIP team	2023

	Recommendation 19: Ways to enable the consistent and accurate recording and extraction of LSIs on LiquidLogic should be considered as a priority to allow robust and timely extraction to facilitate regular performance monitoring and statutory annual return to Scottish Government.	ASP team PIP team SWIFT replacement	2023
	Recommendation 20: ASP are considering the LSI package from Iriss to compile a learning resource for delivery and training on a multi-agency basis.	ASP team	2023

Key Finding and Report Section	Report Recommendation for Consideration	Lead	Required
Continued rise in the number of ASP investigations for self-harm (50 in 2019/20, 79 in 2020/21 to 84 in 2021/22). *(Section 12. Incident Information* *Section 12.1. Type of Harm)*	Recommendation 21: Learning and Development to consider the continued increase in investigations relating to self-harm and the current training and resources in place to support staff in providing effective and timely support.	L&D Group	2023
Variance in the types of harm investigated by age and client group. *(Section 12. Incident Information*	Recommendation 22: ASP team to consider the breakdown of client group and types of harm with a view to developing more targeted communication campaigns based on the analysis above.	ASP team	2023

Section 12.1. Type of Harm)			
Number of investigations where the location of harm was reported as a care home has further decreased and is very low as compared to the national average. *(Section 12. Incident Information* *Section 12.2. Location of Harm)*	Recommendation 23: Self-evaluation activity to scrutinise / investigate reasons for difference between number of investigations where location is a care home as compared to national average (ongoing).	ASP team	2023
Analysis of Fife annual ASP return for 2021/22 and other statistics for Scotland to provide comparison on national basis. *(Section 13. Concluding Remarks)*	Recommendation 24: PIP team to produce a report on Fife ASP return for 2021/22 as compared to national statistics for Scotland once data becomes available from the Scottish Government (anticipated late 2022).	PIP team	Late 2022 / early 2023

14. Reference Documents

This report should be considered in conjunction with the following additional reference documents, which outline strategies for the forthcoming period as well as ongoing workplans and partnership information (press Ctrl and right click on the link to access the documents).

Adult Support and Protection Committee Strategic Improvement Plan 2021-23

https://www.fife.gov.uk/__data/assets/word_doc/0031/176908/ASPC-Strategic-Improvement-Plan-2021-23-FINAL.docx

Adult Support and Protection Improvement Plan 2021-23

https://www.fife.gov.uk/__data/assets/pdf_file/0031/188086/ASPC-Vision-and-priorities-2021-23-1.pdf

Appendix 1: Summary Tables

Section A: Data on ASP Referrals

Question 1: Number of ASP referrals received

Summary of ASP Referrals	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Q1 (Apr to Jun)	375	510	757	725	644	810
Q2 (Jul to Sep)	427	502	659	757	822	668
Q3 (Oct to Dec)	410	588	671	730	687	691
Q4 (Jan to Mar)	453	800	623	755	645	750
TOTAL	1,665	2,400	2,710	2,967	2,798	2,919

Question 2: Source of principal referral

Source of ASP Referrals	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Mental Welfare Commission	0	0	0	0	0	0
Unpaid carer	0	0	0	0	0	0
Others	11	7	1	0	0	0
Healthcare Improvement Scotland	0	0	0	0	1	1
Other member of public	7	178	218	122	2	0
Office of Public Guardian	3	2	0	2	3	7
Care Inspectorate	15	31	0	7	11	42
Scottish Ambulance Service	3	3	0	3	29	38
Self (adult at risk of harm)	38	40	49	50	37	48
Scottish Fire & Rescue Service	77	74	63	69	57	44
Friend / neighbour	136	13	0	35	71	50
Anonymous	25	33	74	89	71	49
Council	272	343	194	193	137	119
GPs	45	64	131	180	138	117
Family	39	48	0	117	159	181

Social Work	216	258	293	310	238	245
NHS	229	365	322	411	344	448
Police	87	249	375	377	664	696
Other organisation	462	692	990	1,002	836	834
TOTAL	**1,665**	**2,400**	**2,710**	**2,967**	**2,798**	**2,919**

Section B: Data on Investigations

Question 3: Number of investigations commenced under the ASP Act

ASP Investigations	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Number of investigations	444	379	339	385	460	375

Question 4a: Number of investigations commenced by age and gender

Age Group	2019/20				2020/21				2021/22			
	Male	Female	Not Known	TOTAL	Male	Female	Not Known	TOTAL	Male	Female	Not Known	TOTAL
16 to 24	16	22	2	40	21	31	2	54	19	24	0	43
25 to 39	37	29	0	66	28	43	0	71	33	47	0	80
40 to 64	55	67	0	122	79	85	0	164	50	71	0	121
65 to 69	10	8	0	18	11	11	0	22	9	11	0	20
70 to 74	6	11	0	17	10	13	0	23	4	14	0	18
75 to 79	9	16	0	25	15	24	0	39	13	14	0	27
80 to 84	17	27	0	44	11	21	0	32	12	16	0	28
85+	17	36	0	53	16	38	0	54	9	29	0	38
Not known	0	0	0	0	0	1	0	1	0	0	0	0
TOTAL	167	216	2	385	191	267	2	460	149	226	0	375

Question 4b: Number of investigations commenced by age and ethnic group

Age Group	2019/20								2020/21								2021/22							
	White	Mixed or multiple ethnic groups	Asian, Asian Scottish or Asian British	African	Caribbean or Black	Other ethnic group	Not known	TOTAL	White	Mixed or multiple ethnic groups	Asian, Asian Scottish or Asian British	African	Caribbean or Black	Other ethnic group	Not known	TOTAL	White	Mixed or multiple ethnic groups	Asian, Asian Scottish or Asian British	African	Caribbean or Black	Other ethnic group	Not known	TOTAL
16 to 24	37	0	1	0	0	0	2	**40**	47	0	1	0	0	0	6	**54**	40	0	0	0	0	0	3	**43**
25 to 39	63	0	0	0	0	1	2	**66**	67	1	1	0	0	0	2	**71**	74	0	1	0	0	1	4	**80**
40 to 64	115	0	0	0	0	0	7	**122**	152	0	0	0	0	0	12	**164**	105	2	2	0	0	0	12	**121**
65 to 69	15	0	0	0	0	0	3	**18**	19	0	0	0	0	0	3	**22**	20	0	0	0	0	0	0	**20**
70 to 74	16	0	0	0	0	0	1	**17**	21	0	0	0	0	1	1	**23**	18	0	0	0	0	0	0	**18**
75 to 79	22	0	0	0	0	0	3	**25**	35	0	0	0	0	0	4	**39**	26	0	0	0	0	0	1	**27**
80 to 84	36	0	0	0	0	0	8	**44**	29	0	0	0	0	0	3	**32**	27	0	0	0	0	0	1	**28**
85+	48	0	1	0	0	0	4	**53**	52	0	1	0	0	0	1	**54**	33	0	0	0	0	0	5	**38**
Not known	0	0	0	0	0	0	0	**0**	0	0	0	0	0	0	1	**1**	0	0	0	0	0	0	0	**0**
TOTAL	**352**	**0**	**2**	**0**	**0**	**1**	**30**	**385**	**422**	**1**	**3**	**0**	**0**	**1**	**33**	**460**	**343**	**2**	**3**	**0**	**0**	**1**	**26**	**375**

Question 5: Number of investigations commenced by primary main client group

ASP Investigations by Client Group	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Dementia	157	101	3	10	11	4
Mental health problem	37	54	40	58	100	57
Learning disability	63	70	44	57	50	36
Physical disability	54	46	97	109	122	98
Infirmity due to age	49	48	47	53	57	49
Substance misuse	19	11	1	10	7	5
Other	65	49	107	88	113	126
TOTAL	**444**	**379**	**339**	**385**	**460**	**375**

Question 6: Type of principal harm which resulted in an investigation (as defined under the ASP Act)

ASP Investigations by Type of Harm	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Financial harm	68	91	52	97	117	76
Psychological harm	46	49	94	84	96	65
Physical harm	120	106	43	95	117	76
Sexual harm	20	19	29	17	19	24
Neglect	104	66	34	36	31	37
Self-harm	19	23	85	50	79	84
Other	67	25	2	6	1	13
TOTAL	**444**	**379**	**339**	**385**	**460**	**375**

Question 7: Location of principal harm which resulted in an investigation (as defined under the ASP Act)

ASP Investigations by Location of Harm	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Own home	264	246	226	227	285	208
Other private address	6	13	9	14	14	17
Care home	128	66	33	37	25	18
Sheltered / supported accommodation	17	5	9	7	15	4
Independent hospital	1	0	1	3	0	0
NHS	16	19	11	14	10	5

Day centre	1	5	0	1	0	1
Public place	9	20	27	16	16	23
Not known	2	5	23	66	95	99
TOTAL	**444**	**379**	**339**	**385**	**460**	**375**

Section C: Data on ASP Case Conferences and Protection Orders

Question 8: Number of cases subject to an ASP case conference

Type of ASP Case Conference	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Initial ASP case conference	29	44	59	58	84	63
Review ASP case conference	15	20	33	25	42	34
TOTAL	**44**	**64**	**92**	**83**	**126**	**97**

Question 9: Number of protection orders granted

No protection orders were granted between 1st April 2021 and 31st March 2022.

Section D: Data on ASP Large Scale Investigations (LSIs)

Question 10: Number of LSIs commenced

ASP Large Scale Investigations (LSIs)	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Number of LSIs	4	3	1	3	2	15

Section E: Data on Outcomes

Question 11: What happened to referrals received

Outcome of ASP Referrals	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Further Adult Protection action	610	1,398	1,825	2,103	2,272	2,560
Further non-AP action	301	332	242	256	130	90

No further action	713	610	560	518	342	206
Not recorded	41	60	83	90	54	63
TOTAL	1,665	2,400	2,710	2,967	2,798	2,919

Outcome of ASP Referrals (%)	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Further Adult Protection action	36.6%	58.3%	67.3%	70.9%	81.2%	87.7%
Further non-AP action	18.1%	13.8%	8.9%	8.6%	4.6%	3.1%
No further action	42.8%	25.4%	20.7%	17.5%	12.2%	7.1%
Not recorded	2.5%	2.5%	3.1%	3.0%	1.9%	2.2%

Question 12: What happened to investigations received

Outcome of ASP Investigations	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Further Adult Protection action	75	48	34	44	59	38
Further non-AP action	214	166	102	131	172	129
No further action	137	157	165	201	227	202
Not known / ongoing	18	8	38	9	2	6
TOTAL	444	379	339	385	460	375

Outcome of ASP Investigations (%)	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Further Adult Protection action	16.9%	12.7%	10.0%	11.4%	12.8%	10.1%
Further non-AP action	48.2%	43.8%	30.1%	34.0%	37.4%	34.4%
No further action	30.9%	41.4%	48.7%	52.2%	49.3%	53.9%
Not known / ongoing	4.1%	2.1%	11.2%	2.3%	0.4%	1.6%

Appendix 2-Updated Adult Support and Protection Competency Framework

Group A – Competences 1-5

Members of this group have a responsibility to contribute to Adult Support and Protection, but do not have specific organisational responsibility or statutory authority to intervene.

- All Support Staff in Health and Social Care
- Day service Staff
- Housing Staff
- Council Based Office Staff
- HR Staff
- Elected Members
- Volunteers
- Befrienders
- Charity Trustees
- Drivers, other transport staff

Staff Group B - Competences 1-12

This group have considerable professional and organisational responsibility for Adult Support and Protection. They have to be able to act on concerns and contribute appropriately to local and national policies, legislation and procedures. This group needs to work within an inter or multi-agency context.

- Social Workers
- Nurses
- Frontline Managers
- Team Managers
- Health and Social Care Providers Service Managers
- Senior Support Workers

Staff Group C - Competences 1-16

This Group is responsible for ensuring the management and delivery of Adult Support and Protection Services is effective and efficient. In addition they will have oversight of the development of systems, policies and procedures within their own organisations to facilitate good working partnerships with allied agencies to ensure consistency in approach and quality services.

- Operational Managers
- Senior Management
- Heads of Assessment and Care Managers
- Service Managers
- Senior Social Workers

Staff Group D - Competences 1-5 and 16-20

This Group is responsible in ensuring their organisation is, at all levels, fully committed to Safeguarding Adults and have in place appropriate systems and resources to support this work in an intra- and inter-agency context.

- Senior Leadership Team
- Chief Executive

Demonstrating Competence

To demonstrate competence staff should present a combination of evidence to their line managers. This could include formal training, completion of vocational/professional awards and work products. The line managers may wish to carry out a professional discussion, question / answer session with you in order to ensure competency in a specific area. A full list of suggested evidence can be found at the end of this document (appendix 2)

If you are required to demonstrate more than one set of competences, for example your current role is within both B and C - you may want to look at both of these competences as you should be able to cross reference your evidence for competences in other groups.

Staff Group A

All Staff to complete this section:

Competencies 1-5	Description	Evidence or Demonstration of Competence/Confidence in this area	Any development Required?	Review Date (minimum of 12 monthly)
1.	I understand that *"adult support and protection is everyone's business"*			
2.	I am able to recognise an adult potentially in need of Adult Support and Protection intervention and take action.			
3.	I understand how to make an ASP referral.			
4.	I understand dignity and respect when working with individuals.			
5.	I have knowledge of Fife Health and			

	Social Care Partnership's multi-agency ASP Procedures.			

Staff Signature …… Line Managers Signature ……..

Date ……..

Staff Group B & C to complete this section

Competence in working with people and delivering Safeguarding Services Competence

Competencies 6-12	Description	Evidence or Demonstration of Competence/Confidence in this area	Any development Required?	Review Date (minimum of 12 monthly)
6.	I have the required knowledge and skills to contribute fully to the Adult Support and Protection process.			
7.	I am aware of and can apply local policy and procedural frameworks when undertaking Adult Support and Protection Activity.			
8.	I ensure service users/carer's are supported appropriately to understand Adult Support and Protection issues.			
9.	I am able to distinguish between observation, facts, information and			

	opinion gained from others in gathering evidence with regard to ASP issues			
10.	I know and understand the legislative context of Adult Support and Protection i.e. Adults with Incapacity (Scotland) Act 2000 and Mental Health Care and Treatment (Scotland) Act 2003			
11.	I maintain accurate, complete and up to date records.			
12.	I am able to demonstrate the required level of skills and knowledge to undertake an Adult Support and Protection Investigation.			

Staff Signature …… Line Managers Signature ……..

Date ……..

Staff Group C (Need to complete B & A also)

Competence in Strategic Management and Leadership of Safeguarding Services

Competencies 13-16	Description	Evidence or Demonstration of Competence/Confidence in this area	Any development Required?	Review Date (minimum of 12 monthly)

13.	I actively engage in supporting a positive multi-agency approach to Adult Support and Protection work.			
14.	I support the development of robust internal systems to provide consistent, high quality Adult Support and Protection service.			
15.	I chair Adult Support and Protection meetings such as IRD discussions OR Case Conferences. (This only applies to Senior Practitioners or Team Managers who role involves chairing ASP meetings)			
16.	I ensure record systems are robust and fit for purpose.			

Staff Signature …….. Line Managers Signature ……..

Date ……..

Staff Group D (need to complete A also)

Competence in Strategic Management and Leadership of Safeguarding Services

Competencies 17-20	Description	Evidence or Demonstration of Competence/Confidence in this area	Any development Required?	Review Date (minimum of 12 monthly)
17.	I lead the development of effective policy and procedures for Adult Support and Protection services in my organisation.			
18.	I ensure plans and targets for Adult Support and Protection are embedded at a strategic level across the organisation.			
19.	I promote awareness of Adult Support and Protections systems within and outside my organisation.			
20.	I develop and maintain systems to ensure the involvement of service users in developing Adult Support and Protection services.			

Development of Competence-Appendix 1

Please make notes of how any competences that have not been demonstrated, can be evidenced in the foreseeable future and dates to when this will be assessed.

Competence:	Actions:	Target Date:
For example, I have knowledge of Fife's Health and Social Care Partnership's inter-agency ASP procedures	CB requires to broaden his understanding of Council Officer training. To attend CO training.	Within next 6 months.

Examples of Evidence to Support Competence Level-Appendix 2

<u>Suggested Evidence Group A</u>

- Clear understanding of their role in making an alert and an Adult Support and Protection referral.
- Clear understanding of their organisation's policy and procedures.
- Understand limits to confidentiality.
- Be able to define 'adult at risk of harm'.
- Know the different types of abuse and how to recognise indicators/signs.
- Contact emergency services where appropriate.
- Know how to make an alert and a referral.
- Know how to record appropriately.
- Value individuality and be non-judgmental.

- Be aware of how own values and attitudes influence understanding of situations.
- Understand how to 'whistleblow' using Local procedures.

Suggested Evidence Group B

- Responds to referrals within specified timescales.
- Identify and reduce potential and actual risks after an allegation of abuse has been made.
- Convene relevant ASP meetings such as IRD or Case Conference meetings as appropriate within specified time scales.
- Contribute effectively to all information sharing.
- Develop protective strategies for those who refuse services.
- Show a clear understanding of the thresholds and pathways for investigating in response to an Adult Support and Protection referral.
- Describe the purpose of a IRD Meeting and Case Conference.
- Describe the purpose of a Protection Plan.
- Use of appropriate forms and recording systems.
- Understand the use of legislation within Adult Support and Protection work including:-
  -Adult Support and Protection (Scotland) Act 2007
  -Mental Health Care and Treatment (Scotland) Act 2003
  -Adults with Incapacity (Scotland) Act 2000
- Recognise service users' rights to freedom of choice.
- Understand the impact that abuse can have on individuals.
- Provide information on local support services that may provide support.
- Provide written and verbal information on Adult Support and Protection processes.
- Demonstrate knowledge of gathering, evaluating and preserving evidence.

Suggested Evidence Group C

- Evidence of protection planning.
- Evidence of report writing.
- Evidence of multi-agency working.
- Explicit understanding of confidentiality and data protection issues
- Demonstrate a thorough knowledge and application of purpose, duties, tasks involved in Adult Support and Protection investigations.
- Plan and carry our agreed strategy to protect an adult from harm during and following an investigation.
- Understand the different roles and responsibilities of the different agencies involved in investigating allegations of harm.
- Demonstrate a clear understanding of Fife Health and Social Care Partnership multiagency policy and procedures.
- Ensure supervision is carried out regularly to support safeguarding activity.
- Ensure effective performance management systems are in place and implemented when poor Adult Support and Protection practice is identified.
- Ensure the workforce has the necessary skills and knowledge to carry our effective safeguarding activity.
- Chair relevant Adult Support and Protection meetings and conferences in line with local policy and procedures.
- Demonstrate effective systems are in place to maintain records including investigation reports, minutes and protection plans.

Suggested Evidence Group D

- Have a strategic understanding of the scope of Adult Support and Protection services across the organisation.
- Work in partnership with a range of key agencies to promote Adult Support and Protection Services.
- Promote the Fife Health and Social Care Partnership's Adult Support and Protection Committee work plan and key priorities.
- Effectively communicates a proactive approach to Adult Support and Protection within your organisation.
- Be able to account for your organisations Adult Support and Protection practice
- Ensure that internal audit systems are robust and meet the requirements for external scrutiny.
- Have a comprehensive knowledge of Care Inspectorate inspection findings and how these will be implemented to support service development in your organisation.
- Be aware of the findings from serious case reviews and any Adult Support and Protection implications for service delivery in your organisation.
- Identify systems and structures in place used to raise awareness of Adult Support and Protection locally.
- Evidence that service users, patients and carers are supported and involved in all aspects of activity, and that their feedback impacts upon service planning and delivery.

Appendix 3-Covering Letter as part of the ASPC's COVID Supermarket campaign

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Fife Adult Support & Protection Committee

Child and Adult Protection Committee Support Team

Police Headquarters

Detroit Road

Glenrothes

KY6 2RJ

Fife Child Protection Committee

To the Shop Manager

Dear Sir/Madam

I write to ask for your assistance to help Fife Child and Adult Protection Committees keep children and adults safe from harm during the current crisis.

The COVID- 19 outbreak and the current lockdown presents a variety of challenges to support children, young people and adults at risk of harm. The closure of schools and nurseries, day and drop-in centers, community hubs, libraries, banks and shops has resulted in people being behind closed doors, away from the people and services who might normally spot problems. We are asking everyone to keep their eyes and ears open for children and adults who may be at risk of harm, abuse or neglect during the COVID-19 crisis. During lockdown it's more important than ever to speak up if you see or hear something worrying about an adult or a child. This includes your staff, customers and delivery drivers, who can all have a part to play.

As part of our ongoing efforts to ensure that people know what harm is and how to report it, we have created the attached poster which details this information and shows the numbers to contact to talk about any concern you may have for both adult and child protection.

It would be appreciated if this poster can be displayed on your community noticeboard or near your shop entrance, so that we can continue to raise awareness of reporting methods and keep our communities safe from harm. I have enclosed an additional poster for display in staff areas and request that you make staff aware that any concerns they may see or hear about can be reported using the phonelines. If you are operating a delivery service, I would ask that you make your drivers aware.

If your staff, either within the shop environment or during deliveries see anything that gives them cause for concern, please assure them that it can be reported, confidentially if preferred, and that all concerns will be dealt with by Social Work and/or Police, handled sensitively and support provided if required.

I appreciate your assistance in this matter.

Yours faithfully

Alan Small

Independent Chair

Fife Child Protection Committee

Chair Alan Small **Lead Officer** Amanda Law

"child protection is everyone's job ….it's our job"

www.fifechildprotection.org.uk

Appendix 4- Communication and Stakeholder Engagement Action Plan

How will we communicate and engage with stakeholders?	Timescale	Responsibility	Measuring Impact
Seasonal ASPC SWAYs (one for the public, another for professionals) Winter 2022 SWAY will focus on "Staying Safe and Keeping Well"	Quarterly	ASPC	Feedback received (annual survey and ongoing) re the bulletin, and items for inclusion
Evaluate ASPC Webpage, and make any necessary recommendations for improvement	January 2022	ASP Team	Website analytics/Visits to site
Harm Awareness Raising Campaigns via SWAY to be provided for joint audience of public and professionals.	Monthly	Learning and Development Group	Increased referrals from members of the public Number of visits to SWAY page
Radio Campaigns	Quarterly	ASP Team, Kingdom FM Radio	Post Campaign Analysis fed back each quarter
Annual Adult Support and Protection Day	February	ASPC	Increased referrals from members of the public
Easy Read Resources/ Review resources for carers and families of adults at risk of harm, produce glossary of resources	March 2022	ASP Team	Feedback received from public and professionals
Inter-agency Guidance and Protocols - This is targeted work to strengthen links and ensure effective pathways of support for a workforce confident in ASP practices.	January 2022, to be updated as necessary	ASP Team	Feedback received from partner agencies as part of annual review of inter-agency guidance and protocol.
Professional updates to be provided relating to what the ASPC has achieved over the last quarter and will work towards over the next quarter	Quarterly	ASPC	ASPC to respond to this feedback in order to improve practice.
Practitioners Forum events	Quarterly	ASP, Learning and Development Group	Appropriate response – as measured by SE+I

			Group Performance Framework Numbers in attendance
ASP Bitesize Awareness Sessions	Last quarter of 2022	ASP Team, Engagement and Participation Co-Ordinator	Feedback from those involved
Service User Engagement Sessions - Consideration to be given to engaging with minority groups and those with specific language requirements, for example, BSL.	Ongoing	ASP Team, QA Officer, SW Teams	Feedback from those affected – Collected by front-line staff, Advocacy (including via website), QA Officer (Post-intervention questionnaire), wider partners, etc
Care Home Awareness Raising Sessions	Annual programme of engagement opportunities to be developed to help improve staff awareness: - Awareness-raising sessions with specific care home partners (via Teams or in person) - Multi agency awareness-raising sessions, eg with third sector partners (via Teams or in person)	ASP Team, Learning and Development Group	Appropriate response – as measured by Performance Framework, Numbers attending sessions across partners

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**5 May 2023**
Title:	**Radiation Protection Annual Report**
Responsible Executive:	**Dr Christopher McKenna Medical Director**
Report Author:	**Jane Anderson, Head of Radiology**

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Legal requirement
- Local policy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

NHS Fife is required to produce a Radiation Protection Annual Report as a function of good clinical governance. The report gives the committee assurance of the activity undertaken by the IR(ME)R Board and the Radiation Protection Committee.

2.2 Background

Fife is legally required to meet the safety requirements of the Ionising Radiation (Medical Exposure) Regulations IM(ME)R. This is achieved through the establishment of general procedures, protocols and assurance programmes and clinical audit. Assurance of the safety and effectiveness of this work is given via the above meetings chaired by the Medical Director.

2.3 Assessment

The report summarises the audit activity, policy and procedure updates and training. There is also a requirement to report all radiation incidents and near misses. NHS Fife has a

positive reporting culture and learns from all incidents. 5 Incidents were reported to HIS in 2022. Additional detail in the report relates to MRI and laser safety.

2.3.1 Quality / Patient Care

The report gives assurance to the commitment NHS Fife has to patient and staff safety with respect to the exposure to ionising radiation, nuclear medicine, MRI and lasers.

2.3.2 Workforce

The challenges around workforce in radiology are well rehearsed however, there have been two radiologists appointed recently.

2.3.3 Financial

Nil.

2.3.4 Risk Assessment / Management

No concerns raised within the report.

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

N/A

2.3.6 Climate Emergency & Sustainability Impact

N/A

2.3.7 Communication, involvement, engagement and consultation

N/A

2.3.8 Route to the Meeting

This report comes direct to the Clinical Governance Committee.

2.4 Recommendation

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

3 List of appendices

- Appendix No. 1, Radiation Protection Annual Report

Report Contact
Christopher.mckenna@nhs.scot
Jane.anderson2@nhs.scot

Radiation Protection Annual Report
April 2023

1. Introduction

The IR(ME)R Board covering IR(ME)R 2017 compliance and the Radiation Protection Committee covering all other aspects of Radiation safety are both chaired by the Medical Director for NHS Fife and have met in line with its agreed role and remit. Minutes of these meetings are included in the appendix. IR(ME)R Board was held on 24/05/2022 and the Radiation Protection Committee on 02/03/2022 and 31/08/2022.

2. Radiation Protection Advisers (RPA) reports

The Committee has received reports from the nominated Radiation Protection Advisers.

The highlights from these reports are as follows

- **Staff Dose report**
  - Staff doses appear to be well controlled in NHS Fife, indicating good working practices and appropriate use of PPE.
  - It is recommended that the following accounts move to quarterly dose monitoring: QMH, VHK assistants (VH2), VHK Cardiology (VH6) and VHK Main department (VH1)

- **RISK ASSESSMENTS**
  - Radiation risk assessments have been reviewed and updated and will be distributed across all services shortly. No issues have been identified.
  - All pregnant staff risk assessments are up to date, robust procedures are in place for identifying staff that require a RA

- **PPE**
  - All personal protective equipment is properly maintained and tested at regular intervals.

- **TRAINING**
  - CPD talks were arranged over several months between summer and autumn 2022 on a number of topics: Radiation Incidents, Environmental Monitoring, PPE, Personal Dose Monitoring, Dose Audits and DRLs. These were delivered over Teams and recorded and made available for staff unable to attend the live training.
  - There is a requirement under IRR17 for regular update training to be carried out which covers the following:

a. IRR17
b. Basic Radiation Physics
c. Biological Effects and Radiation Risk

  - A Scotland-wide approach to this has been taken and three TURAS modules developed which can be taken by any staff with a planned repeat rate of every three years. All radiographers and radiologists now complete these as part of their mandatory training every three years.

- All areas have appointed RPSs.

- IR(ME)R Updates -
  - The employer's procedure was updated to detail that a verbal request for fluoroscopic imaging can be made to the IR(ME)R operator and the IR(ME)R operator can add the electronic referral on behalf of the referrer.
  - The employers' procedures will be updated to reflect inclusive pregnancy check.
  - Most recent Clinical Audit forms show compliance to the regulations and a new process is in place to re-audit this year.

3. Radiation Incidents 2022

- **Radiation Incidents and Near Misses**

  - There were 150 radiation incidents reported in NHS Fife in 2022, with 5 Notifiable incidents. This is comparable with previous records.
  - The detailed RPA report demonstrates a positive reporting culture in NHS Fife.

4. Staffing

All staff competencies are up to date.

There remains a national shortage of Radiologists which is compounded by an increasing workload.

5. Nuclear Medicine

The ARSAC license is due for renewal February 2024.

6. SEPA

Single permit issued by SEPA would need to be amended if the service is extended to include DAT scanning. This will be considered within the business case for service development.

7. RADIATION EQUIPMENT

- Inventory of equipment up to date and all equipment requiring replacement has been escalated through the capital equipment replacement programme with supporting SBARs.
- All faults/downtime is recorded on datix.

Radiology Equipment Replacement 2022/23

The following equipment has been replaced / purchased since the last report:

- Fuji DR X-ray rooms – QMH rooms 1, 2 and 4, SACH, FEOC and VHK room 9
- QMH Fluoroscopy room 6
- VHK CT phase 3
- VHK CT phase 2

All equipment is under service contract and maintained by the respective manufacturers or alternative under contract with NSS to their specification.

8. X-ray Local Rules

- A review of the local rules in in progress.
- Radiation protection have been completing RPS reviews across all areas to review the status and the documentation will be updated in due course.

9. MRI safety

MRI site safety audits were performed for both VHK and QMH MRI departments on the 4th of February 2022. Overall, the sites show excellent compliance with the MHRA guidelines and best safety practice and the MR Lead Radiographer and the team should be commended.

There were 4 incidents recorded in the period 1/10/2020 to 30/9/2021, all of which related to undeclared passive implanted devices (3 aortic valve replacements, 1 aneurysm clips). These were only identified at final

screening when the patient attended the department, leading to a delay in the patient pathway. The MR Responsible Person sent a letter to the referrers in question highlighting the error and additionally pointing them to the TURAS MRI Safety for Referrers module. An organisation wide communication was sent with a quick guide for referrers to improve awareness and minimise risk

9. Laser Safety

- There are currently 9 lasers within NHS Fife; five at QMH (4 theatres, 1 ophthalmology) and four at VHK (2 theatres, 1 oral surgery and 1 ophthalmology). Laser safety is overseen by five Laser Protection Supervisors across the three areas.
- QMH theatres procured a new urology laser in March 2023. A new laser ENT service is currently being set up at VHK. The service will use the CO_2 laser currently used in Oral Surgery.
- The laser safety review of the Oral Surgery CO_2 laser (Jan 23) demonstrated that laser safety is well managed, particularly with regards to laser documentation and staff training. There were a few recommendations relating to recording performance of laser safety checks.
- There have been no laser incidents reported to the LPA in the last year. Queries have been raised by laser operators regarding the laser protective eyewear for the Holmium:YAG urology laser. It continues to be the view of the LPA, and NHS Fife policy that all persons present in an area where Class 3B or 4 lasers are used must wear the protective eyewear they are provided with.

10 Recommendation

The Committee is asked to **note** the contents of the Radiation Annual report.

Appendices

2. IRMER BOARD MINUTES 24 MAY 20

MINUTES RPC 2 MARCH 2022.docx

MINUTES RPC 31 AUGUST 2022.docx

AREA MEDICAL COMMITTEE

(Meeting on 14 February 2023)

No issues were raised for escalation to the Clinical Governance Committee.

Area Medical Committee

UNCONFIRMED NOTE OF THE AREA MEDICAL COMMITTEE (AMC) HELD ON TUESDAY 14 FEBRUARY 2023 VIA MS TEAMS

Present:

Chris McKenna (Chair)	Medical Director
Phil Duthie	Associate Clinical Director H&SCP
Ian Fairbairn	Clinical Director Emergency Care
Susanna Galea Singer	Clinical Lead for Addiction Services & Clinical Innovation
Helen Hellewell	Deputy Medical Director, H&SCP
Fiona Henderson	Fife LMC Honorary Secretary
Iain MacLeod	Deputy Medical Director, ASD
Glyn McCrickard	Fife LMC Representative
Susie Mitchell	Fife LMC Chair
John Morrice	Associate Medical Director Women & Children & Clinical Services
Robert Thomson	Clinical Director for Planned Care

In Attendance:

Catriona Dziech (Notes)	Executive Assistant to Medical Director

1 APOLOGIES FOR ABSENCE

Caroline Bates, Marie Boilson, Claire McIntosh, Sally McCormack, Phil Walmsley

2 DECLARATIONS OF MEMBERS' INTERESTS

There were no declarations of interest.

3 MINUTES OF PREVIOUS MEETING HELD ON 13 DECEMBER 2022

The notes of the meeting held on 13 December 20022 were approved.

4 MATTERS ARISING

i) Revised Constitution – Requirements for AMC in Statute

Item to be removed.

ii) Report from High-Risk Pain Medicine Group
(*emailed Ben 24.01.2023 for a rep)*

Updated to follow.

iii) Update from Realistic Medicine Team

Realistic Medicine Team will attend a future meeting to provide an update.

iv) Circulars PCS (DD) 2022/02 & 03 re new SAS Doctor Contract issued 24 January 2023 – re-issued 24.01.2023
Circular on Pension Re-cycling to be issued to the Committee.
Post meeting Dr McKenna advised Circular out of date – no action taken.

5 STANDING ITEMS

i) Financial Position
Dr McKenna advised the financial position has not changed and remains extremely challenging.

Following Maxine Michie's update at the last meeting it was agreed it would be helpful if she attended twice a year to give a detailed financial update. Once at the end of the current year and then again at the start of the next financial year to set out the scene for the year ahead.

ii) Medicines
Dr McKenna advised there was discussion at ADTC regarding the day-to-day issues for GPs with medicines access and shortages. The challenge to Pharmacy is how to make this easier for patients and GPs to deal with. Dr Mitchell advised pharmacy colleagues to have been very helpful with sourcing out of stock/supply items which lessens the workload for GPs.

Dr Henderson raised the issue of branded versus generic prescriptions where sometimes the savings are small. Dr McKenna highlighted due to good governance the GP prescribing budget was underspent.

iii) Adverse Events Update – considered at the Clinical Governance Oversight Group
Dr McKenna advised the Clinical Governance Oversight Group had signed off the new Adverse Events Policy.

Due to the rising number of cardiac arrests a robust action plan is in place. Gavin Simpson's previous work will be resurrected to take this forward over the next few months.

With regards to Respect, it was agreed work was required to provide assurance before it is integrated into the system. Updates will be brought back to future meetings of the Committee in due course. Dr McKenna suggested the Respect project should be kept in a state of assessment until other digital projects are completed.

iv) Medical Staff Committee
Nothing to report.

v) Update from GP Sub Committee
Dr Mitchell advised general practice are not in a good place and are looking to refresh the GMS Implementation Group to try and consolidate the new contract. Recruitment also remains a concern.

There are challenges dealing with the winter pressures. Plans are also in place to refresh the shared care protocol to have a single protocol for each drug rather than per speciality to help streamline and support the work in secondary care.

Dr McKenna acknowledged there was a real challenge in General Practice. The Board's capacity to take back Practices is also a challenge but there is a proactive programme to address 2C Practices. The three 2Cs are out to tender. The team are also working closely with Practices who have intimated they are struggling. The Board are aware of the issues as there is regular reporting in to EDG via Nicky Connor and her team.

Dr Hellewell advised significant work is being undertaken to encourage practices to come forward sooner and express their concerns to see what help could be offered.

Dr Mckenna advised the Deputy Chief Medical Officers had recently visited Fife. The visit began in Methilhaven Surgery as an example of the challenges faced in general practice. The visit then went to A&E at VHK and on to QMH Day Surgery Unit, Ophthalmology Theatres then to an AWI Community Ward. This ward holds patients who are in long term delay waiting on decisions being made about their long-term care which cannot be made until such time as they have Guardianship addressed. This was to highlight this was not an appropriate setting for these patients.

Throughout the visit it was made clear the significant challenges being faced around workforce issues, realistic medicine, pensions and reigniting the conversation with public around DNCPR.

vi) Realistic Medicine

Realistic Medicine team will attend a future meeting to provide an update.

vii) Medical Workforce

Dr McKenna highlighted the significant medical staffing issues in Adult Mental Health at QMH. A paper is being prepared by the Management Team within the H&SCP setting out a plan for the way forward. There is a concern around the costs associated with use of Agency Locums within Psychiatry.

The Associate Medical Directors for Mental Health have written to the Speciality Advisor for the CMO asking the- SGHD to review what is acceptable and what is routine so that they can prioritise their work.

It was also noted Dr Marie Boilson will be leaving to return to Ireland so there will be new leadership within this Team.

Susanne Galea Singer advised SGHD are pushing for more performance measures around Mental Health and Addictions.

On a positive note Dr McKenna advised there were newly recruited Clinical Directors in Acute who will strengthen medical leadership within the organisation; Dr Robert Thomson, Dr Caroline Bates and Dr Keith Morris.

In terms of Acute there has been successful recruitment of two Radiologists. Both candidates had rotated and trained in Fife and enjoyed working in Fife.

Iain Fairbairn advised Neurology and Cardiology have also successfully recruited recently. Three are three new substantive consultants in ED. Dr McKenna said ED should be celebrated as they have turned things around and built a strong team. A note of thanks should also be acknowledged and recorded to Julie Thomson for her hard work as Clinical Lead.

Dr Hellewell highlighted also within the H&SCP there were challenges within the Sir George Sharp Unit and Rheumatology. MOE is also challenging across Community and Acute.

viii) Education & Training

Dr McKenna and Professor Wood met to discuss becoming a teaching Health Board supporting the University of St Andrews in developing its second primary medical qualification medical school.

6 STRATEGIC ITEMS

i) Update from Health & Well Being Portfolio Board

Dr McKenna advised the Population Health and Well Being strategy is almost ready.

ii) GMS Implementation

No update other than previously discussed.

7 ITEMS FOR INFORMATION

i) Notes of the GP Sub Committee held on: 18 October 2022 & 20 December 2022

Noted

ii) Notes of the Clinical Governance Oversight Group: 18 October 2022

Noted

iii) Notes of NHS Fife Area Drugs & Therapeutics Committee: 7 December 2022

Noted

8 AOCB

i) **Updated Membership List**

Noted.

Dr McKenna closed the meeting by asking members to advise him if there were any specific items, they may wish to discuss at future meetings.

9 DATE OF NEXT MEETING
Tuesday 11 April 2023 at 2pm via MS Teams

AREA RADIATION PROTECTION COMMITTEE

(Meeting on 31 August 2022)

No issues were raised for escalation to the Clinical Governance Committee.

Area Radiation Protection Committee

MINUTES OF THE RADIATION PROTECTION COMMITTEE HELD ON WEDNESDAY 31ST AUGUST 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
Dawn Adams (DA)	Clinical Director, Public Dental Service
Nick Weir (NW)	Head of Imaging Physics
Laura Cluny (LC)	Nuclear Medicine Physicist
Megan van Loon (MVL)	Principal Clinical Scientist, Medical Physics
Sally McCormack (SMC)	Clinical Director ECD
Clare Parry (CP)	Medical Physicist
Simon Willis (SW)	Radiation Protection Adviser & Radioactive Waste Adviser
Nick Weir (NW)	Head of Imaging Physics
Nicola Spark (NS)	SCN Theatres
Gillian McNaught (GMN)	Principal Physicist (Modality lead MRI)
Blair Johnston (BJ)	Principal Physicist (MRI)
Katharine Jamieson (KJ)	Clinical Lead, Radiology
Debbie Slidders (SL)	Dental Therapy and Programme Manager
David Pirie (DP)	MRI Lead Radiographer

Apologies:

Tom Hartley (TH)	Clinical Lead – Radiology - (Katharine Jamieson deputising)
Victoria Bassett-Smith (VBS)	Head of Nuclear Medicine Physics – (Laura Cluny deputising)

NO	HEADING	ATTACHED	ACTION

1. APOLOGIES FOR ABSENCE

As noted above

2. Minute of Meeting Held On 02/03/2022

BJ – Clarification – item 7a – the patient was **un**aware that the phone was in their pillow.

4. Annual Adviser Reports

a. LPA (MvL) — NMD

i. Please see the relevant report in Files section of the Team.

ii. A proposal to spin out the laser safety policy into a separate document was agreed by the committee. MvL intends to raise this at the NHSL committee also.

NW – doing this for MRI would also be sensible.

b. RPA (NMD)

i. Please see the relevant report in Files section of the Team.

ii. CMK – will there be a "lessons learned" session carried out as a result of experiences with the fife orthopaedic centre? This would be useful for other centres to be built. NMD to email JA about this. **NMD**

c. RWA (SW)

i. Please see the relevant report in Files section of the Team.

d. MRSE (NW/BJ)

i. Please see the relevant report and the Safety Policy document in the Files section of the Team.

iii. There was an incident at the end of May involving out of hours access for the Fire Service to a MR controlled area. The investigation by MR safety staff concluded that this was done appropriately and safely. BJ expressed his thanks to the team involved on the day of the incident. BJ to contact JA offline about the healthy volunteer paper and safety training policy. **BJ**

iv. NW – MRI safety training policy has been approved by the NHSL MR safety committee and adopted within the NHSL markings to NHSF. See iii for the action.

5. HSE Consent Applications (SW)

a. Please see the relevant report document in the Files section of the Team.

b. A large number of consents are expected nationwide, but only one for NHSF. A visit from HSE will also be required. Unclear when this will happen, but 28 days' notice will be given.

6. Classification of NM Workers – Update (NMD) – 45:21

a. Please see the relevant report in Files section of the Team.

b. No staff within NM currently receive significant doses, but calculations from areas across Scotland show potential for significant doses in case of accident. Risk assessments and calculations need to be appropriate to cover this. A small financial commitment will be required from NHSF to classify workers when required. Several boards have begun classifying radiopharmacy staff and working from there. Awaiting access to software used to calculate doses. **JA**

c. JA – DR Blair in occupational health would need notified of this change.

d. CMK – this should be taken to HR (Rona Waugh) before occupational health.

7. Radiation Incidents Q1 and Q2 (CP)

a. Please see the relevant report in Files section of the Team.

b. Majority of incidents are repeat exposures. No notifiable incidents in last two quarters.

8. AOCB

Emergency Preparedness /RMU (SW)

i. Lothian was recently involved in a STACK exercise in case of an incident at Torness Power Station. There is an expectation for Fife emergency departments to have protocols in place to deal with such an incident.

ii. Who would be the most suitable teams to speak to about this? – CMK – A&E Lead (Julie Thomson); Public Health (Joy Tomlinson (Director).

b. Artificial Optical Radiations Directive Compliance (NMD)

i. New regulations were brought in, in 2010 for artificial optical radiation, including blue light phototherapy. Hoping to carry out an amnesty to find relevant devices within Fife and Lothian, most likely below £5k in value. This includes equipment used to treat jaundiced babies at home and UV boxes for hygiene checks.

ii. CMK – Iain Forrest if the contact for NHSF Medical Physics. Vein finders are likely to fall under this. NMD to email MP about this. **NMD**

9. DATE AND TIME OF NEXT MEETING

March 2023 TBA/TBC

NHS FIFE CANCER GOVERNANCE & STRATEGY GROUP (Meeting on 30 March 2023)
No issues were raised for escalation to the Clinical Governance Committee.

NHS Fife Cancer Governance & Strategy Group

NHS FIFE CANCER GOVERNANCE & STRATEGY GROUP (CGSG)

Unconfirmed Note of the Meeting Held at 14:00 on Thursday 30th March 2023 via Microsoft Teams

Present:	**Designation:**
Susan Fraser (SF)	Associate Director of Planning & Performance
Nick Haldane (NH)	Lead Cancer GP
Ben Hannan (BH)	Director of Pharmacy & Medicines
Murdina MacDonald (MM)	Lead Cancer Nurse
Rishma Maini (RM)	Consultant - Public Health
Chris McKenna (CM) Chair	Medical Director
Kathy Nicoll (KN)	Cancer Transformation Manager
Frances Quirk (FQ)	Assistant Director Research, Development & Innovation
Nicola Robertson (NR)	Associate Director of Nursing, NHS Fife
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
Joanna Bowden (JB)	Consultant – Palliative Care
Nicky Connor (NC)	Director Health and Social Care
Izzy Corbain (IC)	Patient Representative
Claire Dobson (CD)	Director of Acute Services
Fiona Forrest (FF)	Deputy Director of Pharmacy
Alistair Graham (AG)	Associate Director Digital and Information
Janette Keenan (JK)	Director of Nursing
Jennifer Leiper (JL)	Patient Representative
Neil McCormick (NM)	Director of Property and Asset Management
Margo McGurk (MMcG)	Director of Finance and Strategy
John Robertson (JR)	Lead Cancer Clinician - Surgery
Amanda Wong (AW)	Associate Director of Allied Health Professions
In Attendance:	**Designation**
Rebecca Hands (RH)	Clinical Governance Administrator (minute taker)
Devesh Dhasmana (DD)	Consultant – Respiratory Medicine

		Action
	Welcome	
	CM 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 13 January 2023 via Microsoft Teams**	
	The Unconfirmed Note of 13 January 2023 was **accepted** as an accurate record.	
3.	**Action Log**	

		Action
	020622#1 – This action is around a paper that BH brought to the cancer ops group in relation to the letter in regard to the National Oncology Taskforce. CD provided the paper. This has been brought to the group for information. Action to be closed. 041122#6 – Meeting has been set up. CM asked that this meeting get brought forward. BH is chairing the Acute Cancer Services Delivery Group next week and will establish with KN what needs to be done and for when. BH advised they will then liaise with CM and CD. 041122#8 – KN has emailed CD with the other cancer sites and what their current processes are. KN will bring this back to the next meeting.	**BH/KN** **KN**
4.	**GOVERNANCE**	
4.1	**Acute Cancer Services Delivery Group Update**	
	BH advised they are now meeting monthly and are making good progress and understanding in their operations. Some of the items discussed at the last meeting were: • Overview of cancer high risks • CEL 30 • Effective Cancer Management Framework • Effective Breach Analysis SOP • Cancer Waiting Times BH advised that the group has been instrumental in overseeing the return of systemic cancer therapy delivery from QMH to VHK in line with pre pandemic arrangements. It has been going well, only a few teething issues.	
4.2	**Cancer Risks**	
	BH advised the risks are being monitored appropriately. BH advised an SBAR was sent out with the papers and advised the group to read over the SBAR. The number of risks being reported is unchanged (11). Updates are as follows: • Risk 43 - Vascular access for Haematology/Oncology: As requested on 4 November 2022, the wording of the risk has been amended. • Corporate Risk 2297 - Cancer Waiting Times: It was previously proposed to the Group, that the risk description should be expanded to include the 31 day standard due to current removal of waiting times adjustments for social isolation, and also to include robotic prostatectomy, which has been recently repatriated from NHS Lothian and is now a NHS Fife service. This proposal was accepted by the Finance, Performance & Resources Committee on	

		Action
	17 January 2023 and reported to Fife NHS Board on 31 January 2023. Risk Rating and Level: There have been no changes to risk ratings or levels i.e. movement in terms of improvement or deterioration since the last report. Closed Risks: No risks have been closed since the last report. New Risks: No new risks have been identified since the last report.	
4.3	**Cancer Framework Risks**	
	SAS advised they now have a list of the risks. SAS and KN met to look at scoring and the management actions around those risks. This work is underway and will be brought back for consideration.	
4.4	**Terms of Reference Review – CGSG**	
	SAS advised this has been brought to the group for its yearly review and there is a copy in with the papers. CM advised they should invite a realistic medicine lead to join this group. CM asked if there was something in the Terms of Reference about overseeing the work plan for the framework. SAS advised it states this in section 1.1 This is to be reflected in 5.1. CM advised after SAS makes the minor changes they are suitable for another year.	**SAS** **SAS**
4.5	**Terms of Reference Update – Cancer Leadership Team**	
	KN advised as the Cancer Framework has now been written, they have reviewed the Cancer Leadership Team Terms of Reference. These have been updated to reflect our remit: • To ensure the framework remains relevant. • To review and update the Cancer Framework and Delivery Plan, monitoring actions. • To ensure processes are in place to deliver access targets. • Assure the Cancer Governance and Strategy Group that appropriate governance mechanisms are in place, escalating where appropriate. The group approved the revised Terms of Reference.	
5.	**STRATEGY/PLANNING**	
5.1	**Cancer Framework Launch**	
	CM advised the framework went to the board for assurance. CM advised	

		Action
	this framework was very well received. SAS advised they plan to launch it through Blink and they will go back out with a questionnaire for next year's action plan.	
5.2	**Projects Update**	
	Community Pharmacy BH advised they have a short life working group commencing in April. BH advised it has been difficult to get traction due to circumstances out width their control but has been assured this will be rectified. There is prep work ongoing in regard to pathways. BH hopes to bring back a visual paper on what this will look like in May. *RCDS Expansion* MM advised that within RCDS they have received 1400 referrals. 934 of these referrals have met the criteria. Cancer is diagnosed in 12.3% of the patients and 36% of the patients are referred onto a significant benign pathology pathway. The most common malignancies detected are; • Lung (24) • Upper GI and HPB (18) • Colorectal (14) They have also diagnosed some haematology cancers; • Lymphoma (9) • Melanoma (5) • Leukaemia (5) The top 3 specialities for the benign pathways who receive referrals for onward investigation are; • Endoscopy • Radiology • Respiratory The top 4 leading symptoms for referral are; • Weight loss • Abdominal pain • Abnormal bowel habits • Nausea A SBAR was submitted to the Planned Care Directorate looking at lifestyle medicine to do a test of change. The trial has been approved by the directorate. The directorate will take this to the Senior Leadership Team.	

		Action
	Concerns were raised regarding where this would sit out with the pilot. CM queried using resource that is intended to be used towards cancer patients and targeting it towards patients who do not have cancer and asked why it is being used for patients who should be pointed elsewhere. MM advised they were testing the concept only in RCDS and if the concept works, they will then scale that up to the site specific cancers. RCDS is not just about confirmed cancer, it is also about excluding cancer. If there is no management plan for symptomatic patients, the aim is to help the patient manage their condition. In January they started a GI test of change. To date they have received 170 referrals. Of those who completed their pathway, 53% were male and 47% were female. The top 4 leading symptoms for referral were: • Dysplasia • Pain • Weight loss • Dyspepsia Since they started in January they have diagnosed 8 cancers; • Stomach (1) • Lung (1) • HPB (3) • OG (3) The conversion rate to cancer in the test of change is 12.1%. They have taken some learning from this test of change. *Pathways Review* Optimal Lung Cancer Pathway: The project team continues to review processes within the diagnostic phase of the pathway. Some cost neutral changes have been made to improve waits between steps such as same day/next day CXR and introduction of enhanced vetting. They are looking to swap around days of investigations and clinics to avoid delay to MDT discussion. These improvements have reduced: ○ The start of the pathway by 10-14 days (pre referral) ○ 1 day reduction on vetting ○ Save a potential 7 days by changing the days of clinics (aim for earlier MDT discussion) A bid has been put forward to support implementation of the pathway. They had a meeting with Scottish Government last week to go through the bid and Scottish Government have partially supported the ask. The bid need to be tweaked and will be sent back this week for final review.	

		Action
	○ 0.5wte Consultant/Project Lead ○ 0.5wte Single Point of Contact Pathway Navigator ○ 0.5wte Lung Service Pathway Navigator ○ 0.4wte Admin support for Radiology – for administration of same day CXR, etc ○ Funding to support outsourcing for same day CT reporting Unfortunately funding is non-recurring therefore focus will be on set up and implementation of an improved pathway with an exit strategy (TBC) in place should recurring funding not be possible. We should receive confirmation regarding the funding shortly. CM advised that they need to have some sort of policy about CXR so staff know what to expect. KN to speak to someone from Radiology regarding this. Prostate Improvement Pathway: Good progress is being made on the prostate pathway. They have already made small changes to improve the pathway: ○ They are updating SCI Gateway to include referral guidance notes. Digital and Information colleagues have produced a draft page which will be reviewed with a GP lead prior to next steps. The aim of this is to improve the quality of referrals being received from Primary Care. ○ The way oncology appointments are being managed has been changed to release capacity. ○ Prescribing hormones at point of appointment has reduced waits to treatment. The CRUK nurse-led model from referral to MDT will be the biggest change that is being made in the pathway. The planned go live date for this is May 2023 and work has started on the implementation phase	**KN**
6.	**FUNDING**	
6.1	**Funding Update**	
	KN advised they have been told to expect CWT funding, similar to last year (£682k) on a non-recurring basis again, however, they are looking to make this funding on a recurring basis and have said this may be from next year. RCDS funding for Fife for 23/24 has already been confirmed. It is expected that head and neck will become the next optimal pathway to be published and this will come with associated investment.	

		Action
7.	**QUALITY/PERFORMANCE**	
7.1	**Cancer Waiting Times**	
	KN advised that across Scotland USoC referrals remain 33% higher than pre covid levels. The Q4 2022 publication is not due to be published until 7 April. Quarter 4: • 62 day we achieved 72.6%. There were a total of 62 breaches with 45 (73%) of them in urology. • For 31 day we just missed the target with 94.8%. There were 18 breaches and all of them were in urology. Quarter 1: • Performance deteriorated for both standards. • 62 day 68.7%. There was a total 71 breaches with 48 (68%) of them being in urology. • We did not meet the 31 day standard again achieving 91.9%. There were 28 breaches. 75% of the breaches were in urology (21 breaches). Across the two quarters, the tolerance of breaches is 11 for 62 day and 17 for 31 day. BH advised they will put CWT in regard to prostate on the agenda for the Acute Cancer Services Delivery Group to discuss the improvement gaps. BH will liaise with CD around what is required. CM advised it would be helpful to see it laid out in a paper. BH advised he can provide a paper at the next meeting.	**BH** **BH**
7.2	**Quality Performance Indicators**	
7.2.1	**Lung 2020**	
	DD went through the papers that were shared with the group. Case ascertainment for NHS Fife is **82.8%**. In NHS Fife **299** patients (**361** previous cohort) were diagnosed with Lung cancer. NHS Fife met **18** of the **24** (including sub-QPIs) QPIs for Lung cancer. **QPIs Not Met:** • **2 (i) Pathological Diagnosis of Lung Cancer:** QPI 2 (i) has come under further scrutiny in the most recent QPI review (FR2). Frozen	

		Action
	sections prior to definitive surgery are now included as pre-treatment pathology; and, PS 3 & 4 have been excluded, which now aligns Scottish measurements of pathological confirmation rates with those of NHS England, Wales and Northern Ireland, all of which do not include patients with poor fitness levels, i.e. PS 3-4, in pre-treatment pathological analyses. Indeed the performance levels across SCAN are now narrowly missing the target in 3 of the 4 SCAN health boards. Results compare favourably to the NHS England rate of 72% of patients with pathological confirmation rate for patients of PS 0-2. The target was not met SCAN-wide. Fife had a shortfall of 2.6% (38 cases). • **QPI 12 (i) Patients with SCLC who receive chemotherapy ± radiotherapy:** The QPI was passed by NHS Borders & NHS Dumfries & Galloway in 2020. The target was not met by NHS Fife with a shortfall of 5% (7 cases) or by NHS Lothian with a shortfall of 24.2% (26 cases). Valid clinical reasons were provided for most patients who did not receive chemotherapy. • **15 (i) Cytology or Histology Prior to Thoracic Surgery:** This QPI was passed by NHS Borders in 2020.The target was not met by the other 3 health boards: NHS D&G had a shortfall of 15% (6 cases); NHS Fife of 13.2% (13 cases); and NHS Lothian had 6.2% (30 cases). Valid clinical reasons were provided for the majority of patients with only 4 patients (8.2%) where no reason was documented. • **15 (ii) Cytology or Histology prior to Radical Radiotherapy**: Allowances should be made where small numbers and variation may be due to chance. Aggregation of results over time may be useful, in future years, to clarify results where numbers are small. It should be noted that disproportionate percentages can be a consequence of small numbers. The target was not met across SCAN region in 2020. NHS Borders had a shortfall of 15% (2 cases); D&G of 8.3% (3 cases); NHS Fife of 35% (15 cases); and NHS Lothian had 36% (15 cases). Valid clinical reasons were provided for the majority of patients with only 2 patients (2.9%) where no reason was documented. **ACTION PLAN 2020** All health boards to record Herder scores at MDM for all patients without pathology who are referred for radical radiotherapy. **QPI 16 Brain Imaging for Lung Cancer Patients with N2 Disease:** The denominator criteria in QPI 16 generate very small cohorts. Results should be viewed with a degree of caution as they may simply be a consequence of small numbers and, where variation might be due to chance. QPI 16 was passed by NHS Borders and D&G in 2020. The target was not met by NHS Fife where there was a shortfall of 6.1% (1 case) nor by NHS Lothian with a shortfall of 14.2% (5 cases). Valid clinical reasons	

		Action
	were provided for most patients. It should be noted that it is appropriate, and right, to go ahead with emergency and urgent treatment (if prior to CT Head) for best patient outcome. **QPI 17 Clinical Trials:** Total recruitment remains very low. Lung clinical trial eligibility criteria are complex and challenging which prevents many patients from entering trials. Most trials have been geared towards targeted therapies but going forward new trials for palliative patients, and with less exclusion, are becoming available. There was one action identified for NHS Fife.	
7.2.2	**HPB 2021**	
	CM advised there are a few questions that need answered in regard to this QPI. SAS and KN to meet with Syed Naqvi to go through this QPI and to present this on his behalf at the next meeting. KN advised she can also liaise with the Cancer Audit Facilitators who know the data.	**SAS/KN**
8.	**LINKED COMMITTEE MINUTES**	
8.1	**Cancer Managers' Forum (03/02/2023)**	
	This was noted by the group.	
8.2	**Acute Cancer Services Delivery Group (08/02/2023)**	
	This was noted by the group.	
8.3	**Cancer Leadership Team (24/01/2023 & 21/02/2023)**	
	This was noted by the group.	
8.4	**Cancer Prehabilitation Implementation Steering Group (31/01/2023)**	
	This was noted by the group.	
8.5	**SCAN Regional Cancer Planning Group (11/11/2022)**	
	This was noted by the group.	
8.6	**SCAN Regional Data Reporting Group (07/03/2023)**	
	This was noted by the group.	
8.7	**SCAN Regional Prehabilitation Discussion (07/03/2023)**	
	This was noted by the group.	
8.8	**Cancer Delivery Board (07/12/2022)**	
	KN advised this has changed to Cancer Performance and Delivery Board. The focus will be to drive performance and improvements. Boards will be asked to develop detailed improvement plans for their 62-day performance. This will link in with the recent Planned Care Planning Guidance returns and 2023/24 CWT Funding Allocations.	

		Action
8.9	**Regrading Framework Group (17/02/2023)**	
	KN advised she has sent out a Regrading Framework consultation to the clinical leads and to the Acute Cancer Services Delivery Group.	
8.10	**Cancer Waiting Times Data and Definitions Group (20/01/2023)**	
	This was noted by the group.	
9.	**Items to Note**	
	No items to note	
10.	**ISSUES TO BE ESCALATED**	
	No issues to be escalated. CM advised they would like to take the RCDS Expansion paper to EDG onwards to committees.	
11.	**ANY OTHER BUSINESS**	
	CM asked FQ if they should have Cancer Research as a standing item on this agenda. FQ agreed to this.	**RH**
12.	**Date of Next Meeting**	
	The next meeting will be on Wednesday 31 May 2023, 09:30-11:30 via MS Teams	

CLINICAL GOVERNANCE OVERSIGHT GROUP (Meeting on 14 February 2023)
No issues were raised for escalation to the Clinical Governance Committee.

Clinical Governance Oversight Group

Date: 14/02/2023
Enquiries to: April Robertson
Telephone Ext: Microsoft Teams

CONFIRMED MEETING NOTE OF THE NHS FIFE CLINICAL GOVERNANCE OVERSIGHT GROUP HELD ON TUESDAY 14th FEBRUARY 2023 via MICROSOFT TEAMS

Attendees

Lynn Barker (LB)	Associate Director of Nursing, HSCP
Norma Beveridge (NB)	Interim Associate Director of Nursing, Acute
Dr Sue Blair (SB)	Consultant in Occupational Medicine
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
Dr Helen Hellewell (HH)	Associate Medical Director, HSCP
Janette Keenan (JK)	Director of Nursing
Aileen Lawrie (AL)	Associate Director of Midwifery
Dr Iain MacLeod (IM)	Deputy Medical Director, Acute
Dr Chris McKenna (CMcK) (Chair)	Medical Director
Dr John Morrice (JM)	Associate Medical Director of Woman & Children
Elizabeth Muir (EM)	Clinical Effectiveness Manager
Shirley-Anne Savage (SAS)	Associate Director of Quality & Clinical Governance
Amanda Wong (AW)	Director of Allied Health Professions

In attendance

Rebecca Hands (RH) (minute taker)	Clinical Governance Administrator
Alistair Graham (AG)	Associate Director, Digital & Information
April Robertson (AR)	Clinical Governance Administrator
Dr Gavin Simpson (Dr S)	Consultant in Anaesthetics

Apologies

Andy Brown (AB)	Principal Auditor
Benjamin Hannan (BH)	Director of Pharmacy & Medicines
Sally O'Brien (SO'B)	Head of Nursing, Fife HSCP, Nursing Directorate
Sally McCormack (SMcC)	Associate Medical Director, Emergency Care & Planned Care
Siobhan Mcilroy (SM)	Head of Patient Experience
Nicola Robertson (NR)	Associate Director of Nursing, Corporate Division
Geraldine Smith (GS)	Lead Pharmacist, Medicines Governance

	Items	Action
1	**Apologies for Absence**	
	Apologies for absence were noted from the above members.	
2	**Minutes of the last meeting held on 20th December 2022**	
	The Group confirmed that the note from the meeting held on the 20th December 2022, was a true reflection of what was discussed.	

3	**Matters Arising/Action List**	
	Action Ref 4.5 (Scottish Health Technology Group Quarterly Bulletin 2022 and Risk Assessment) - IM & EM have met to discuss the process, and it has been agreed that this will reported back to meeting throughout the year. EM has been in contact with HIS and the expectation was that all Boards in Scotland have to consider the assessments as they come in. A flowchart has been made about Fifes process in regard to this. This action can now be closed.	

3.1	Clinical Governance Framework **(SAS)**	
	3.1.1 SBAR Clinical Governance Framework **(SAS)**	
	SAS advised the Framework has come to the meeting for final sign off after some very minor changes asked for by the Internal Auditors. It will now be considered at the Board Meeting at the end of March 2023.	
3.2	NHS Fife Adverse Events Policy **(CF)**	
	CF informed the group that the policy has come to the meeting for final comments and/or sign off. AL advised that “MBRRACE UK” was missing from pg 9 paragraph 4.2, and that in pg 21 it states “by expectation”, this should read “by exception”. CMcK advised that we have taken legal advice regarding sharing of information from significant/local adverse events review which is reflected in the policy and fundamentally this should be the “Learn Summary”. The reports are written for NHS Fife and not patients/families or outside agencies. CMcK is happy for the policy to be signed off and has given the group 24 hours for further comments before going for sign off and publish.	
3.3	Scottish Health Technology Group **(IM / EM)**	
	Item has been discussed under item 3.	
3.4	Adverse Events Improvement Plan	
	3.4.1 SAER approval process update **(CF)**	
	CF advised after the presentation of 5 Year Synopsis at the previous meeting (20th December), another meeting had been arranged to discuss the key points and to see if there was anything that could be done to alleviate some of the pressures and progress SAERs quicker. Discussion was about the time allocation to present the SAER to the executive panel. A decision was made to trial a change in process. Two separate panels have been set up with a potential for a third where all the SAER reports are reviewed by an Executive led panel without the presentation from the review teams. The process includes the following: • When any SAER is commissioned, the Fife Adverse Events Team	

(FAET) will send out to the service the 70 day target and will identify the Technical Lead and Lead reviewer.

- That information comes back to FAET and they will then send out the templates along with the scope document and again publish the 70 day target date for the report to come in.
- The draft report should be reviewed by Heads of Nursing and or Clinical Director prior to submission to the executive led panel. This step of the process has been added following a discussion around the quality of the reports which should be a final document.

CF asked for confirmation from NB (in absence of NR), that NR had taken an action from one of the panel meetings to go to the Associate Nurse Directors' Meeting and ask them to consider how we can tighten up the review of the process before the report goes for final sign off. The decision was made that this should now go through Heads of Nursing and/or Clinical Directors.

NB agreed that due to some quality issues and variation in the reports that the new route had been agreed in principle, however, the Directorate Team would have to agree this before it goes for final review.

JK advised that after looking at several reports she agreed the standard of reports should then be much clearer resulting in faster reviewing time so more reports could be reviewed.

CF also advised that some training/education may be required for a quicker/slicker sign off process. The reviewed changes would be made directly on to the live document, the review teams would then have 2 weeks to look at changes and suggestions required to get it to sign off. It would then come back to the same panel and be signed off at that stage. This will be a trial and will be reviewed again at the end of May.

CMcK added that it had also been agreed that if the review team required Director input prior to sign off, a meeting would be arranged. If it is felt a full meeting of the panel is required, this would also be arranged. We should recognise this is just getting started and there is an underrepresentation of the Health & Social Care Partnership which will be resolved.

This is a move away from the previous way of working which would be faster and actually tracked, still giving rise to a full review meeting if required. It was asked if a third and potentially a fourth panel can be set up to have a panel running every week.

HH asked about generating conversation with regard to the Scope and how we ensure that happens. CF agreed the scope had been a bit displaced within the change process, however, after a discussion previously with NR it was being suggested the Scopes were taken to the SAER Panels to be reviewed along with the SBAR, however, there is currently a backlog of Scopes.

This was agreed and the scope documents are now reviewed weekly at the executive led panel.

IM felt this was a very robust process where previously a lot of time was taken out of peoples diaries, this would now mean one meeting per month.

CMcK advised there was nothing to stop a meeting happening to discuss an upcoming challenging meeting conversation with family to ensure everyone is

	on the same page. The group should remain mindful when a family is involved, and also if there is a complaint. He encouraged everyone to let the Group know outside this meeting if they had any further thoughts or concerns.	
	3.4.2 HSCP SBAR review - new process update **(LB)**	
	LB advised that there was now a small group in place, who meet briefly every Tuesday & Friday. They are using these as a learning platform and taking this back to their teams in the Partnership. SBARs can be reviewed the night before, and discussion happens in the morning prior to them being sent off. This information is being collated to be looked at down the line. HH reiterated how well this has been working, having a rich discussion and making good use of clinical time. Hopefully in time this will enhance decision making but that they are happy for any feedback around it. CF responded that she was happy to hear the feedback and as the new process is working well, Acute Division is due to move over to the same type of process from 1st March 2023. The next part of the plan is the trigger list, starting with Healthcare Associated Infections. A meeting has already been set up to ensure that there are not any groups already in existence that could be tapped in to. Some discussion was had over HAIs and how best these should be graded. JK informed the group that after 3 dialysis events (deemed a super event), there was to be a cluster review instead of 3 separate reviews. CMcK feels this is a breakaway from policy; however, this could be a test of change. CF informed the group an expert panel was to be set up to review these cases, and that this would aid collective learning. NB advised each case would be reviewed separately but also another meeting where all 3 cases would be discussed as there are so many similarities.	
4	**GOVERNANCE**	
4.1	Drug Death Cluster Review Process Paper **(Dr Galea Singer)** c/f to April	
	This item will be carried forward to the next meeting.	
4.2	General Practitioner Data Sharing **(AG)**	
	4.2.1 SBAR General Practitioner Data Sharing **(AG)**	
	AG shared a presentation around an update to General Practitioner Data Sharing. This will now include audit access and a fair warning in place. They will be introducing a break glass function to the Clinical Portal (with reasoning for access). The final addition, and most importantly, will be patient choice. The patient has the choice to opt out of data sharing the Emergency Care Summary should they wish to. These items have been approved by the Information Governance & Steering Group. CMcK added this is a very important development after what seems a very lengthy process to get to this point of data sharing. The break glass function	

	would help users to make a conscious decision of whether they really needed to access the data. HH agreed that this is good to make clinicians consider what detail they would need to know, and this would assure patients that only those who needed to know the detail were accessing it.	
4.3	Duty of Candour Annual Report **(SAS)**	
	4.3.1 SBAR Duty of Candour Report **(SAS)**	
	SAS advised SAER was still lagging behind since Covid. There are 36 adverse events requiring Duty of Candour to be determined. The main reason for this is there has been an increase in treatment required for 20 of these patients. There has been a slight improvement in terms of the process, we have been strong in notifying the patient and providing an apology where required. We are still behind in arranging meetings with patients/families. There have been a number of changes on page 8 of the document. It is being recommended that we pick up what's happened this year in next year's report. The report has been brought to today's meeting to seek permission to take it forward to the EDG and then to the Clinical Governance Committee. AL highlighted that there were no Duty of Candours from the GP practices which was unusual. SAS explained that there are only 5 GP practices that sit within this report so not the totality of GP practices. It's probably not due to any "lag" but that we don't usually see many 'Duty of Candours' coming from the 5 practices. HH agreed that the 5 practices only covered a very small amount of people in Fife and an adverse event of sufficient severity breach would occur very rarely, also GPs already have very robust processes around Duty of Candour. FF asked if there is any further look back at the actions from these complaints where there could be learning resulting in a reduction in those types of incidents. CMcK stated this hasn't been possible so far due to 3 years of Covid, however, the Organisational Learning Group would be able to investigate. This is an excellent point that hopefully there would be opportunity to embark on. SAS agreed that the Organisational Learning Group would be the ideal place for this and now with IM on board the group were just "finding their feet".	
4.4	Fife Partnership Review of Children and Young People's Deaths - Annual Report **(JK)**	
	4.4.1 SBAR Fife Partnership Review of Children and Young People's Deaths **(JK)**	
	JK reported that annually there is a requirement for Health Boards to publish a Children and Young Person's Death Review Report. On 1st October 2021 a National system for the reviewing and learning from the deaths of children and young people was established. The Fife Partnership Review of Children and Young People Deaths Commissioning Group was established in October 2021.	

	The commissioning group's core membership is multi-disciplinary and multi-agency. This supports learning and improvement, both locally and nationally, from every child or young person's death in Scotland. By the end of 2022 there were 19 deaths in Fife which met criteria for review. This is for deaths of children under 18 or 26 if they are still in receipt of aftercare. This suggests that the number of deaths reviewed in 2022 was lower than the anticipated 30 – 35 reviews per annum, calculated from the last 5 years average. All 19 deaths have been discussed at the monthly commissioning group. 9 of the deaths were expected and 10 were unexpected, all in children under 18. The Child Death Review Team now has a substantive workforce and although £11000 was received from the Scottish Government, NHS Fife provided the rest of the funding to ensure there was a team in place. NB asked JK what the input from families/carers was on this process. JK advised that this was dealt with as part of the review, it is positive that there is feedback and some discussion around child suicide. JM added that a key ask within the national guidance is around supporting and involving bereaved families in the review process. NHS Fife has created a substantive nurse coordinator post. In most cases the Child Death Review Coordinator will be the link person for the family. JM added that this is still developing, and are part of the process, asking them what they want from the review and feeding back any learning. All cases are so different and more complex than anticipated crossing agencies and sometimes boards. There needs to be improved feedback not only to families but to the various teams involved around the death and the care of the patient.	
4.5	Annual Statement of Assurance for Clinical Governance Oversight Group **(SAS)**	
	SAS advised that this was still a work in progress and thanked everyone who had filled in the questionnaire while encouraging others to do so by Thursday 16th February. This will be brought back to the next meeting.	**SAS**
4.6	NHS Fife Clinical Policy & Procedure Update **(EM)**	
	EM advised at their December 2022 meeting, the NHS Fife Clinical Policy & Procedure Coordination & Authorisation Group approved one new procedure. As an organisation, we now have 95 clinical policies and procedures. The new procedure that was approved at the December 2022 meeting was: • FWP–PRWSDWC-01 - NHS Fife Wide Procedure for the Management of Patients Referred with a Suspicion or Diagnosed with Cancer At the December meeting one Fife wide procedure, and one ASD procedure were past their review date. There is work in progress for both of these. The group were given assurance that there is a 98% compliance rate for all NHS Fife clinical policies and procedures.	

4.7	NHS Fife Activity Tracker **(EM)**	
	EM advised the group that there was one new consultation since December which was Standards for Gender Identity Healthcare Services for Adults and Young People. This came in late last week, however, this has been shared with the services and the consultation closed yesterday. The other consultation is from Healthcare Improvement Scotland (HIS), who will be doing the Developing Standards for Cataract Surgery. This has been shared with Planned Care and Clinical Lead, Peter Wilson has identified a colleague to participate in the standards.	
4.8	Corporate Risk Register **(PC)**	
	PC advised that the number of risks on the register remains the same at 18 and that 6 of these risks are aligned to the Clinical Governance Committee. In terms of any movement, there will be a deep dive on the COVID 19 risk which will be presented to the next Clinical Governance Committee in March, it is proposed that the risk be reduced from a high to moderate which is positive. Otherwise, the risks and risk levels are static, and mitigations are updated as required. PC advised that for the last committee in January 2023, AG did a deep dive in to the Digital & Information risk which is relevant across the organisation.	
4.9	Scottish Health Technology Group Update **(EM)**	
	EM advised this was to show the group the process. An update report has been pulled which lists the recommendations and the assessments. This will identify the people that we are going to link in with to undertake the reviews. EM thanked JM, HH and SMcC who are giving guidance on the correct or most appropriate clinical lead to contact. As IM indicated earlier, this item could be brought back to this group twice a year with a list of recommendations, assessments and what work has been undertaken within our own organisation to review and assess what this means. Today is the first time this report has been pulled and presented to the group. There is a flow chart, an email and a report that we would be asking people to complete which could be shared with this group for information and assurance. EM informed the group that Dr Eleonora Saturno completed a report in regards to the vCreate Neuro for the diagnosis and management of adults and children with epilepsy and other neurological disorders. EM advised that this process was being trialled and a more detailed process would be brought to the next meeting.	**EM**
4.10	NHS Fife Clinical Effectiveness Register **(EM)**	
	EM advised this paper shows the last 6 months of projects registered. 42 projects have been registered. They follow up with the projects that have been completed to try and get copies of reports or presentations. These are then shared within the directorates in the Acute Services Division, and the	

	directorates report these through their directorate reports to the Acute Services Division Clinical Governance Committee.	
5	**STRATEGY/PLANNING**	
6	**QUALITY/PERFORMANCE**	
6.1	Q2 Deteriorating Patient Report **(Dr S)**	
	Dr Simpson shared the Deteriorating Patent report with the group.	
6.2	Deteriorating Patient Improvement Plan **(Dr S)**	
	Dr S presented the Deteriorating Patient Improvement Plan with regard to the concerning rise in rates of cardiac arrests. The projection has unfortunately come to fruition with the highest rates for 6 years. Rates were already high, we had 80 cardiac arrests by the end of last year, after discussion it was decided to try and do something about this. Dr S stated that thanks to Cheryl Waters and EM from Clinical Effectiveness we have a very robust quarterly report. Unfortunately this shows that our last 8 months have been above the mean for what our cardiac arrests should be and we are rising nationally compared to the mean. We have a very well established and comprehensive review process. There is a Deteriorating Patient Group which was re-started last year. Everyone had input for designing the group including: • The ethos • Why it was needed • What the problems are • What the measurement frameworks are going to be • How we are going to report • Where we are going to report these findings to It also highlighted that all the processes in our plan were in line with HIS and Scottish Patient Safety Programme (SPSP) principles and guidelines. Dr S felt that a narrower group was possibly needed of people who could meet more frequently to action elements of the plan. There are generic principles which are in line with the Know The Score principles, these are: • Improved recording of Patient Vital Observations using Patientrack e-obs and Early Warning Scores (EWS) • Better use of Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) • Introduction of Hospital Anticipatory Care Plans (HACP) • Introduction of Structured Response reviews for high EWS (SSR) • Comprehensive CA reviews/auditing (Emergency Bleep Meetings (EBM) Dr S mentioned Jennifer Louden (Charge Nurse, Ward 44) who has done a lot of work with regard to Know The Score, and in that area the rate of obs on time has significantly increased from around 40% to 100% so this shows what can	

	be achieved in a short space of time. It was noted that over the next 6-9 months there would hopefully be some improvements and these would be reported back to this group. CMcK added he was pleased to see so much important work done and asked if there was any Project Management Support. EM advised the group that GSi had been meeting with Tom McCarthy. There was discussion around how best to use Tom's team to drive forward some elements, possibly the Scottish Structured Response as this is an area we are not currently doing well with. Also that there would have to be some finance for promotional materials. A meeting is in place with the Comms Team later today where they could hopefully give some costings. CMcK commented that this had to be a top priority for us as an organisation and that a budget would be found for this. Dr S felt that there were so many changes in staff, both medical and nursing, that often these messages get lost and focus was detracted over the last 2 years. If we re-highlight the points to a critical mass of people who are aware of the principles, there would be a change in behaviours. CMcK advised that there had been a request from Dr Aylene Kelman for funding to promote RESPECT, which is with regard to anticipatory care which it would be worth tying in to this plan. Dr S advised that the Comms Team are project managing NEWS2 which is intrinsic to this and are to be involved with Welch Allyn machines which are to be trialled. This will improve obs on time and Patientrack. Many elements cross link and improvements should be seen. CMcK advised this is to be brought back to the next meeting at the top of the agenda.	**Dr S**
6.3	NHS Fife Integrated Performance & Quality Report **(CMcK)**	
	This item was noted by the group.	

7	**Adverse Events & Duty of Candour Status Update**	
7.1	Adverse Events KPIs and Incident Flashcards **(CF)**	
	CF shared the December KPIs and highlighted 3 points for noting. The number of overdue SBARs throughout January 2023 had been considerable. Last week began with 13 overdue SBARs and this week the number has reduced to 5. There has been an improvement in the closure of Major Adverse Events, over the last 5 months. Compliance with the closure of actions associated with major/extreme adverse events remains poor and will be a focus of the improvement work for this year. CF shared the revamped flashcard which is now month 9, this gives more richness to the data and a fresh presentation of the data. Focus of the month for January was around the information added to the Datix and to remind staff not to add patient details on the free text boxes as these are shared widely as	

	part of the Datix notification emails. CMcK added this was a very easy to read and a helpful snapshot.	

8	**PATIENT EXPERIENCE**	
8.1	Patient Experience Flash Card **(JK)**	
	JK shared the patient experience flashcard with the group. It was noted that work was currently being done with regard to how they capture complaints, information and data. It shows there has been a drop in stage 2 complaints received. This is still a work in progress, however, it should help to keep a better eye on the data going forward.	
9	**LINKED COMMITTEE MINUTES**	
9.1	NHS Fife Clinical Policy & Procedure Coordination & Authorisation Group 12 December 2022 **(EM)**	
	The minutes of the meeting were noted by the group and no escalation is needed.	
9.2	NHS Fife In Patient Falls Steering Group 2 February 2023 **(NB)** c/f to April	
	This item was noted by the group.	
9.3	NHS Fife Tissue Viability Steering group 19 January 2023 **(LB)**	
	The minutes of the meeting were noted by the group and no escalation is needed.	
9.4	NHS Fife Resuscitation Committee – no meeting date	
	This item was noted by the group.	
9.5	NHS Fife Organisational Learning Group December 2022 & January 2023 - cancelled	
	This item was noted by the group.	
9.6	Acute Services Division Clinical Governance Committee – 18 January 2023 cancelled	
	This item was noted by the group.	
10	**ITEMS TO NOTE**	
10.1	SPSP Acute Adult Collaborative January 2023 Update	
	This item was noted by the group.	
11	**ISSUES TO BE ESCALATED**	
	No issues to be escalated.	

12	**ANY OTHER BUSINESS**	
	No Other Competent Business.	
	Date of Next Meeting 18th April 2023 09:30 via Microsoft Teams	

DIGITAL & INFORMATION BOARD (Meeting on 19 April 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 APRIL 2023, 0900, VIA MS TEAMS

Present:

Chair - Dr Chris McKenna	Medical Director
Alistair Graham	Associate Director, Digital & Information
Rachel Heagney	Head of Improvement, Transformation & PMO on behalf of Director Health & Social Care
Maxine Michie	Deputy Director of Finance on behalf of Director of Finance & Strategy
Claire Dobson	Director of Acute Services
John Chalmers	Clinical Lead, Digital & Information
Janette Keenan	Director of Nursing
Duncan Wilson	Lead Pharmacist on behalf of Director of Pharmacy & Medicines

In Attendance:

Andy Brown	Principal Auditor
Lynn Barker	Director of Nursing
Helen Hellewell	Associate Medical Director
Marie Richmond	Head of Digital Strategic Delivery, Digital & Information
Claire Neal	(Minute) PA to Associate Director, Digital & Information
Charlie Anderson	Head of ICT, Fife Council
Allan Young	Head of Digital Operations, Digital & Information
Miriam Watts	General Manager, Emergency Care

Apologies:

Caroline Somerville	Partnership Representative
David Miller	Director of Workforce
Sharon Mullan	General Practitioner
Amanda Wong	Associate Director, AHPs
Torfinn Thorbjornsen	Head of Information Services, Digital & Information
Joy Tomlinson	Director of Public Health
Margaret Guthrie	Head of Information Governance & Security / DPO

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 - 24/01/23

Minutes were reviewed and agreed. Updates were provided for completed action.

3 Matters Arising

3.1 PACS Outage – January 2023

A Young advised this item was discussed at the previous meeting in January and they were waiting on the finalised critical report to be concluded. This report has now been finalised and brought back to Board to provide an update.

A Young noted there was a hardware fault occurred on node 1 and we should be able to rely on node 2 but there was a fault within the main controller. This failed resulting in both nodes being unavailable.

The supplier, Phillips has now reviewed and are monitoring the activity so if one of the nodes fails then the backup will work.

C McKenna queried if assurance can be provided this will not reoccur. A Young provided assurance with the mitigations and monitoring this should not happen again.

No comments were raised.

Provided to Board for an update.

3.2 Back to Referrer Issue

M Richmond provided a background to this item explaining that an issue was alerted regarding the GP Back to Referrer letters and if text was not removed or print button unticked then the letter would not be sent to GP. Work has been undertaken with Information Services and reviewing all letters that weren't issued, and from this analysis there could be possibly 7672 letters that haven't been issued although some services have confirmed they have alternate means of communicating with GPs

M Richmond provided a summary to the issue that arose with the setup of the system, and they are currently in discussions with Intersystems regarding this issue.

A full investigation will be undertaken to see how this has impacted patients and to ensure this does not happen again.

A Graham noted conversations are ongoing with other NHS Boards to see if this is just NHS Fife or wider.

Concerns were raised by Dr McKenna regarding the consequences of this and the liability of supplier. We are unsure of any potential harm to patients. A brief conversation was undertaken. M Richmond confirmed this will continue to be addressed with Intersystems.

It was noted the mitigations put in place and communications regarding this issue were good.

It was decided this paper should be presented to EDG to provide consideration of escalation.

Action – A Graham to review and take to EDG. **AG**

No other comments were raised.

3.3 Digital Maturity

A Graham noted this item is a requirement as part of the delivery plan from Scottish Government to conclude the Digital Assessment. The previous assessment was held in 2019 and this is now the second reiteration.

A Graham highlighted the assessment covered the full range of service provided across Health and Social Care.

A presentation was delivered by M Richmond to provide an overview of Digital Maturity. Background was provided to items:

- Undertaken in 2019 and feedback received from this helped form and ensure our Digital Strategy was on track.
- There are a few key areas
- Timetable.
- Once launched, 6 weeks to complete.
- Questionnaire is issued, completed, and is then forwarded to Scottish Government. Feedback shall then be provided, and we can take learning from this.

M Richmond provided summary on the DMA Self-Assessment Structure and noted offer of support is available for completion of questionnaire. They are attending SLT meetings and with Executive Teams.

M Richmond listed a few findings they hope will support:

- Inform the targeting of future support and investment.

- Embed better use of digital ways of working from the outset.
- Identify gaps in knowledge, confidence, and access at all levels to facilitate better targeting of support at a national, regional, and local level.

A Graham noted this will be used for consultation for digital strategy and could be used for the Digital Strategy required as part of the IJB planning requirements.

No comments were noted.

3.4 Annual Delivery Plan

A Graham presented a slide, noting we are aligning our Annual Delivery Plan (ADP) to the Scottish Government requirement. We will best align our activities to the ADP and will provide feedback to Scottish Government.

A Graham provided an overview of presentation.

M Richmond noted the biggest challenges we face are delays.

No other comments were noted.

4 Risk Management

4.1 Risk Management Report

A Graham introduced paper and advised this report is for providing assurance to the Board:

A brief update was provided to the paper noting the below:

- Risk profile high – Risk 1738, Clinical Portal Licencing is now closed
- Risk profile medium – Risk 1266, Location of Network Infrastructure and Risk 2344, Threat of Supplier Industrial Action
- Risk profile low – 1178, loss of access to 3rd party solutions

Continuation of monitoring of all risks and how they are managed. We try to mitigate risks and there is no significant change to risk rating in this reporting period.

Feedback was provided by A Graham on how we categorise risks and an update provided on continuing to monitor the ITIL alignment with risk 2192.

Dr McKenna noted assurance taken from report and as with other reports very comprehensive presentation.

No other comments were raised.

Assurance noted.

4.2 Risk Management Dashboard

A Graham shared a slide and provided an overview on the continuing improvement work with performance on risk management and to improve the developing dashboard. This is now being used as a corporate tool and is part of the Risk & Opportunities Group. We are using data from Datix and moving into a dashboard.
C McKenna queried if this has been tested on any teams, A Graham noted they are at early stages but once ready will be presenting to other groups.

This is item noted for information only.
No other comments were raised.

4.3 Risk Tolerance Framework

A Young introduced item advising SBAR brought to Board to explain the link between Network and Information Systems (NIS) and the wider NHS Fife risk appetite statement. Digital and Information (D&I) wish to expand into our own framework, and we are seeking agreement with the suggested tolerance levels.

A Young provided a background to the paper and risk appetite.

The tolerance categories and the tolerance level are below:

- Data Breaches - Low
- Infrastructure - Moderate
- Access Controls - Moderate
- Information Assets - Moderate
- Supplier Management - Moderate
- Threats and Vulnerabilities - Low
- Operational Performance – Low

A Young provided a brief explanation to each consequence rating and why they are categorised, low, medium, and high. These are aligned with NISD assessment and the NISD thresholds.

C Anderson queried the partnership integration and raised a concern to ensure these tolerance levels also align with the Local Authority in support of the joint activities for the Health and Social Care Partnership. After a brief discussion it was decided C Anderson and A Young to continue this conversation offline.

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:

- We currently have one EOL 2003 Server with mitigation in place.
- Account provisioning has improved, a new team has been established with additional staff recruited.
- Cyber Score is consistently below 30 which is good.

A Young noted the performance summary for this quarter was majority within KPI's and green and was content with work ongoing within department.

C McKenna reiterated A Youngs comment, and it is a reassuring report and shows the hard work. Thank you and well done.

No comments were raised.

6 Strategy and Programmes / Project

6.1 Programme & Projects Update

M Richmond introduced item and provided an update to some of the items within the project update. A brief update is noted below:

- We continue to work at pace, but a large number of projects to complete. We understand the pressures which are ongoing within NHS Fife and the challenges with the delivery.
- Digital Health Care requests continue to be an issue, but we are engaging with departments to discuss this additional work.

- A brief update provided to the team changes. These will now be Regional Projects, Digital Projects, Digital Clinical Leads and Digital Enablement, rather then the term Strategy and Programmes.
- Delays to National Programmes causing issues with timelines and the staffing resource. We continue to provide feedback to National.
- HEPMA, work continuing, thanks for Pharmacy for their assistance. We are still in discussions regarding the contract, but we hope this will be completed shortly. This will then process to Chair and Chief Executive for confirmation and then on to NSS.
- eRostering, cohort 1 concluding on 2nd May with seven areas onboarded. Concerns raised on the business as usual (BAU), discussions continue. Challenges continue with the link between SSTS and eRostering, dates are continuing to be delayed, with no timeline provided.
- Morse, Phase 1 to be completed end May 23, great work has been undertaken. We now move to Phase 2 and hope for this to be completed in one year.
- Digital Pathology, go live in May.
- LIMS, work ongoing, timeline has been delayed but still hopeful. Meetings continuing with supplier.

H Hellewell queried the removal of "wet signature", M Richmond advised this is at very early stages and once information received will provide updates.

C McKenna thanked for the update and the huge amount of work completed but also continuing. A suggestion was noted of possibly providing a summary of the Programmes and Project update to the wider organisation to show the work ongoing within D&I. **MR**

Action – M Richmond will review and speak with Communications.

6.2 Extending the EPR

A presentation was delivered by A Graham to provide an update to the approach to extend EPR.

A Graham provided an overview of the presentation and gave a background to the three elements:

- Scanning Process
- Digitisation Process
- Digital First Model

We need to query what we want to digitise and be clear on our implementation plans.

A brief discussion was undertaken noting the benefits and the urgency. A decision was taken for further discussions to continue as part of EPR Governance group. Effective working in AMU considered a priority.

6.2 Extending the EPR

M Richmond introduced the Terms of Reference item and provided background to paper.

Studies have been undertaken on EPR on what was successful and what has not been successful. An example of this is Digital not discussing with Clinicians.

M Richmond provided an overview of ToR and we are looking for comments and representatives to part of this Group. Feedback received from Acute SLT.

The aim of EPR Steering Group will focus on three fundamental areas of digital transformation:

1. The paper record which is currently held for the patient
2. Prevention of paper being added to this record
3. Our Digital Front Door

We will ensure this meets the needs of the Clinician and patient, being mindful of digital exclusion and how we can support them. An example of this was Community Hubs.

M Richmond noted this paper shall be circulated to the Board and would appreciate any comments and recommendations on membership.

Discussions were held and a concern was raised.

It was decided this paper should be taken to EDG for further discussions. **AG**
Action - A Graham to present paper at EDG

7 Finance

7.1. Capital Availability Impact

A Young provided an overview to item noting this has been presented to Board to alert to the challenges within our 2023/2024 Capital spend. Our budget has been halved from one million to five hundred thousand.

A background was provided to presentation noting there are four main areas for capital consideration in 2023/2024 and a highlight of the associated risks of zero investment. Examples of these are provided below:

Endpoint Computers, *medium risk* we are currently in a good position with replacement stock covered from COVID or issued from stock.

Server Hardware, *high risk*, Sci Store Hardware is end of life October 2023. GP Locals Servers.

Telephony, *low risk* as telephone refresh was completed in 2016.

Network & Security, *high risk*, main hospital CISO firewalls coming to end of life, primary and secondary core switch connectivity.

A Young noted a projected spend for 2023/2024 as £745k with an overspend of £245k.

A brief discussion was held on the above. A Young advised they will raise any risks through Datix and will for discussion at FCIG.

Paper provided for information purposes only.

8 Escalation to Clinical Governance Committee

It was noted there is nothing to highlight to CGC at present but with further information to follow on Back to Referrer issue this will be provided.

9 Documents for Approval/Comment

9.1 D&I Annual Workplan

A Graham provided a summary of workplan.

Approved by Board

9.2 D&I Review of TOR

A Graham highlighted the ToR has been updated to reflect the Digital Strategy. An addition to membership for Property and Estates.
Approved
9.3 D&I Statement of Assurance

A Graham noted the Statement of Assurance will be presented to EDG and CGC, any comments that are received will be updated.

A summary was provided to items within Assurance Statement from 22-23. Any comments to please feedback.

A discussion was held on the purpose of the Assurance Statement and its purpose.

10 AOCB

No other points of business were raised.

Dr McKenna thanked everyone for attending and for all continued hard work from D&I.

10 DATE OF NEXT MEETING

Wednesday 19th July 2023

QUALITY & COMMUNITIES COMMITTEE

Meeting on 10 March 2023

No issues were raised for escalation to the Clinical Governance Committee.

Quality & Communities Committee

Fife Health & Social Care Partnership

Supporting the people of Fife together

UNCONFIRMED MINUTE OF THE QUALITY & COMMUNITIES COMMITTEE
FRIDAY 10 MARCH 2023, 1000hrs - MS TEAMS

Present:	Councillor Rosemary Liewald (Chair) Councillor Graeme Downie Councillor Lynn Mowatt Councillor Sam Steele Councillor Margaret Kennedy Ian Dall, Service User Rep, Chair of the PEN (ID) Morna Fleming, Carer's Representative (MF) Paul Dundas, Independent Sector Lead (PD)
Attending:	Dr Helen Hellewell, Deputy Medical Director (HH) Nicky Connor, Director of Health & Social Care (NC) Lisa Cooper, Head of Primary Care and Preventative Care Services (LC) Rona Laskowski, Head of Complex and Critical Care Services (RLas) Catherine Gilvear, Quality Clinical & Care Governance Lead (CG) Simon Fevre, Staff Side Representative (SF) Sally O'Brien, Head of Nursing (SO'B) Kathy Henwood, Head of Education and Children's Services (Children and Families/CJSW and CSWO) Avril Sweeney, Risk Compliance Manager (AS) Lesley Gauld, Team Manager Strategic Planning Ronan Burke, Interim Adult Support and Protection Coordinator Alan Small, Independent Chair Fife Adult Support and Protection Committee and Fife MAPPA SOG (AS)
In Attendance:	Jennifer Cushnie, PA to Deputy Medical Director (Minutes)
Apologies for Absence:	Sinead Braiden, NHS Board Member (Chair) (SB) Dr Chris McKenna, Medical Director Ben Hannan, Director of Pharmacy and Medicines Lynn Barker, Director of Nursing Roy Lawrence, Principal Lead for Organisational Development & Culture Fiona McKay, Head of Strategic Planning, Performance & Commissioning Lynne Garvey, Head of Community Care Services (LG)

No	Item	Action
1	**CHAIRPERSON'S WELCOME AND OPENING REMARKS** As Sinead Braiden was unable to attend the meeting, Cllr Liewald, Vice Chair, kindly stepped into Chair in Sinead's absence. Unfortunately, the meeting was not quorate (*requires 2 voting members of the Committee present, one from NHS Fife and one from Fife Council*) therefore the Minutes from the previous meeting of 18.01.23 can only be reviewed and not formally Approved. These shall be carried over to the next meeting. Cllr Liewald welcomed all to the meeting. She stated, although the Agenda was fairly short, the items included were robust and should prompt meaningful discussion. Meeting protocol was advised. As there were guests from outwith the Committee and normal attendance, the Agenda was to be taken out of order.	
2	**DECLARATION OF MEMBERS' INTEREST** No declarations of interest were received.	
3	**APOLOGIES FOR ABSENCE** Apologies were noted as above.	
4	**MINUTES OF PREVIOUS MEETINGS HELD ON 18 JANUARY 2023** The previous minutes from the C&CGC meeting on 18 January 2023 were reviewed and no alternations or corrections were requested. As the meeting was not quorate, these minutes will be Approved at the next Quality & Communities Committee meeting on 3rd May 2023.	**S Braiden**
5	**ACTION LOG** No items raised from the Action Log.	
6	**GOVERNANCE**	
	6.1 Joint Inspection of Adult Services Improvement Plan NC introduced the report in FMcK's absence. The report was presented for the Committee's awareness and discussion. NC gave background to the report advising, between June and November 2022**,** the Care Inspectorate and Health Improvement Scotland carried out a joint inspection of services provided to adults with complex needs, living in Fife. The purpose of the inspection was to investigate partnership working both strategically and operationally, to seamlessly deliver services which achieve good health and wellbeing outcomes for adults. NC outlined the key strengths found and the areas for improvement, along with the grades given for each key area. The Improvement Plan itself sets out each of the key areas for improvement, the improvement desired, where responsibility lies, how improvement will be measured, expected completion dates with updates.	

	There was discussion around the impact of the Pandemic, how services operated and adapted and the consequences for those in need of support, and for staff. Staff were commended for their great efforts to enable the Partnership to continue to deliver good outcomes to most people. The success of greater collaborative working was discussed and improved integration of services. The inspection will aid in the priorities for future development.	
	6.2 Mainstreaming the Equality Duty and Equality Outcomes Progress Report – Jan 2023 Cllr Liewald introduced Lesley Gauld, Strategic Planning Team Manager who was presenting the report in the absence of FMcK. LG gave a summary of the report which was being brought to the Committee for discussion. LG advised Joint meetings have been held with other Partnerships and the Equality & Human Rights Commission to ensure plans are robust. She referred to Appendix 2 which shows the Action Plan and also the EQIA which will be used in the production of the savings proposals for the Medium-Term Financial Strategy. LG invited questions or comments from the Committee. MF thanked LG for the report which she had read with interest. She commented she would like to see the specific mention of Carers be included in the Equality Outcome 6. She also felt there should be some indication of attempts to reach Carers in Equality Outcome 7. LG acknowledged this point and will look to ensure the voice of Carers is included and strengthened. Discussion took place around the outcomes in the report and there was much interest in how progress is measured and recorded.	
	6.3 Fife Adult Support and Protection Committee Biennial Report 2020-2022 Alan Small explained it is a legislative requirement, each Adult Support and Protection Committee are asked to produce a Biennial Report. In Fife, an Annual Report is produced for year in between the Biennial Report as AS felt it the report is a vehicle to keep people appraised of the work of the Committee. AS introduced the Biennial Report covering 2020-2022, which covers the majority of Lockdown, during the Covid Pandemic. He advised, Scottish Ministers decree that there should be specific Care Inspectorate Inspections conducted looking solely at Adult Support and Protection. Previously, this was included in Older People Inspections. This brings Adult Support and Protection more aligned with Child Protection. AS gave a comprehensive summary of the content of the report which takes the reader through a journey of 2020-2022 within the Service, outlining progress, innovative thinking and .	

	AS advised he is stepping down as Chair of Fife Adult Support and Protection Committee. He was happy to say he felt he was leaving on a high as over the previous 8 years, through partnership working and achievement, Adult Support and Protection has been taken to the next level in Fife. AS spoke of the Inspection which was conducted using a relatively new and very thorough process, which he described. The outcome was extremely positive and AS read out some of the highlights, which included "Adults at Risk at harm typically experienced improvements to their safety, health and wellbeing due to the collaborative efforts of social work, health professionals and police officers", "initial enquiry process is *highly* effective", "adults at risk of harm benefitted from sound, well documented investigative practices". AS felt there has been some frustration over the years as there has been a lack of feedback from Scottish Government, however, this is to change as they are now carrying out a collation exercise looking at all areas of Scotland with key themes. This is expected early Spring 2023. AS introduced Ronan Burke, Interim Adult Support and Protection Coordinator. RB felt it was important to note that the Committee continued to push very hard to drive forward improvement actions during unprecedented times throughout 2020-2022. He also acknowledged support of partnership bodies, which has been greatly appreciated. He felt AS summarised well what has been taking place over the past 2 years. He stated, areas of improvement will be driven forward through the Adult Support and Protection Strategic Improvement Plan, which was approved by Committee in Jan 2023. As the Committee pushes ahead, RB was keen to move to a more qualitative and deeper understanding of the complexities of people's lives the Service are involved with. He explained, underpinning this approach as a focus of transforming data collection and use to gain greater insight of the quality of response, to all stakeholders. He spoke of comms campaigns which have, and are, running and raising awareness within the wider community. Cllr Liewald felt the report is very robust and welcomed it. She agreed with AS and RB, the report is full of data but it is also gives a real personal insight. She queried what "non-adult protection action" refers to. AS advised, if a person does not meet the required criteria, it does not necessarily mean the case is closed. There will still be effort to improve the vulnerable person's circumstances/risks under a case management level. MF commended AS and RB on the report and queried the expression "identifying as female". She asked if this includes trans people. AS advised, if someone choses to identify as female, then they are referred to as female. He elaborated on the various	

	scenarios. A representative from Fife Equalities sits on the ASP Committee and work is being done with them around gender ethnicity. NC felt the IJB should be very proud of what has been achieved through the ASP Committee which is an example of excellent interagency working and stepping up of areas where Adult Protection has not been as strong as Child Protection. She thanked AS very much and acknowledged the significant improvements he has overseen during his tenure in post. She also thanked RB for the excellent report.	
	6.4 Chief Social Work Officer's Report 2021-2022 KH who presented the report, which is based on the new Scottish Government template, giving consistency across all local authorities and IJB's in Scotland. The report covers 2021-2022 and comes annually to Q&CC, the Children Services Committee and to Scottish Government. The report captures where Fife are in terms of children and families work, children, adult and older people's health & social work and Social Care Services are during the timeframe. . Discussion centred around looked after children, before, during and after the Pandemic and the lasting effects felt. Kathy Henwood advised pre-Pandemic there were ~ 150 children placed outwith Fife, these children have returned to Fife and in most cases this has been successful. KH told of 3 new permanent Corporate Parenting Development Worker posts which have been filled by care experienced employees. KH advised the report is jointly in respect of Children & Families, Criminal Justice and the SW aspect of HSCP. Key achievements, partnership working during the Pandemic, Carers, Mental Health and Workforce Planning were all described. The Chair thanked KH for the report.	
	6.5 Review of IJB Risk Management The Chair introduced Avril Sweeney, Risk Compliance Manager who presented the report in the absence of Audrey Valente, Chief Finance Office. AS gave a background to the report which she advised is to support the delivery of the Strategic Plan. The Policy and Strategy were created by the Partner bodies in 2016 in line with the Integration Scheme. It was refreshed in 2019 and required to be reviewed again following the approval of the updated Integration Scheme in March 2022. The refresh considered the development of Risk Appetite, the distinction between processes for IJB Strategic Risks and Partner Operational Risks, the removal of the "Corporate" Risk category and the IJB Governance and HSCP organisational structure	

	changes, including the roles and responsibilities of the Governance Committees. The Chair thanked AS for the report, no questions were presented.	
7.0	**ITEMS FOR ESCALATION** No items for escalation.	
8.0	**AOCB** No further business raised.	
9.0	**DATE OF NEXT MEETING –** Friday 30th June 2023, 1000hrs MS Teams	

HEALTH & SAFETY SUBCOMMITTEE

(Meeting on 10 March 2023)

The Health & Safety Subcommittee approved their Terms of Reference, and they are attached as an appendix.

The Health & Safety Subcommittee Annual Statement of Assurance 2022-23 is provided under item 6.1 on the agenda.

Minute of the H&S Sub-Committee Meeting
Friday 10 March 2023 at 12.30 pm on Teams

Present
Neil McCormick (Chair), Director of Property & Asset Management (NMcC)
David Miller, Director of Workforce (DM)
Conn Gillespie, Staff Side Representative (CG)
Nicola Robertson, Associate Director of Nursing (NR) (for Janette Keenan)

In Attendance
Billy Nixon, H&S Manager (BN)
Ann-Marie Marshall, Acting Senior H&S Advisor (A-MM)

The order of the minute may not reflect that of the discussion

No.		Action
1.	**Welcome & Apologies** NMcC welcomed those present to the meeting. Apologies were noted from Dr Chris McKenna, Janette Keenan (Nicola Robertson), Paul Bishop and Rona Laskowski.	
2.	**Minute/Matters Arising**: The Minute of 20.01.23 was approved as an accurate record. Matters arising were all either complete, in progress or identified elsewhere on the agenda.	
3.	**Covid-19 Update**: There was no update with respect to Covid-19 as the position was the same as at the January meeting.	
4.	**Governance Arrangements**: 4.1 Terms of Reference (ToR) A copy of the ToR for the H&S Sub-Committee was distributed to members of the group and the Sub-Committee **approved** the updated ToR. 4.2 Annual Statement of Assurance The Annual Statement of Assurance was **approved** by the sub-committee subject to the attendance for the current meeting being updated.	

	4.3 Annual Work Plan 2023-24 The H&S Sub-Committee Annual Work Plan 2023-24 was distributed to members of the group. The Annual Work Plan 2023-24 will be published at each H&S Sub-Committee meeting and any changes will be reflected accordingly. The group **noted** the H&S Sub-Committee Annual Work Plan 2023-24.	
5.	**Operational Updates** 5.1 H&S Sub-Committee Incidents Report (Dec-Feb 2023) A copy of the H&S Sub-Committee Incidents Report (Dec-Feb 2023) was distributed to members of the group. BN presented the Incidents Report for the period December to February 2023 to the group in his role as H&S Manager. Interviews for the Manual Handling Trainer vacancies had been held with 2 successful candidates. DM agreed to follow up if the recruitment process could be accelerated as the candidates could start with immediate effect and this would help in providing the capacity to continue the ambitious training plan identified. Interviews for the post of the Manual Handling Co-ordinator post will be held in early April. Once the post is filled, this will then complete the team. Thanks were extended to BN and his team. 5.2 Staff Governance Standards - Improved & Safe Working Environment SBAR NMcC and CG gave an update on the "heartening" feedback that had been coming back from the pilot areas in Learning Disabilities through Wendy McConville. Staff had found the process to be positive and had felt empowered to proposes solutions as part of an action plan to reduce stress in the workplace. A more formal update would be given to the APF and Staff Governance Committee together with the Sub-Committee in due course. All agreed that this piece of work could have a positive impact on reducing stress in the workplace and allowed staff to be empowered to contribute positively and engage with the process. 5.3 Manual Handling A-MM gave an update to the Sub-Committee on all of the positive progress that had been made in improving the Manual Handling service.	**DM**

	The Sub-Committee were advised that all points on the Internal Audit (B22/21) Manual Handling Training findings had now been agreed as complete. The Sub-Committee took assurance from the update and thanked A-MM and her team for all the hard work that they had undertaken in re-designing the service. 5.4 Lateral Lifter for Arjo Hoists Meetings have taken place with HoN's, Head of Patient Experience and Director of Nursing for Acute Services on the introduction of lateral lifters throughout NHS Fife for raising the fallen person. The lateral lifter allows the patients to be lifted horizon tally from the floor which has been documented as best practice. All agreed this would be a positive step moving forward. From this, A-MM had a meeting with Arjo and quotes have been obtained and sent out. Further discussions will take place on the quantity and location of the lateral lifters and also staff will need to be trained in its use by the manual team and A-MM. We will concentrate on the higher risk areas first and deliver training on the wards. Lateral Lifter for Arjo Hoists training will also be included in induction training and changes are being made to the Manual Handling Policy to reflect this.	
6.	**NHS Fife Enforcement Activity** There has been no recent HSE enforcement activity to report within NHS Fife. Enforcement Activity within other Boards NHS Grampian – Violence and aggression enforcement due to lack of Risk Assessments in place. NHS Highland – Manual Handling issues. It was agreed that BN would liaise with other Boards to ensure that any learning points from enforcement activity could be identified and acted on within NHS Fife.	
7.	**Policies & Procedures** NMcC - A list has been published as part of EDG around all outstanding policies and procedures across the Board. This was filtered to include only outstanding Health & safety related policies. BN assured the Sub-Committee that all outstanding policies and procedures other than those that were outside the remit of his department eg smoking had been updated and were in the process of approval through the General Policies Group.	

8.	**Any Other Business** There was no other business to attend to and the meeting was closed.	
9.	**Date & Time of Next Meeting** Friday 9 June 2023 at 12.30 pm on Teams	

HEALTH & SAFETY SUB-COMMITTEE
CONSTITUTION AND TERMS OF REFERENCE

Original Version: March 2022
Version Update [1]: November 2022
Version Update [2]:: January 2023
Version Update [3] & Final Approval: March 2023

1. PURPOSE

1.1 The purpose of the Health & Safety Sub-Committee is to ensure that the NHS Fife Board provide a safe and secure environment for patients, members of the public and its staff whilst meeting all of its statutory obligations in relation to Health and Safety.

2. COMPOSITION

2.1 The membership of the Health & Safety Sub-Committee will be:

Neil McCormick	Director of Property & Asset Management
David Miller	Director of Workforce (from Jan 2023) [2]
Dr Chris McKenna	Medical Director
Conn Gillespie	Staff Side Representative
Rona Laskowski	Head of Complex Critical Care Services, Fife HSCP (from September 2022)[1]
Janette Keenan	Director of Nursing (from March 2023)[3]

2.2 Where group members are unable to attend a scheduled meeting, they should provide apologies in a timely manner and arrange for an appropriately briefed and authorised deputy to be present.

2.3 Occupational Health and Health & Safety Advice will be provided by the appropriate Health & Safety or Occupational Health Professional.

2.4 Officers of the Board will be expected to attend meetings of the Sub-Committee when issues within their responsibility are being considered. In addition, the Chair of the Sub-Committee will agree with the Lead Officer to the Committee which Director/s and other Senior Staff should attend meetings, routinely or otherwise.

2.5 The Health & Safety Manager shall serve as Lead Officer to the Committee.

3. QUORUM

3.1 No business shall be transacted at a meeting of the Sub-Committee unless at least two members are present. There may be occasion when, due to the unavailability of the above, the Chair will ask other EDG members to act as members of the Sub-Committee so that quorum is achieved. This will be drawn to the attention of the Board.

4. MEETINGS

4.1 The Health & Safety Sub-Committee shall meet as necessary to fulfil its purpose but not less than every six months.

4.2 In the absence of the Chair, a member of the group will chair the meeting.

4.3 The agenda and supporting papers will be sent out at least five clear days before the meeting.

5. REMIT

5.1 The remit of the Health & Safety Sub-Committee is to;

- agree a comprehensive Health & Safety Management structure and strategy for NHS Fife;
- consider NHS Fife's performance in relation to its effective management of Health and Safety;
- review action taken by the Chief Executive on recommendations made by the Sub-Committee, the Health and Safety Executive or Scottish Ministers on Health and Safety matters;
- support the operation of health and safety delivery via appropriate arrangements and monitor the development and implementation for all operational Health and Safety issues;
- undertake an annual self assessment of the Committee's work;
- produce an Annual Statement of Assurance for presentation to the Board, via the Audit and Risk Committee. The proposed Annual Statement will be presented to the first Committee meeting in the new financial year or agreed with the Chairperson of the Committee by the end of May each year for presentation to the Audit and Risk Committee in June.

5.2 The Sub-Committee shall draw up and approve, before the start of each financial year, an Annual Work Plan for the Sub-Committee's planned work during the forthcoming year.

5.3 The Sub-Committee shall provide assurance to the Board, via the Clinical Governance Committee, on achievement and maintenance of Best Value standards,

relevant to the Sub-Committee's area of governance as set out in Audit Scotland's baseline report "Developing Best Value Arrangements".

6. AUTHORITY

6.1 The Sub-Committee is authorised by the Clinical Governance Committee to investigate any activity within its Terms of Reference and in so doing, is authorised to seek any information it requires from any employee.

6.2 In order to fulfil its remit, the Health & Safety Sub-Committee may obtain whatever professional advice it requires and request Director/s or other officers of the Board to attend meetings where required.

6.3 Delegated authority as detailed in the Board's Standing Orders is set out in the Purpose and Remit of the Sub-Committee.

7. REPORTING ARRANGEMENTS

7.1 The Health and Safety Sub-Committee reports directly to NHS Fife's Clinical Governance Committee on its work. Minutes of the Sub-Committee are presented to the Clinical Governance Committee by the Sub-Committee Chair who provides a report, on an exception basis, on any issues which the Sub-Committee wishes to draw to the Board's attention.

7.2 The Health & Safety Sub-Committee will also bring to the attention of the Staff Governance Committee any issues that are of relevance to that Committee in terms of the workforce.

7.3 The Corporate Risk Register will be scrutinised by the relevant Committees of the Board with a bi-annual update on all changes to the Corporate Risk Register being submitted to the Audit and Risk Committee.

Neil McCormick
(Chair)
H&S Sub-Committee

Infection Control Committee

INFECTION CONTROL COMMITTEE 5 April 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

05th April 2023 at 1400 via Teams

Item No	Subject	
1	**Attendees**	
	Janette Keenan, Director of Nursing (Chair)	**JK**
	Lizzie Dunstan, Senior Infection Prevention & Control Nurse	**ED**
	Keith Morris, Consultant Microbiologist	**KM**
	Pryia Venkatesh, Consultant Microbiologist	**PV**
	Suzanne Watson, Senior Infection Prevention & Control Nurse	**SW**
	Norma Beveridge, Associate Director of Nursing (ASD	**NB**
	Paul Bishop, Head of Estates	**PB**
	Sophie Gilven, Head of Nursing for Acute Services	**SG**
	Pauline Anne Cummings, Risk Manager	**PC**
	Catherine Gilvear, Fife HSCP Quality and Clinical and Care Governance Lead	**CG**
	Midge Rotherham, Support Services Manager	**MR**
	Jamie Gunn, Health Protection Nurse Specialist	**JG**
	Fiona Bellamy, Senior Health Protection Nurse Specialist	**FB**
	Bev Young, PA/Office Manager Infection Control Team	**BY**
	Apologies Julia Cook, Mirka Barclay	
2	**Minute of Previous Meeting** Group approved previous minute as an accurate reflection	
3	**Action List** Action list updated by members of the meeting.	
4	**Standing Items**	
4.1	**Risk Register** PC gave a brief summary of the papers that were distributed to members of the meeting. 1 risk has been closed and a high risk still ongoing with decontamination and theatre. PC advised there are 2 ICC risks relating to CDI and SAB standards, JC will update accordingly to reflect the letter received from Scottish Government. **Deep dive review:** a meeting has been held and this has been discussed with Paul Bishop. **Heat map:** PC advised a heat map has been completed to highlight the distribution of risks. **Cataract Risk:** KM highlighted to the members of the committee that the cataract risk update. PC advised this was about the modular ceiling for an update regarding this risk. Is this risk active and should this be datix'd. ED advised modular ceiling is to go onto the risk register and KM has completed the relevant paperwork. KM advised after testing organisms were identified on the tiles and needs to be recognised as a risk. In order to protect the organisation of potential claims and complaints. PB requested KM meet out with the ICC to discuss this issue. **Humidity:** PC and KM raised Humidity risk and PB advised this is not for ICC and can be addressed at the ventilation group meeting.	
4.2	**HAIRT Board Report** ED presented the HAIRT report, which covers validated data for quarter 4, up to February 2023. ED advised the following **Challenges:** 5-dialysis line related SAB in 2023 and 2 in 2022; renal services are to arrange a super SAER/LEAR to investigate linkage. PWID 1 so far has been reported. **ECB:** Slight rise in the number for the last 12 months up to end of February 2023.	

	CDI: increase from January to end of Feb 12 cases in total 3 for last year including HCA increase **SSI:** still on hold and local teams are supported. KM noted to the members of the meeting although the SSI surveillance is on hold, there has been a rise of severe C-section infections. **COVID 19:** – Spike noted from December to January, ED advised a risk assessment is being completed for each of our targets. **SAB:** After assessment, this is 9 and target is 6 by the end of 2024. **MRSA Screening:** 100% compliance compared to 74% for national. KM noted this is due to the screening being accessible on patientrak. **PWID**: KM advised members of the meeting that assurance has been requested that staff are trained and the tools are being used – however no assurance has been given by the team. CG raised with members of the meeting if an SBAR can be requested and this will be discussed out with the ICC. **CDI**: currently at moderate risk, target set to reduce to low risk by march 2024. **ECB**: eCatheter maintenance tool is in testing phase and is being tested on ward 54. Hospital ECB 36.2% which is above national rate. Current risk rating is 12 and target for below 6 for March 2024. **UCIG:** KM advised all community acquired CAUTI will be datix'd by the district nurse and a group will review them and foresee a reduction in cases within the community. **Hand Hygiene:** nothing to report as no central location for reporting. Issue has been raised with Ehealth. NB also raised concern with this and is being worked as a matter of urgency in order to have a centralised source of reporting. This has been incorporated into the daily IPC walk around at ward level. NB advised happy to support. CG requested clarification if the hand hygiene centralisation of evidence is on the risk register. JK advised there is work in progress and concluded this will be required to be added to the risk register. PC advised a scoping template will be sent to begin this process. **Domestic and Estates:** Green for both areas. MR advised NHS Fife are above average for Scotland **Outbreaks:** No norovirus to report, 2 outbreaks of flu and 22 COVID-19 Jan- end of Feb 2023.
4.3	**Care Home Update** SW updated members of the meeting the care home team are continuing to support care homes in Fife including referrals from HPT and care home leasing team. Proactive care homes support with challenges from care inspectorate inspections and outbreaks. Terminal clean training will be focused on within the care homes over next few months. Education and training outbreak training has been delivered and managers keen to accept SICPS training also. **QI project** **CAUTI bundle –** implemented into 4 homes and results highlight education, training, and promotion of catheter passport and promote to offer support and training. Hoping to roll out further in conjunction with Candice Ross. KM advised pleased to see number of catheters removed as a result of the CAUTI bundle work PC raised with members of the meeting if the education and training completed within the care homes, if this data can be presented to members of the meeting. SW advised this data would be collated and presented at the next ICC meeting. FB advised IPCT care home support is key and an asset to NHS Fife, Regional service working for public health test of change will be completed and FB will bring paper for next ICC meeting to summarise works. JK advised the aspects of care reduction from care homes admission is a direct result of IPCT, HPT support.
4.4	**NHSS National Cleaning Services Specification** MR advised above national average and green zone. Ward closures and COVID=19 remain challenging. JK advised positive feedback was given to the domestic teams from the HIS inspection. KM and ED reiterated positive feedback for the work the domestic services team do.
4.5	**Learning Summaries** PC advised post op cataract complication – PAG was held in relation to this, identified all protocols and polices were in place. One of issues identified was post-surgery information and education for patient and family this has been developed and improved by promoting hand hygiene with patients, families and carers.
4.6	**National Guidance** ED advised DL target for CDI and SABs COVID 19 validation has ceased, as advised in a DL letter that was received. CMO spring vaccination programme has been shared. **Birds and Cryptococcus risks in healthcare** ED stated to mitigate risks. PB advised meeting members in Fife all ventilation systems are being checked for netting to ensure no birds can access these systems. PC advised the risk was on the register and was closed in January 2023.

	Marburg virus disease in Equatorial Guinea and Tanzania Outbreaks in February and March with high fatality rate, however deemed a risk is low for Scotland. VHK 51 and front doors have been advised to ensure correct PPE. KM advised members of the meeting that the guidance is out of date for the acute services division. If a case does appear the organisation would have major issues in dealing with this. KM requested if this issue can be addressed. JK and NB will discuss out with this meeting. **Appendix 21** ED advised merge of appendices 21 &22. **Appendix 20 and Risk Assessment** ED advised members of the meeting that since the last ICC, a meeting has been held with ARHAI Scotland. A short life working group will be required once revision of the appendix is published.
4.7	**HEI Inspections** **NHS Fife HIS Inspections** Unannounced Inspection of QMH Wards 1,2,4 and Ravenscraig Ward was on 8th February 2023- report awaited, due 17.4.23 JK Advised positive feedback received around IPCT and domestic teams
4.8	**Quality Improvement Programmes Verbal Updates** **PWID** **UCIG** Verbal Update. The last UCIG was held on 17/3/23.
4.9	**Education** ED advised training programme continues. Supporting all NHS Fife and volunteers, teams sessions or face-to-face and pre-recorded training are available.
4.10	**Infection Prevention & Control Audit Programme Update** ED advised audits have a dedicated IPC audit nurse and most inpatient and outpatient wards audits up to date, with very little slippage for the 2 yearly rolling audit programme. HH compliance and technique is also incorporated within this.
4.11	**HAI-SCRIBE** 3 major local projects include GP practices, Antenatal, ward 24 project and theatre refurbishment. The National Treatment Centre (NTC) has opened. The Kincardine and Lochgelly practice remains at the outline business stage JK advised working with NHS Assure the working relationship has improved and lessons have been learned for other treatment centres. JK updated regarding Lochgelly and Kincardine project is awaiting confirmation of funding.
4.12	**Capital Planning** **NTC Orthopaedic centre:** the centre is now open. **Lochgelly and Kincardine Health Centre:** capital funding still to be approved. No update
4.13	**NHS Fife HAI Scribe Planning Group-** For noting
4.14	**Infection Prevention and Control Annual Work Programme Update** For noting
5	**New Business**
5.1	**Incidents/Outbreaks/Triggers** **COVID-19 ASD** **COVID 19 HCSP** **Influenza** **Endopthalmitis** **Renal SABs** Members **noted** the reports
5.2	**The HCAI Interim Strategy Development** JK notified members of the meeting that a draft interim strategy was received and aim to launch on 25/5/23. Strategy itself has outlined 7 strategic goals with a delivery plan and focus on reducing the overall incidents of HAI and support the recovery of NHS Scotland.

5.3.	**ICNET AND LIMS** ED advised members of the meeting a new interface LIMS is currently being built to replace Masterlab. Initial deadline was March 2023 however, this has been extended to end of September 2023. Testing is underway and once complete ICNET will link to the new system.
5.3.1	**ICNET CONTRACT** ED advised contact is up for renewal and a national negation is underway.
6	**Infection Control Committee's Sub Groups – Minutes/notes of meetings**
6.1	**Infection Prevention & Control Team** Members **noted** the notes of the meeting
6.2	**NHS Fife Decontamination Steering Group** Members **noted** the notes of the meeting
6.3	**NHS Fife Antimicrobial Management Team** Members **noted** the notes of the meeting
6.4	**NHS Fife Water Safety Management Group** Members **noted** the notes of the meeting
6.5	**NHS Fife Ventilation Group** Members **noted** the notes of the meeting
6.6	**Quality Reports** Members **noted** the notes of the meeting
7	**Any Other Business**
	UKHSA Briefing: *Pseudomonas aeruginosa* national outbreak: ED advised this is a UK security alert cases have been reported in England and unsure of the source of the outbreak. 27 confirmed cases and 24 probable. Initial hypothesis for source of organism is from a contaminated product. **Terms of Reference:** All members of the meeting agreed **Water Safety Group ICC Water Feature:** ED raised with members of the meeting that any water outlet is strictly monitored which includes any aspect of water from ice machine to water fountain for staff. During a routine visit to ICU it was discovered that a water feature was installed. During the HAI SCRIBE it was highlighted that a water feature was not to be includ adjacent to a high risk area. There has been communication with the ICU consultant, to have water feature removed. The water feature has been turned upside down and emptied of stagnant water. PB will confirm how it was purchased and plan to have this removed. **SAB annual Reports:** KM brought the SAB annual report to the attention of the members. KM reported 92 SABS in total last year 2022, 0 MRSA and all Local ICC targets were met. 18% were HAI and 2 were PVC related SABS. KM noted a significant number of SSTI that have been picked up from both the acute and community acquired SABs. Work is ongoing for management of standardising skin and soft tissue health in the community. NB advised members of the committee a point prevalence study is currently ongoing for the ePVC and patient track, the findings of which will be fed back at the next ICC meeting. CG raised a question to KM about PVC and wounds oversight plan. CG advised this will be raised with the relevant management in order to ensure this work is progressing. SG noted to the members of the team the increase of referrals from maternity and an email has been sent to IPCT and tissue viability team to link with each other to ensure this issue is being investigated **IPQR:** PC requested clarification around HAIRT and IPQR risks. JK advised this would be raised at the next Clinical governance Committee in May 2023.
8	**Date of Next Meeting**
	ICC meeting schedule 2022-2023.

Wed 07th June 2023	1400-1600	Via Ms teams

INFORMATION GOVERNANCE SECURITY & STEERING GROUP

(Meeting on 11 April 2023)

No issues were raised for escalation to the Clinical Governance Committee.

NOTE OF THE INFORMATION GOVERNANCE AND SECURITY STEERING GROUP HELD ON TUESDAY 11TH APRIL 2023, 0900 VIA MS TEAMS

Present:

Alistair Graham	Associate Director Digital & Information (Chair)
Frances Quirk	Assistant RIK Director
Brian McKenna	HR Manager on behalf of Director of Workforce
Susan Fraser	Associate Director of Planning and Performance
Audrey Valente	Chief Finance Officer on behalf of Director of Health & Social Care
Joy Tomlinson	Director of Public Health
Sally Tyson	Head of Pharmacy on behalf of Director of Pharmacy & Medicines

In Attendance:

Andy Brown	Principal Auditor
Margaret Guthrie	Head of Information Governance & Security / DPO
Allan Young	Head of Digital Operations, Digital & Information
Kirsty MacGregor	Associate Director of Communications
Peter Donaldson	Information Security Manager
Claire Neal	(Minute) PA to Associate Director, Digital & Information

Apologies:

Claire Dobson	Director of Acute Services
Janette Keenan	Director of Nursing
Sharon Mullan	General Practitioner
Margo McGurk	Director of Finance & Strategy/ Deputy Chief Executive
Gillian MacIntosh	Head of Corporate Governance
Helen Hellewell	Associate Medical Director
Dr Chris McKenna	Medical Director
Elizabeth Gray	Patient Relations Officer (on behalf of head patient relations)

1 CHAIRPERSON'S WELCOME AND APOLOGIES

A Graham welcomed everyone to meeting and apologies noted. A Graham advised as apologies are noted for the Chair and Vice Chair, they have consulted the ToR and the meeting can continue with the Quorate members as noted in above present.

2 MINUTE & ACTIONS OF PREVIOUS MEETING 31st January 2023

Minutes were reviewed and agreed they were a true record and actions were discussed and updated accordingly.

3 MATTERS ARISING

3.1 - e-Financial SBAR

A Graham introduced item noting this has been brought to Group for awareness. An overview was provided, noting a conversation has been undertaken with A Graham and K Booth regarding the change in arrangements and Ayrshire and Arran have provided assurance that a suite of document shall be made available e.g., DPIA.

This paper is for **noting** only.
No comments were raised by Group.

3.2 - ICO Audit – March 2023

A Graham provided a background to this item explaining the ICO have conducted a programme of audits within all Health Boards and NHS Fife hosted, the ICO in March 2023. This item is the initial report received.

M Guthrie spoke to this item noting ICO only mention the areas for improvement. NHS Fife report was reasonable. Some of the areas of recommendations will be addressed in Qtr1 and other findings will take the whole financial year to review.

M Guthrie provided a brief overview of the audit findings. Listed below is an example of a few of these findings and when these are hoped to be reviewed.

- **0.1 Management Framework, Low priority**, updated in April.
- **02.A New Information Asset Register, High priority**. This result was expected, we are currently working on the new information asset register (IRA) we have challenges with identifying owners and additional training recommended.
- **05.A Policies & Procedures, Medium Priority**. This is due to resourcing issues and will be added to the process and changes to policies will be reviewed. Target completion Qtr. 1.
- **07 Provision of more specific DP Training for specialised roles, Medium priority**. We are going to challenge this recommendation as lot of documentation was provided.
- **08.A Written contracts in place with every processor acting on behalf of the organisation, High priority.** We shall work with the Contract Manager to review. There could be a challenge with NSS.
- **09, 10 and 11. Written contracts include all the details, terms and clauses required under the UKGDPR. High Priority.** This will be reviewed.
- **18. A**. **The organisation acts on the outputs of a DPIA to effectively mitigate or manage any risks identified. High Priority.** We are currently reviewing DPIA, and a process created so a notification can trigger when required to be reviewed. A few systems do not have the necessary documentation required. This is under review.
- **18 B. High Priority**. We are going to challenge. Communications will require to be issued to advise staff of the reporting within 72 hrs to the ICO if a breach.

M Guthrie advised they are happy with the result, and they are aware of the areas that require review. A Graham also reiterated the report was good and we know where priorities are, and these items will be incorporated into the workplan for 2023-24.

M Guthrie noted the work and effort undertaken to receive this result. Starting with around a 10% compliance to current is a great achievement.

F Quirk thanked for the update and for the outcome. If there is anything they can assist or any actions that are required to contact.

S Fraser also noted the feedback from report was good and nothing fundamental of concern.

A Brown queried if there will be a follow up from ICO regarding the audit actions. M Guthrie replied that it is unlikely as they provide the feedback and leave with the Board to complete. A review of the whole of NHS Scotland will be undertaken rather than individual Board.

M Guthrie noted only a highlight was provided but should there be any further queries please contact directly. A tracker will be provided to the Group to provide an update on actions.

No further comments were raised.
For **noting**.

4. IG&S ASSURANCE ACTIVITY TRACKER

4.1 - Presentation on Revised Framework

A presentation was delivered by A Graham to provide an update to the revised framework and to provide assurance to the Group.

A Graham noted since October a mapping exercise was undertaken to describe the challenges of aligning the Accountability Framework with also the NISD, and the Cyber Resilience Framework. We are reviewing this by categories and controls. A brief summary was provided to this slide. Collating evidence from October to January we agreed to utilise ICO categories which will develop an assurance framework.

We have adopted a version of the IPQR, which is well known in the organisation and demonstrates the monitoring and improving. Some of the actions were highlighted in the previous item.

We have broken the Executive Summary into four sections

- Report Section and Update.
- Performance Measures Summary
- Risk Summary
- Key Milestone / Changes

A Graham provided a brief overview to the above.

No other comments were raised.

4.2 - Accountability and Assurance Framework

A Graham noted this is a continuation to the previous item, and to provide assurance to the Group and to others if necessary. A brief introduction was provided. We focus our work from ICO, external and internal audits and then address the action based on these.

A Graham delivered presentation; a few points of the presentation are noted below.

- Report sections and summary of frequency of updates.
- Performance Measures Summary
- Risk Summary

Performance Assessment Reports, this is divided into ten sections, further information was provided on these individual sections.

S Tyson, provided thanks to this paper and for the clarity as it is clear what is trying to be achieved and this model could be used in other frameworks.

B McKenna queried if the targets are set locally, A Graham noted these are set through regulations, frameworks, and legal compliance. B McKenna provided feedback to the training figures, and these have been highlighted to Learning and Development Department.

Additional comments were provided by Group on a very comprehensive and easy to understand.

A Graham thanked Group for this feedback, and we shall continue to finalise and will issue before next meeting.

5 RISK MANAGEMENT

5.1 - Risk Management Report – April 2023

A Graham introduced paper and advised this report is for providing assurance to the Board.

A brief update was provided to the paper noting the below:

- There are a total of 26 risks which are actively being managed.
- 8 high risks, 14 moderate and 3 low to very low risk.

- All risks are monitored and with the target levels reviewed.
- 10 risks have improved their status with risk 2103 going from high to a low risk.
- Risk 1372 & 2349 were at moderate, but these are now low.

A Graham provided feedback on how the risk profile is categorised and provided a brief update to a few of the risks on the profile. Risk 1500 has deteriorated, one of the root causes are external to the organisation. Over the last few years there have been successful attacks e.g., HSE, SEPA and more recently a Health Care provider.

A Young presented a slide to explain the Cyber Threat Risk Management. A brief explanation was provided of the 4 objectives of NISD:

- Managing IT Security Risk – Risk 2321
- Protecting Against Cyber Attack – Risk 2322
- Detecting Cyber Security Events – Risk 2323
- Minimising Impact of Cyber Threats – Risk 2324

NISD Audit will take place in August, and management actions are assured through the NISD.

A Graham provided feedback to graphic on App1 showing the improvement to risks since last year.

J Tomlinson queried if there were any insights from the Risk & Opportunities to the IG&S Steering Group. A Graham provided feedback to the query noting there are deep dives undertaken. We are currently waiting to hear what additional information may be required from these groups.

No other comments were raised.

Assurance taken from this report.

5.2 - IG&S Risk Management Framework

A Graham provided background to this item noting A Young, P Donaldson and M Harris have been working on the Framework and this paper has been provided for discussion.

P Donaldson provided feedback to the item noting after the last NISD Audit as part of the controls, risk and in particular Cyber Risk is a mandatory compliance area that requires effective and diligent oversight. We require to document risks and what we are prepared to tolerate.

We have identified 7 tolerance categories:

- Data Breaches - The organisation has a **LOW** tolerance.
- Infrastructure - The organisation has a **MODERATE** tolerance.
- Access Controls - The organisation has a **MODERATE** tolerance.
- Information Assets - The organisation has a **MODERATE** tolerance.
- Supplier Management - The organisation has a **MODERATE** tolerance.
- Threats and Vulnerabilities - The organisation has a **LOW** tolerance
- Operational Performance - The organisation has a **LOW** tolerance.

P Donaldson provided a summary of each of the topics above.

A Graham noted where there are legislatives requirements and where there is risk to the organisation these are low.

A Young delivered a presentation to provide further information on the above. If we are going to introduce a tolerance framework, we need to put consequence of the risk materialising. This will allow additional steps to review. Information advised to the NISD thresholds.
A Brown queried, how is this used in practice. A Graham replied we will review the practical prioritising e.g., DPIA's in place for systems, this is important. We will carry risk beyond our tolerance level but it regarding the treatment plans within our tolerance level.

J Tomlinson thanked for this paper and provided feedback on the way the framework is explained. How are we going to test these categories and ensure feedback is received from all and not just this Group. A Graham noted we need to translate, and we if we are content, we can evidence. Further discussions are required and communications on what does it mean.

No further comments were raised.

Approved by Group

6. DOCUMENTS FOR APPROVAL/COMMENTS

6.1 - IG&S Steering Group Review of TOR

A Graham noted ToR brought to Group to review.

A Brown queried within the purpose section noting other committees had been asking for explicit comment on the responsibility of Groups for the IJB. A Valente also noted that had been asked and both queried if necessary for this Steering Group

Conversation with A Brown and A Valente to be taken offline to discuss further.

Action – A Brown and A Valente to confirm requirements for ToR

6.2 - IG&S Steering Group Annual Workplan

A Graham noted ToR brought to Group to review and provided feedback to the amended workplan.

No comments were raised.
Approved

6.3 - IG&S Steering Group Annual Assurance Report

A Graham provided a brief overview of the Annual Assurance Report and noted a few of these activities:

- IG&S Steering Grp in April 2022 was stood down to current pressures within NHS Fife.
- Data Sharing
- Work of SAR SLWG
- NISD action plan.

A Brown queried within the Risk section for the tolerance level to be added. Item to be considered

A Graham asked Group to provide any comments and report shall be presented to M McGurk so signing.

No comments were raised.

7. ITEMS FOR ESCALATION TO CLINICAL GOVERNANCE COMMITTEE

A Graham noted they will check with M McGurk if the ICO Audit is an appropriate item for CGC. No other items to escalate to CGC.

8. AOCB

M Guthrie highlighted the SLWG for SAR'S was noted within the ICO audit report and the requirement for all areas to support the single point of contact work. A meeting is scheduled to discuss this further on impact to Legal Service and an update will be provided.

9 DATE OF NEXT MEETING:

Thursday 13th July 2023, 1430, via MS Teams

MEDICAL DEVICES GROUP

(Meeting on 8 March 2023)

No issues were raised for escalation to the Clinical Governance Committee.

Medical Devices Group

Minute Medical Devices Group
Wednesday 8 March 2023 at 2 pm on Teams

Present

Iain MacLeod, Deputy Medical Director (Chair) (IMacL)
Neil McCormick, Director of Property & Asset Management (NMcC)
Alistair Graham, Associate Director Digital & Information (AG)
Amanda Wong, Director of Allied Health Professionals (AW)
Donna Galloway, General Manager, Women Children & Clinical Services (DG)
Claire Fulton, Lead for Adverse Events, Clinical Governance (CF)
Iain Forrest, Medical Physics Manager (IF)
John Brown, Head of Pharmacy (JB)
Julia Cook, Infection Control Manager (JC)
Maxine Michie, Deputy Director of Finance (MM)
Miriam Watts, General Manager, Primary Care (MW)
Nicola Robertson, Associate Director of Nursing (NR)
Robyn Gunn, Head of Laboratory Services (RG)
Rose Robertson, Assistant Director of Finance (RR)
Satheesh Yalamarthi, Consultant, General Surgery (SY)

Andrea Barker, Note Taker

The meeting was recorded on Teams
The order of the minute does not necessarily reflect that of the discussion

		Action
1	**WELCOME & APOLOGIES** Apologies were received from Chris McKenna, Claire Steele (John Brown), Shirley-Anne Savage (Claire Fulton), Aylene Kelman, Kevin Booth & Murray Cross.	
2	**MINUTE OF LAST MEETING/MATTERS ARISING** The Minute of 16.08.22 (unconfirmed) amended* was approved by the group. *(Item 7.1 Scan for Safety Programme wording change by IF).	
3	**GOVERNANCE** 3.1 Medical Devices Group Terms of Reference	

NMcC has incorporated all comments made at the last meeting into the 'draft' version presented today. NMcC added that it may be beneficial to keep the ToR updated as we as we go through the first few meetings to make sure that the group is capturing everything it needs to.

SY – From a clinical level and service level, it would be helpful to have a clear understanding of the processes to be undertaken around the route of a Business Case following approval at SLT.

NMcC – Business Cases will follow the undernoted route:

- Capital Equipment Management Group (CEMG)
- Fife Capital Investment Group (FCIG)
- Executive Directors Group (EDG)
- Finance, Performance & Resources Committee (FP&R)

The **Capital Equipment Management Group** focuses on the mechanics of the co-ordination and prioritization of the procurement and allocation of often scarce resources.

The **Medical Devices Group** is around setting the direction of travel and the standardization of equipment by ensuring that the correct policy decisions are being made around the type of equipment being purchased ie fully compliant, modern and fit for purpose.

The **Medical Devices Group** reports to:

Clinical Governance Committee

The idea is that the two groups are carrying out different roles, with set rules on both groups ensures linkage is made.

3.2 GP/E4 Medical Equipment Management Policy

IF – feedback has been received from the General Policies Group with some minor textual amendments to the document.

Comments

NR – Under item 2 Operational System – point one, it talks about higher value capital equipment and lower value equipment replacement planning. What is the cut off is between low and high?

MM – The criteria for something to fall under capital funding is if the purchase is over £5,000, or if it is under £5,000 and you are buying a number of the said item and collectively they exceed £20,000 then they will go to the Capital Equipment Management Group for discussion.

	Last week at the FCIG, we improved the governance around the processes for bids coming forward for equipment which was subsequently approved at the meeting. We must ensure, however, that these are reflected correctly in this document before final approval. To Summarise: **Action** – IF will make the relevant changes that the General Policies Group have asked for. **Action** – Once the necessary changes have been made, IF will then forward the policy to MM and her team via e-mail correspondence and if everyone is happy, the document will be approved. 3.3 GP/E4-01 Medical Physics Operational Procedure IF – The General Policies Group suggested some minor textual amendments to the document which will be completed and then forwarded onto NMcC to sign off. 3.4 GP/I4 Digital Solutions Procurement Policy AM – The GP/I4 Digital Solutions Procurement Policy is at consultation stage as the document has gone through a fairly major re-write. We are looking to consult on the procedural aspect, and are asking if there is anyone from the Medical Devices Group who would like to be involved in this process? There is a specific section that relates to this group, which is detailed under Networked Physical Devices of which medical devices are a subset of. We will then have a process that is effective and allows us to sign these devices off from a NISD data and security compliance point of view. IF – Confirmed he is happy to be part of the consultation process. IF – In relation to many of the devices we purchase, the Medical Physics Technicians attend courses on how to maintain them. They are also advised on the specific applications required to connect to the device in order to run the Maintenance Programme. The software is provided free of charge. There is no Maintenance Contract involved. IF – I would be interested to know what the governance is around this? AG – The supplier would be responsible for holding our transmitting data and this would probably be picked up under the software systems and applications part at this end. We certainly need to govern the applications and systems that support this. **Action** – IF & AG to meet out with the meeting and take forward.	**IF** **IF/MM** **IF/AG** **AG**

	Action – AG agreed to bring GP/I4 Digital Solutions Procurement Policy back to the Medical Devices Group when it next meets on 14 June 2023.	
4	**FOR DISCUSSION** 4.1 NHS Fife Review of Medical Equipment Management NMcC – Having given consideration to medical devices and the setting up of the Medical Devices Group, I thought it would be helpful to have an independent specialist come in and have a look at how we manage medical devices in Fife with a view to obtaining recommendations in terms of what our work plan is and our priorities going forward. I asked a colleague from NHS Forth Valley, Bryan Hynd who is the Head of Medical Physics for his assistance. Brian is well renowned across Scotland and has carried out similar reviews before for NHS Grampian and NHS Tayside. Recommendations include: a. Improvements to the Medical Physics Workshop Facilities at VHK I have asked PB and IF to work together to try and locate more appropriate accommodation to address some of the points that have been raised. b. Departmental Structure IF and his team in Medical Physics are too far away from the strategic component of the Board. At present, IF feeds in through the Estates Sector Manager, David Lowe and then through the Head of Estates, Paul Bishop. We felt that the way that we manage medical devices across Fife should be brought further up the hierarchy of NHS Fife. It was also felt that we may benefit from a Head of Medical Physics which will assist with being able to carry out a lot of the work that is required to be overseen by this group. In the short-term, we have moved IF to report directly to Paul Bishop which brings him up to a Fife wide level. A job description for a service lead for Medical Devices has been drafted and will shortly go through the grading process. The post and corresponding job description has been included in our Strategic Planning Resource Allocation (SPRA) for next year. c. Equipment Management Database	

It is important for NHS Fife to have a reliable equipment management database which can help when existing equipment requires to be replaced.

The database can be used as a strategic planning tool not only to support the CEMG, but also a database that is fully compliant and holds the necessary information required to run the Scan for Safety Programme effectively. The database is called eQuip and has been offered to NHS Fife by the Scottish Government (SG) and will allow us to carry out a data transfer and a thorough cleaning up of our existing data, previously held on the MICAD system.

Equip will link into the RFID system and allow us to be able to locate key pieces of equipment across the Victoria site at any given time.

We are looking at the implementation of a passive RFID system and an RFID asset tagging printer has been purchased in order to carry this out. This will effectively allow us to affix RFID labels to equipment which can then be easily traced by the use of a detector.

Equipment will be able to be shared more easily NHS Fife wide.

d. Scan for Safety

In order to move forward and meet the requirements of MHRA, IF and the Medical Physics team supported by AG and the D&I team are looking at the implementation of Scan for Safety with a view to installation in the coming months.

This will require strong policies to support it.

The requirement is for all new equipment to be transparent in order for us to be able to easily log equipment into the system and keep the inventory up to date. This will prevent some of the problems that we have encountered in the past.

e. Planned Replacement Programme/s

NHS Fife is looking into whether we can be more efficient in terms of maintenance contracts when purchasing equipment by standardizing contracts. Consideration is being given to employing additional staff to maintain and cut down on the money we spend on third party suppliers.

f. Moving Forward

NMcC – It is my intention, if this group agrees, that we create an Action Plan from this showing clear direction on what we want to achieve.

Over the coming year and in future years, there is a requirement for us to

identify the key parties to support that process in order for the group to monitor the implementation of the recommendations.

Comments

NR – There is at least some recognition of good practice and staff complemented on their training, but otherwise I thought it was overall quite negative as the summary section mentions an increased risk of clinical incidence and potential interruption to services.

NR – Is there a risk that equipment could come through that has not been certified or approved through infection control and do we know what sort of risk this would pose for clinical services?

NMcC -There are some risks in there and these are exactly why we are doing this, which is to point out that if equipment is purchased by staff and there is no recognition of this by the organization, then the opportunity is missed for it to be recorded as a medical devices asset.

The review is quite factual and I do accept that some of the feedback was positive and that we do a lot of things well. It has, however, highlighted that we have not invested enough in medical devices and the management of medical devices over the past few years.

This also has a knock-on effect in terms of the digital aspect as a lot of equipment now has the capability of being connected up to the network.

Overall, IF and the Medical Physics team should be commended on the fact that they have all entered into this with goodwill.

Overall, this review is not to be taken as a form of criticism and we should take it as an opportunity to improve on existing practices.

IMacL – The document is factual in that it is setting down what NHS Fife should be aiming to work towards. By taking the positives out of the review is important but there was a lot of complements and what has been achieved in the face of difficult circumstances.

DG – I noted the lack of control around the purchasing of equipment as we see that all the time, and there is no control over it. If you link up with the Point of Care Committee, there are items that are supposed to come through the Committee that do not. There are no invalidating processes in place.

In terms of the Quality Management System and the international standards, Labs work very tightly to ISO 15189 standards. There is a lot of learning to be undertaken around wrapping up all of our processes.

	SY – Moving forward, in terms of medical equipment, we as Clinicians should consider how we work closely with D&I together with the Medical Devices Group. IMacL – That is the purpose of this group and your points are well made and will evolve over the course of the next few meetings alongside governance issues and cost implications. If we get it right, there will be significant benefits for our patients, our processes and our overall efficiency. RR – As Chair of the CEMG, I would welcome some of the recommendations of this particular report as CEMG is based around securing the finance, coordinating the procurement, the monitoring, the forecasting and influencing additional finance where we can. One of the main reasons of this group is to ensure the appropriate compliance criteria is met which extends to section 4.1 of the report. Not only does this cover capital equipment but also covers revenue equipment. My question on the mechanics then is how is all this going to work? We have already anchored that FCIG has approved a strengthened governance paper to do with the Five-Year Replacement Plan. What has been agreed is that the Five-Year Replacement Plan will be endorsed at the respective senior leadership team meetings or equivalent groups which would then go to FCIG for approval. MM – What is key and basically the most important recommendation in that report is the appointment of that strategic lead for medical devices as they will have an influence on the development of those five-year plans. The CEMG and FCIG may have to be a little flexible as things may change as well as things move forward whilst the group is in its infancy period. By having that strategic leader in place will help take a lot of that forward. NMcC – We do not have all the answers at the moment; however, it is important that we continue developing our five-year plans. It is important that the Medical Devices Group is kept up-to-date.	
5	**<u>FOR INFORMATION</u>** 5.1 <u>SAN2301 – National adverse incident reporting and safety alert systems for medical devices, IVDs, estates, facilities, social care equipment and PPE</u> (04.01.23) The above document was circulated to the group for information. NMcC – Adverse Incident Reports and Safety Action Notices (SANs) are controlled and distributed by Gillian MacIntosh and her team. It would be beneficial for this team to turn its attention to how this works, that the	

	distribution is going to the correct people and Gillian's team are supported by the experts in the field. IMacL – Useful to note a possible cross-link as Elizabeth Muir has a process in place around SANs that have come in under the Clinical Governance Framework. They are tracked, sent out for action and any recommendations and reports are returned, where necessary.	
6	**MINUTE FOR NOTING** 6.1 The Capital Equipment Management Group minute of 03.11.22 was circulated for information and noted by the group.	
7	**ANY OTHER BUSINESS** 7.1 Proposed 2023 Meeting Dates The 2023 proposed quarterly meeting dates were approved by the group. Post Meeting Note – Teams invites for 2023 meetings were sent out to the group. **Issued on 08.03.23** (AB) 7.2 Minute/Relevant Paper/s Distribution to CEMG (RR) RR – Is the group happy for CEMG to receive minutes and ToR from the Medical Devices group to raise their awareness? **Approved** 7.3 Governance Paper (Medical Devices) to FCIG (RR) Would it be possible to have a copy of the governance paper that went to FCIG around the Medical Devices group? Once the group is a little bit more mature we can adapt it further where this group sits within the process. **Approved** **Action** – NMcC/MM to forward on a copy to RR. 7.4 Scan for Safety Meetings (IMacL) IMacL advised that he had attended several Scan for Safety meetings representing NHS Fife. The agenda is moving ahead and the team is up and running with their website established. In relation to pilot sites for the Scan for Safety Programme roll out, NHS Fife falls quite far down the line. We are looking around being involved 2025 at the earliest. In the first instance, they are working with NHS Greater Glasgow & Clyde and NHS Lothian as the bigger providers in terms of implantable devices.	NMcC/MM

	We, therefore, have a bit of leeway before the Programme makes its way to us, however, I will update as soon as I receive any further information. 7.5 Live examples for discussion at future meetings (IMacL) One suggestion for discussion at the next meeting: Infusion devices	
8	**DATE & TIME OF NEXT MEETING** Wednesday 14 June 2023 at 2 pm on Teams.	

RESEARCH, INNOVATION & KNOWLEDGE OVERSIGHT GROUP

(Meeting on 29 March 2023)

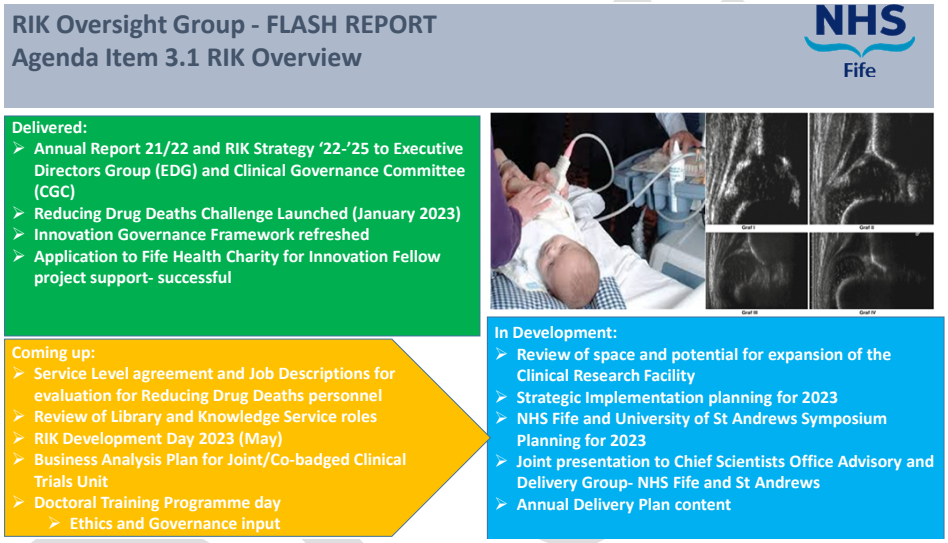
No issues were raised for escalation to the Clinical Governance Committee.

Research, Innovation & Knowledge Oversight Group

RESEARCH, INNOVATION & KNOWLEDGE OVERSIGHT GROUP MEETING
MINUTES
Microsoft TEAMS,

	29 MARCH 2023 (2.30pm – 3.30pm)	**ACTION**
	Present: Dr Chris McKenna, Medical Director, Executive Lead for Research, Innovation & Knowledge (CMcK) Prof. Frances Quirk, RIK Assistant Director (FQ) Dr Grant Syme, Physiotherapist Consultant (GS) Neil Mitchell, Innovation Manager (NM) Anne Haddow, Lay Advisor (AH) Ben Hannan – Director of Pharmacy (BH) Alistair Graham, Associate Director, Digital & Information (AG) Shirley-Anne Savage, Associate Director of Quality and Clinical Governance (S-AS) Sophie Given – Head of Nursing – Acute Services (SG) Karen Gray, Lead Nurse (KG) In Attendance: Roy Halliday, R&D Support Officer – minutes (RH)	
1.0	**CHAIRPERSON'S WELCOME/APOLOGIES AND OPENING REMARKS** **Apologies;** Prof. Colin McCowan, Head of Population Health and Behavioural Science Division, University of St. Andrews Prof. Frank Sullivan, Director of Research, University of St. Andrews Doreen Young, Head of Practice & Professional Development Morwenna Wood – Director of Medical Education	
2.0	**STANDING ITEMS**	
2.1	**OVERSIGHT OF R, I K OVERSIGHT GROUP MINUTE** CMcK welcomed all to the meeting and two new attendees introduced themselves, Sophie Given, the newly appointed Head of Nursing for Acute Services and Shirley-Anne Savage, acting Associate Director of Quality and Clinical Governance The RIK Oversight Group Minutes were accepted with amendment correction to section 7.1 change August 2923 to August 2023. **Completed Actions:** Action 3.1: An SBAR has gone to the EDG to advise that Fife will be the lead board for the Reducing Drug Deaths Innovation Challenge. Action 4.1: Input has been provided to the structure and curriculum for the Masters in Health Professional Education. Action 5.2: NM is working with Innoscot Health to redraft the proposal.	

	Action3.1: SHARE recruitment letters – FQ advised that we have recently approved for a SHARE recruiter to start face to face recruitment in Outpatients. SHARE are also happy for recruitment letters to be digital.	
2.2	**OVERSIGHT OF RIK OPERATIONAL GROUP MINUTE AND ACTION LIST** FQ discussed an action with Pharmacy and cost savings, work is taking place to assist with forward planning around capacity and capability and to align with support required.	
3.0	**STRATEGIC PRIORITIES/INITIATIVES**	
3.1	**RESEARCH AND DEVELOPMENT**	



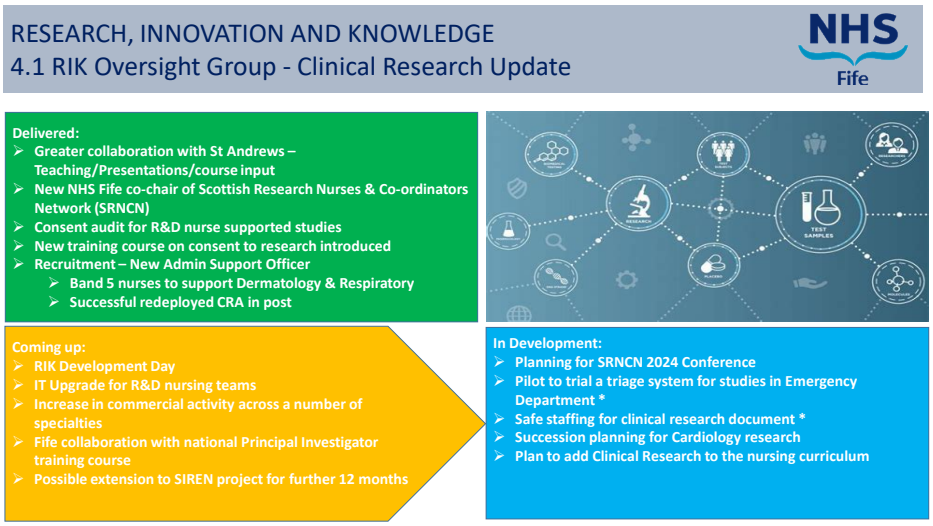
FQ advised that the RIK Annual Report and RIK Strategy had been submitted to the Executive Director's Group and Clinical Governance Committee. The Reducing Drugs Deaths Challenge was launched at the end of January.

The Innovation Governance framework has been reviewed and refreshed and is now ready for implementation.

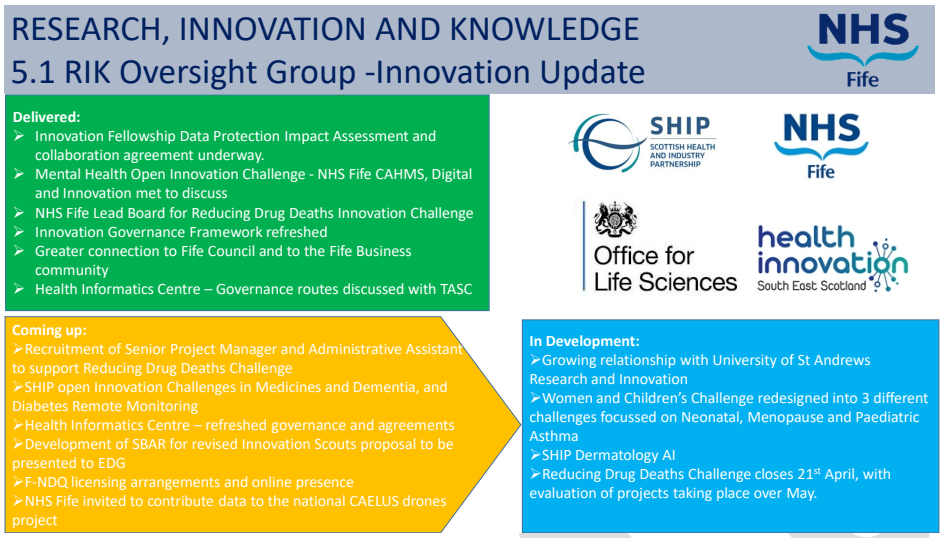
A successful application was made to the Fife Health Charity for Innovation Fellowship project support. Joyce Henderson recently met with Vinton Cerf who is an Internet pioneer and is recognized as one of "the fathers of the Internet" the meeting was to discuss his initial interest in our project, he will also be in Scotland in October and our aim is to connect him with Professor Dame Anna Dominiczak to discuss the wider Clinical Innovation portfolio in Scotland.

A strategic review of Library & Knowledge Services roles is underway to plan for more strategic leadership and to make better make use of our resource and capability, in particular digital support and providing more targeted support to a likely increasing complement of medical students.

Planning is underway for this year's RIK Development Day which will take place on 04th May.

	FQ is working with Professor Frank Sullivan and the Director of Business Transformation and Planning at St. Andrews on the business plan for a joint/co-badged Clinical Research Facility. Part of this plan is a space review and will be needed for a potential expansion of our current Clinical Research Facility. FQ also advised that planning is underway for this year's joint symposium with St. Andrews (25th October). FQ and Professor Frank Sullivan will be delivering a presentation to the Chief Scientists Office Advisory and Delivery Group around joint project's and cooperative working (04th June). CMcK noted the significant work that is taking place.	
4.0	**RESEARCH AND DEVELOPMENT**	
4.1	**CLINICAL RESEARCH UPDATE**  KG highlighted from her report advising that she has been appointed as co-chair of the Scottish Research Nurses & Coordinators Network, with the aim to provide training, material support and help to steer the direction of research nurses in Scotland. A Consent Audit training course has been devised and can be delivered to anyone at NHS Fife or St. Andrews. Three new members of staff have joined the team this quarter. A national Principal Investigator's training programme is being developed, largely based on the one at NHS Fife, with the help of the NRS forum, It will be available to all Scottish Health Boards. The SIREN study is due to close at the end of March 2023, it may be extended for another 12 months. KG is working with others to include Clinical Research in the national nursing curriculum.	

5.0	**INNOVATION**	
5.1	**INNOVATION UPDATE**	



NM advised that the Scottish Health and Industry Partnership (SHIP), Small Business Research Initiative (SBRI) for Mental Health has commenced and there are two companies working with Health Innovation South East Scotland (HISES), these companies will be looking at ways to interact with patients in the CAMHS waiting lists.

NHS Fife Innovation and Fife Council have fostered a closer relationship over the last few months which will allow a greater collaboration with the Fife business community and enables us to distribute any funding opportunities and Innovation calls to the Fife business community for engagement.

NHS Fife is the Lead Board for the Reducing Drugs Death challenge and funding has been made available to recruit a Senior Project Manager and Admin Assistant, Job descriptions and person specifications have been drafted and are currently with HR for review.

NM advised that the NHS Fife developed Fife Neuro Developmental Questionnaire (FNDQ) has received interest from other Boards and Trusts to use within their own services and for research at Universities. This is currently being discussed with the Central Legal Office with regards to licensing agreements and what potentially would be required to put it as an online resource that would be hosted by the Psychology service.

The SHIP Women and Children's Innovation challenge had received so many high quality applications, that it was decided to redesign the challenge and it has now been separated into three challenges, which will be "Neonatal Care at Home", "Innovative Use Technology" and "Menopause Services".

5.2	**REDUCING DRUG DEATHS CHALLENGE**	

NM advised that NHS Fife has taken the role of lead Board, as part of HISES, for the Reducing Drug Deaths National Innovation Challenge. This Challenge is a collaboration between Scottish Health and Industry Partnership (SHIP) and the UK Office for Life Sciences (OLS) and will allow applicants to bid for a share of £5M. This challenge will be split into two phases where projects in early development can apply for four £100,000 grants. Two successful companies from phase 1 will then move forward to phase 2 where they will receive £500,000 for further development. This is a UK wide challenge and, as noted, we will receive some additional funding to assist with the recruitment of new staff to provide programme management and admin support.

NHS Fife Innovation team will be managing all the queries regarding the challenge which is anticipated will mostly be relating to the scope of the challenge and connection to test bed partners as well as queries regarding costs and budgets.

NM added that this was an excellent opportunity for NHS Fife and would put us in the spotlight highlighting our reputation as a leader in research and innovation as well as highlighting our position within HISES as a valuable contributing member of the regional test bed.

CMcK thanked NM for the update and thought this was really exciting news.

CMcK left to attend another meeting and FQ took over the chair.

BH added that he is more than happy to support this in any way he can.

SG added that she had previously worked with the Scottish Drugs Forum this is an area that she is really interested in so would be more than happy to become involved wherever she could.

NM to follow up with BH and SG

6.0	**LIBRARY & KNOWLEDGE SERVICES**	

6.1	**LIBRARY STAFFING REVIEW** Discussed in 3.1	
7.0	**PARTNERSHIP UPDATES**	
7.1	**DOCTORAL TRAINING PROGRAMME** FQ advised that Cohort 2 Fellows have been appointed and are currently undertaking their run-in period. Polly Black a research nurse from NHS Lothian/UoEdi is undertaking a project in Falls in patients with multimorbidity supervised by Peter Donnelly, Frances Quirk, Rishma Maini and Colin McCowan. Katy Hill an Infectious Diseases trainee in NHS Lothian is undertaking a global health project to better understand the impact of multimorbidity in patients being treated for TB in Uganda and Tanzania supervised by Derek Sloan, Christine Sekaggya and Stella Mpagama. The call for proposals for Cohort 3 was launched today and timelines for this year's recruitment are set out below. One key difference this year is that the scheme will also be open to healthcare scientists. Project calls open Wednesday 29th March, project calls closes Friday 26th May, short listing Tuesday 13th June, projects chosen and job advert Monday 17th July, Interviews will take place in early October.	
7.2	**JOINT RESEARCH OFFICE** FQ advised that plans are underway to host another NHS Fife/St. Andrews joint symposium in October 2023 (25th October). FQ and Professor Frank Sullivan will be delivering a presentation to the Chief Scientists Office Advisory and Delivery Group around joint projects and cooperative working (June 4th).	
7.3	**NHS FIFE & UNIVERSITY OF ST. ANDREWS PARTNERSHIP** FQ advised that NHS Fife is currently developing an internal strategy to support the ambition to advocate and lobby for teaching hospital status. The document will be brought to this group when available.	
7.4	**R&D/FIFE COMMUNITY ADVISORY GROUP**. AH updated from her report (attached to the Agenda) and wished to draw attention to the Fife Community Advisory Group meeting taking place on 27th April where the group have approached researchers, involved in a project relating to public procurement in the NHS and 'value for money', to provide an update on their study. NHS colleagues are welcome to attend this event. AH also advised that the lecture on AI technology to diagnose bowel cancer will take place 06th April. Anyone wishing to attend these meeting can email AH direct.	
7.0	**AOCB** Post meeting note: The Research Capacity and Culture Survey quantitative outcomes have been published. PDF of Journal Article attached to Minutes.	

	BMC_HealthServices Research_RCCT_202:	
8.0	**DATE AND TIME OF NEXT MEETING** Wednesday 21st June, 11.00 – 12.00	

Resilience Forum

RESILIENCE FORUM

(Meeting on 1 March 2023)

No issues were raised for escalation to the Clinical Governance Committee.

Department of Public Health
Cameron House, Cameron Bridge, Leven, KY8 5RG

Unconfirmed minute of the NHS Fife Resilience Forum Meeting held on Wednesday 01st March 2023 at 2:00pm via Microsoft Teams

Present:

Joy Tomlinson, Director of Public Health (Chair)	**JT**
Susan Cameron, Head of Resilience	**SC**
Craig Burns, Resilience Officer	**CB**
Kirsty MacGregor, Associate Director of Communications	**KMcG**
Susan Fraser, Associate Director of Planning and Performance	**SF**
George Brown, Resilience Officer	**GB**
Siobhan McIlroy, Head of Patient Experience	**SMcI**
Malcolm Fowles, Deputy Head of Digital Operations	**MF**
Donna Galloway, General Manager	**DG**
Samantha McLaughlin, Resilience Advisor, Scottish Ambulance Service	**SMcL**
Lorraine King, Business Manager	**LK**
Stevie Rutherford, Personal Assistant	**SRR**

ACTION

1. Welcome and Introductions

Chair opened the meeting and welcomed Siobhan McIllroy.

2. Apologies

Apologies were received from Lynne Garvey, Alison Henderson, Allan Young, Fiona McKay, Jeanette Keenan, Neil McCormick, Nicola Robertson, Alastair Graham, David Miller, Olivia Robertson and Paul Bishop

3. Minutes of previous meeting (01st December 2022)

The minute was agreed as an accurate record of the meeting

3.1 Action Tracker

The action tracker was reviewed and updated.

4. Matters Arising

Severe Weather Framework

SC

SC reported that the Severe Weather framework document was presented to the Executive Director Group (EDG) early January 2023.

After reviewing EDG noted some formatting was required and a universal communication message was needed.

SC reported further feedback was also received around payment of the service level agreement- in which this is required to be able to reimburse Fife 4x4 volunteers with fuel expenses, which will be formalised with the finance team.

SC reported that Bitesize Business Continuity training exercises are ongoing.

Major Incident Plan Framework Action Cards

SC reported that draft Action cards were included in an update for EDG on 19th January 2023, feedback was received from EDG regarding the escalation pathway and universal communication. GB continues to work on this and an updated version will be prepared.

Business Continuity Planning

SC advised that we have been working closely with Fife Health and Social Care Partnership regarding the Master Repository for Business Continuity plans. SC advised that the Resilience team are hoping to have an overarching report ready for Quarter 4.

Vulnerable Person PARD – Person at Risk Distribution List

LK provided an update on this piece of work on behalf of Lynn Garvey.

LK advised that the Short Life Working Group continues to progress and Fife Council are looking at a Data Protection Impact Assessment (DPIA), this is a process agreed internally in Fife Council. LK further reported this piece of work will be tested and moved forward by Fife Council.

Digital Resilience

SC reported this work is now completed re solar flares and that AY had indicated adequate resilience planning was in place.

Scientific & Technical Advice Cell – (STAC)

SC reported that there is updated guidance and this has been circulated by the East of Scotland LRP.

Bomb Threat & Suspicious Package

SC reported universal communications will be added and the framework document will be then cascaded following the update.

Lockdown Framework

SC advised the group that a short life working group has been setup. CB commented that the framework document has been forwarded to Donna Galloway, Lynn Garvey and Neill McCormick for further review. A communication message has been added. Work has begun to update the document from the feedback received. The document will be circulated again in due course.

5. Resilience Governance & Assurance

5.1 Business Continuity Assurance of Capability Returns

SC advised that the timeline for completion of the capability returns have been extended to allow more time for staff to complete the returns. Health and Social Care were initially omitted from the circulation and therefore have only started working on their Business Continuity plans.

SC has spoken with appropriate general managers within NHS Fife to offer support. SC hopes to have an update in quarter 4.

5.2 Update on progress towards internal audit actions

SC reported that the internal audit team are likely to focus their activity next year on those areas with business continuity plans assessed as amber. There are 133 areas identified across NHS Fife. A check and refresh exercise on business continuity has been carried out.

Internal audit are extending timescales slightly in respect of the NHS Fife major incident plan. This is to enable the framework documents to be place.

SC reported that tests with EDG have been carried out and the team are working hard to have the correct terminology and internal process escalation simplified and clearer.

The response from Emergency Department (ED) has been good and SC commented that audit appreciate that we have a suite of framework documents and not just a single document.

5.3 Stakeholder Framework Document Assurance Checklist

SRR displayed on screen.

SC advised that for any documents we hold, there should be standard formatting which should include, date of issue, name of document, any update made from external agency / partners.

Once the document is drafted, it is cascaded through EDG and any other subsequent groups or meetings, the checklist is used until the document is ratified.

6. Whole System Overview

6.1 Planning & Performance (Winter Planning/other)

SF reported that she is planning the winter review and can confirm the review session will run on 20th April. Within this session, there will be a group discussion, a look back at the challenges and issues from last year and what we can do differently next year.

SF gave an update on the annual delivery plan and noted that there is no input from resilience and SC would like some input from the team. SF to have a conversation out with the meeting.

ACTION – SF to speak to SC re annual delivery plan. **SF**

SF informed the group, that the system and flow group and still meet on a weekly basis.

6.2 SAS Overview

SMcL reported that things seem to be improving across the service and that escalation level was down to rate 2 following it being at rate 4 in regards to the Resource Action Plan over the festive period. SMcL also reported that there were still ongoing significant challenges.

SMcL reported that the Scottish Ambulance Service major incident plan has been updated and is being rolled out to internal staff.

It was reported that the NHS Communications Testing from Scottish Ambulance Service health boards is due to take place in March 2023.

6.3 H&SCP – Persons at Risk Distribution Lists NHS Fife (PARD)

This was discussed under matters arising.

LK reported that Shona Robinson from Fife Council is linking with Falkirk Council to clarify their position.

LK reported that she has no further update on behalf of the Health and Social Care Partnership Local Resilience Group. LK Continues to do a blackout matrix for areas of concerns and progressing with Business Continuity Assurance visits.

6.4 PREVENT – Audit Tool 6.4a – GOV.SCOT, 6.4b Quarter 3 Return

SC advised that she provides a quarterly return to Health EPR Scottish Government Colleagues on the training for PREVENT, this is one of the mandatory requirements across NHS Fife.

CB is liaising with Police Scotland colleagues to arrange some face to face training alongside our colleagues in Health and Social Care.

SC reported Scottish Government have sent the Resilience Team a self-assessment toolkit. A PREVENT action plan needs to be created for NHS Fife. The Resilience team will arrange a short life working group to progress this piece of work.

SC reported Kevin Reith from HR will look at getting PREVENT duty being covered in new employee contracts.

ACTION - SLWG to be convened to take forward an action plan for PREVENT, security leads, HR, Health and Social Care Partners, Patient Experience, Digital, and possibly clinical leads (Medical and Clinical). **SC**

7. Digital Sit Rep – Cyber Incident 5/8/22

MF provided a brief update on the consequences of the Adastra Urgent care Platform cyber incident. The system is now functioning as normal again. Laptops are provided for the cars; a setup was carried out by communications rather than Adastra themselves. The national team have reviewed the security and are happy with the platform as it stands now.

JT asked if this incident should be considered closed. MF agreed.

7.1 BIA Revised Business Continuity Template

SC provided an update on behalf of Kathleen Bolton. SC explained that digital needs a little bit more assurance and information around the business impact analysis that is required for business continuity planning.

Previous business impact analysis template did not provide enough detail. Katherine Bolton is looking to identify gaps and assist colleagues with their business continuity impact assessment.

No changes were suggested to the updated document and it was recommended this is ratified.

8. Emergency Plans

8.1 STAC - Appendix 8.1a and 8.1b

The East of Scotland Local Resilience Partnership approved the above plan on 26th January 2023, and it will be published on Resilience Direct.

ACTION: SC to share ratified document. **SC**

8.2 Universal Communication (Framework Document)

CB reported this is to ensure and standardise a single communications message on all framework documents. It was noted how important it is to have the Communications team coordinating sending and receiving messages and inserting information where needed.

9. Training & Exercising

9.1 Mighty Oak

JT provided an overview about exercise Mighty Oak, which is the national power outage test exercise, is being setup to test UK and Scottish Government structures primarily. The focus of this exercise will be a national power outage, it is thought this will take place in late March 2023. The primary purpose is to look at the government structure and how the information will flow.

JT went onto say local resilience partnerships have had discussions about involvement. This is being encouraged by Scottish Government and they have asked LRPs to consider which elements we want to exercise locally.

JT reported that on the 30th March, LRP in Fife will be organising an face to face meeting, JT and SC will attend for NHS Fife.

9.2 Business Continuity Testing & Exercising Program (From March 2023)

SC reported that she has support from the Acute Directorate Senior Leadership Team to commence testing and exercising of Business Continuity Plans from March. A one-hour session will be held in all departments to discuss their plans and to undertake a gap analysis with them.

10. Upcoming Significant Events

GB reported that there will be testing at Diageo sites around Fife, he advised it may be November before this takes place.

GB reported the World Cycling Championships will be taking place in August this year and will potentially pass-through Stirling and Edinburgh. There may be a learning opportunity in the format of a tabletop exercise for the event.

10.1 Regional Resilience Events Brief

The monthly Resilience events notification was published and circulated in December 2022.

Fife Council send the events brief monthly to the Resilience mailbox and this is circulated to relevant colleagues.

There will be road closures in St Andrews for the filming of the TV Series ‘’The Crown’’. Details are available on the Fife Council website.

GB reported Knockhill have published their itinerary for the remainder of the year. ‘’ The Best of Scottish Motorsport’’ will take place on 15th and 16th April.
NHS and Military staff are receiving free entry to both events.

11. Any other business

Nothing was raised.

12. Date of next meeting

Thursday 08th June at 1400hrs

12.1 **Schedule of meetings for 2023**

Thursday 08th June at 2:00pm
Thursday 07th September at 2:00pm
Thursday 14th December at 2:00pm