NHS Fife Clinical Governance Committee

Fri 02 September 2022, 10:00 - 12:30

MS Teams

Agenda

10:00 - 10:00
0 min

1. Apologies for Absence

Christina Cooper

10:00 - 10:00
0 min

2. Declaration of Members' Interests

Christina Cooper

10:00 - 10:00
0 min

3. Minutes of Previous Meeting held on Friday 1 July 2022

Enclosed *Christina Cooper*

Item 03 - Clinical Governance Committee Minutes (unconfirmed) 1 July 2022.pdf (11 pages)

10:00 - 10:10
10 min

4. Matters Arising / Action List

Enclosed *Christina Cooper*

Item 04 - Clinical Governance Committee Action List - 20220902.pdf (3 pages)

10:10 - 10:20
10 min

5. ACTIVE OR EMERGING ISSUES

5.1. Covid-19

Verbal *Chris McKenna*

10:20 - 10:45
25 min

6. GOVERNANCE MATTERS

6.1. Annual Statement of Assurance for Clinical Governance Oversight Group

Enclosed *Chris McKenna / Gemma Couser*

Item 06.1 - Annual Statement of Assurance for Clinical Governance Oversight Group.pdf (6 pages)

6.2. Board Assurance Framework - Quality and Safety

Enclosed *Chris McKenna*

Item 06.2i - SBAR BAF - Quality & Safety.pdf (3 pages)
Item 06.2ii - Appendix 1 BAF - Quality & Safety.pdf (2 pages)
Item 06.2iii - Appendix 2 BAF - Quality & Safety - Linked Operational Risks.pdf (3 pages)

6.3. Board Assurance Framework - Strategic Planning

Enclosed *Margo McGurk / Susan Fraser*

- Item 06.3i - SBAR BAF - Strategic Planning.pdf (3 pages)
- Item 06.3ii - Appendix 1 BAF - Strategic Planning.pdf (1 pages)

6.4. Board Assurance Framework - Digital and Information

Enclosed *Alistair Graham*

- Item 06.4i - SBAR BAF - Digital & Information.pdf (4 pages)
- Item 06.4ii - Appendix 1 BAF - Digital & Information.pdf (2 pages)
- Item 06.4iii - Appendix 2 BAF - Digital & Information -Linked Operational Risks.pdf (2 pages)

10:45 - 10:55
10 min

7. RISK

7.1. Draft Corporate Risk Register & Dashboard

Enclosed *Margo McGurk*

- Item 07.1i - SBAR Draft Corporate Risk Register & Dashboard + Annex 1.pdf (4 pages)
- Item 07.1ii - Annex 2 Proposed Risks for Inclusion in the Corporate Risk Register.pdf (7 pages)

7.2. Development of Assistant Practitioner Role

Enclosed *Janette Owens*

- Item 07.2 - SBAR Proposal to Develop Assistant Practitioner Role.pdf (24 pages)

10:55 - 11:25
30 min

8. QUALITY / PERFORMANCE

8.1. Integrated Performance and Quality Report

Enclosed *Chris McKenna / Janette Owens*

- Item 08.1i - SBAR Integrated Performance and Quality Report.pdf (3 pages)
- Item 08.1ii - Appendix 1 Integrated Performance and Quality Report.pdf (13 pages)

8.2. Healthcare Associated Infection Report (HAIRT)

Enclosed *Janette Owens*

- Item 08.2i - SBAR Paper One - Healthcare Associated Infection Report (HAIRT) Priorities.pdf (6 pages)
- Item 08.2i - Appendix 1 Healthcare Associated Infection Report (HAIRT).pdf (28 pages)
- Item 08.2ii - SBAR Paper Two - Healthcare Associated Infection Report (HAIRT) Standards.pdf (6 pages)
- Item 08.2ii - Appendix 1 Healthcare Improvement Scotland Infection Prevention and Control Standards.pdf (24 pages)

11:25 - 11:45
20 min

9. DIGITAL / INFORMATION

9.1. Hospital Electronic Prescribing and Medicines Administration (HEPMA) Programme

Verbal *Chris McKenna*

9.2. Information Governance and Security Steering Group Update

Enclosed *Alistair Graham*

- Item 09.2 - SBAR Information Governance and Security Steering Group Update.pdf (9 pages)

11:45 - 11:55
10 min

10. PERSON CENTRED CARE / PARTICIPATION / ENGAGEMENT

10.1. Patient Experience & Feedback Report - Quarter 1

Enclosed *Janette Owens*

Item 10.1 - SBAR Patient Experience and Feedback Report Quarter 1.pdf (12 pages)

11:55 - 12:15
20 min

11. ANNUAL REPORTS

11.1. Nursing, Midwifery, Allied Health Professionals – Professional Assurance Framework

Enclosed *Janette Owens*

Item 11.1i - SBAR Nursing Midwifery Allied Health Professionals – Professional Assurance Framework.pdf (4 pages)
Item 11.1ii - Appendix 1 Nursing Midwifery Allied Health Professionals – Professional Assurance Framework.pdf (16 pages)

11.2. Occupational Health Annual Report

Enclosed *For noting*

Item 11.2 - SBAR Occupational Health & Wellbeing Service Annual Report 2021-22.pdf (19 pages)

12:15 - 12:20
5 min

12. FOR ASSURANCE

12.1. Delivery of Annual Workplan

Enclosed *Gemma Couser*

Item 12.1 - Delivery of Annual Workplan.pdf (6 pages)

12.2. Proposed Clinical Governance Committee Meeting Dates 2023/24

Enclosed *Gillian MacIntosh*

Item 12.2 - Proposed Clinical Governance Committee Meeting Dates 2023-24.pdf (1 pages)

12:20 - 12:25
5 min

13. LINKED COMMITTEE MINUTES

13.1. Acute Services Division Clinical Governance Committee held on 15 June 2022 (unconfirmed)

Enclosed

Item 13.1i - Cover Paper Acute Services Division Clinical Governance Committee Minutes 20220615.pdf (1 pages)
Item 13.1ii - Acute Services Division Clinical Governance Committee Minutes (unconfirmed) 20220615.pdf (18 pages)

13.2. Area Clinical Forum held on 4 August 2022 (unconfirmed)

Enclosed

Item 13.2i - Cover Paper Area Clinical Forum 20220804.pdf (1 pages)
Item 13.2ii - Area Clinical Forum Minutes (unconfirmed) 20220804.pdf (9 pages)

13.3. Area Medical Committee held on 14 June 2022 (unconfirmed)

Enclosed

Item 13.3 - Area Medical Committee Minutes (unconfirmed) 20220614.pdf (5 pages)

13.4. Cancer Governance & Strategy Group held on 2 June 2022 (unconfirmed)

Enclosed

Item 13.4 - NHS Fife Cancer Governance Strategy Group Minutes (unconfirmed) 20220602.pdf (8 pages)

13.5. NHS Fife Clinical Governance Oversight Group held on 14 June 2022 (unconfirmed)

Enclosed

Item 13.5 - Clinical Governance Oversight Group Minutes (unconfirmed) 20220614.pdf (6 pages)

13.6. Digital & Information Board held on 28 July 2022 (unconfirmed)

Enclosed

Item 13.6i - Cover Paper Digital & Information Board 20220728.pdf (1 pages)
Item 13.6ii - Digital & Information Board Minutes 20220728.pdf (9 pages)

13.7. Fife Drugs & Therapeutic Committee held on 22 June 2022 (unconfirmed)

Enclosed

Item 13.7i - Cover Paper Fife Drugs & Therapeutic Committee 20220622.pdf (1 pages)
Item 13.7ii - Fife Drugs & Therapeutic Committee (unconfirmed) 20220622.pdf (6 pages)

13.8. Fife IJB Quality & Communities Committee held on 5 July 2022 (unconfirmed)

Enclosed

Item 13.8 - Fife IJB Quality & Communities Committee Minutes (unconfirmed) 20220705.pdf (8 pages)

13.9. Health & Safety Subcommittee held on 10 June 2022 (unconfirmed)

Enclosed

Item 13.9i - Cover Paper Health & Safety Subcommittee 20220610.pdf (1 pages)
Item 13.9ii - Health & Safety Subcommittee (unconfirmed) 20220610.pdf (6 pages)

13.10. Infection Control Committee held on 8 June 2022 (confirmed) & 3 August 2022 (unconfirmed)

Enclosed

Item 13.10i - Infection Control Committee Minutes (confirmed) 20220608.pdf (6 pages)
Item 13.10ii - Infection Control Committee Minutes (unconfirmed) 20220803.pdf (6 pages)

13.11. Ionising Radiation Medical Examination Regulations Board (IRMER) held on 24 May 2022 (unconfirmed)

Enclosed

Item 13.11i - Cover Paper Ionising Radiation Medical Examination Regulations Board (unconfirmed) 20220524.pdf (1 pages)
Item 13.11ii - Ionising Radiation Medical Examination Regulations Board Minutes (unconfirmed) 20220524.pdf (5 pages)

13.12. Information Governance & Security Steering Group held on 6 July 2022 (unconfirmed)

Enclosed

Item 13.12i - Cover Paper Information Governance & Security Steering Group 20220706.pdf (1 pages)
Item 13.12ii - Information Governance & Security Steering Group Minutes (unconfirmed) 20220706.pdf (5 pages)

12:25 - 12:30
5 min

14. ESCALATION OF ISSUES TO NHS FIFE BOARD

14.1. To the Board in the IPQR Summary

Verbal

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

Verbal

12:30 - 12:30
0 min

15. ANY OTHER BUSINESS

12:30 - 12:30
0 min

16. DATE OF NEXT MEETING - FRIDAY 4 NOVEMBER 2022 AT 10AM VIA MS TEAMS

Fife NHS Board

Unconfirmed

MINUTE OF THE NHS FIFE CLINICAL GOVERNANCE COMMITTEE HELD ON FRIDAY 1 JULY 2022 AT 10AM VIA MS TEAMS

Present:

C Cooper, Non-Executive Member (Chair)
M Black, Non-Executive Member
A Wood, Non-Executive Member
S Fevre, Area Partnership Forum Representative
A Lawrie, Area Clinical Forum Representative
J Owens, Director of Nursing
J Tomlinson, Director of Public Health

In Attendance:

J Brown, Head of Pharmacy *(Deputising for B Hannan)*
N Connor, Director of Health & Social Care *(Part)*
S Cosens, NHS Lothian *(Item 7.1 only)*
C Dobson, Director of Acute Services
S Fraser, Associate Director of Planning & Performance *(Part)*
A Graham, Associate Director of Digital & Information
S Harrow, NHS Lothian *(Item 7.1 only)*
H Hellewell, Associate Medical Director, H&SCP
G MacIntosh, Head of Corporate Governance & Board Secretary
M McGurk, Director of Finance & Strategy
E Muir, Clinical Effectiveness Manager
F Quirk, Assistant Research, Innovation & Knowledge Director *(Item 7.2 only)*
C Reid, NHS Lothian *(Item 7.1 only)*
H Thomson, Board Committee Support Officer (Minutes)

Chair's Opening Remarks

The Chair welcomed everyone to the meeting.

The Chair highlighted that as the easing of restrictions continue, and with the rising numbers of Covid cases, there are still unprecedented pressures across the whole health and social care system. The Chair recognised the dedication of our staff and volunteers and thanked them for their ongoing hard work.

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

1. Apologies for Absence

Apologies were noted from members S Braiden (Non-Executive Member), K MacDonald (Non-Executive Whistleblowing Champion), C McKenna (Medical Director) and C Potter (Chief Executive), and attendees B Hannan (Director of Pharmacy & Medicines), L Campbell (Associate Director of Nursing), G Couser (Associate Director of Quality & Clinical Governance), J Morrice (Associate Medical Director, Women & Children's Services) and M Wood (Interim Associate Medical Director for Surgery, Medicine & Diagnostics).

2. Declaration of Members' Interests

There were no declarations of interest made by members.

3. Minutes of the Previous Meeting held on 29 April 2022

Updates to the previous minutes were made as follows:

- Item 5.2, paragraph 3: typo corrected.

- Item 5.3, paragraph 4 expanded to read: A Wood, Non-Executive Member, requested further information on the reasons for not meeting the Cancer Waiting Times 62-day target (Risk 2297). The Medical Director advised that the performance metrics would sit within the Finance, Performance & Resources Committee and the operational aspects are discussed at the Cancer Oversight Group. Clinical aspects are also discussed at the Cancer Oversight Group, with assurances coming from that Group to this Committee.

- Item 6.2, paragraph 5 expanded to read: Following a question from A Wood, Non-Executive Director, on the review of the Major Incident Plan, it was advised an update will be included in the report at the July Committee meeting.

- Item 7.3, paragraph 2 expanded to read: A Wood, Non-Executive Director, questioned if there continues to be an ongoing system issue in the reporting of hand hygiene trends, and highlighted page 12 of the report at 5.1 where it states hand hygiene trends are unable to be reported. The Director of Nursing advised that hand hygiene audits are included in the HAIRT Report (page 19 & 21), and that this data is being captured via the LanQIP dashboard. The Director of Nursing agreed to take forward the reference on page 12 – unable to report trends.

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

4. Matters Arising / Action List

<u>Action Item 1 - Adult Support and Protection Biennial Report 2018-2020</u>
The Director of Nursing advised that work is being carried out in relation to the number of reported self-harm cases and the link to the Psychological Therapies Services and Addiction Services waiting lists. M Black, Non-Executive Member, raised concern over the delay in the timeline for the report coming to the Committee and the Director of Health & Social Care advised that there had been an oversight and confirmed a report will come to the meeting on 2 September 2022, for assurance.

<u>Action Item 2 - Clinical Governance Framework</u>
The Associate Medical Director advised that the Clinical Governance Framework is actively being worked on, and, due to timelines being revised, the framework will come to the November Committee meeting.

M Black, Non-Executive Member, raised concern over the revised timeline for the framework and expressed displeasure over the delay. The Associate Medical Director advised that the framework has been delayed twice for feedback due to extreme service

pressures. The Director of Finance & Strategy added that engagement is vital, and assurance was provided that the Internal Auditors had referenced the delay as a minor slippage, which was unavoidable and symptomatic of wider system pressures, given the significance of the report.

Action Item 4 - Health & Safety Workplan
A Wood, Non-Executive Director, questioned if there is a plan or opportunity for an assurance report to come to the Committee at regular intervals in terms of the delivery of the Health & Safety Workplan. The Director of Nursing agreed to ask the Chair of the Health & Safety Subcommittee for an update.

Action: Director of Nursing

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

5. ACTIVE OR EMERGING ISSUES: COVID-19

The Director of Public Health provided a verbal update and advised of an uptake in reported Covid cases within the Region, which is being driven by two new variants: Omicron ba.4 & ba.5. It was reported that the pattern of cases is not as severe as it was in the past, due to the benefits of the vaccinations. It was noted, however, that there has been an uptake in the number of care homes affected.

The Associate Medical Director reported on the impact of staffing across the system due to the rising case numbers. It was also reported that there continues to be a high number of the population coming into the hospitals to be assessed, however, less are requiring more intensive therapy. Assurance was provided that work is ongoing to mitigate the staffing pressures and ensuring all areas are safe.

S Fevre, Area Partnership Forum Representative, questioned if there is any further support for staff in terms of booster vaccinations and if that would support prevention of positive cases within our workforce. The Director of Public Health advised that booster vaccinations will be nationally led, and that it is anticipated that correspondence will be received from the Joint Committee on Vaccination and Immunisation (JCVI), who make the determination of vaccination weaning and the benefit to the population, in the coming weeks.

The Chair questioned if there is any indication that there would be any supply issues for vaccinations in the future. The Director of Public Health advised that there will be restrictions in terms of numbers of supplies that are available, and the JCVI would make the decision on the best way to use the resources.

Following a question from M Black, Non-Executive Director, on reverting back to one visitor in the hospitals, the Director of Public Health advised that allowing for one visitor reduces pressures on staff and also reduces the footfall, which subsequently should reduce risk to patients in our hospitals. It was noted discussions have taken place through the Executive Directors' Group on wider communication to the population regarding raising awareness for individuals to protect themselves.

M Black, Non-Executive Director, questioned the impact of long Covid. The Director of Public Health reported that a full understanding of the different elements of support that is required to those with long Covid is not yet available. It was noted specific work is

ongoing in relation to recovery and rehabilitation of Covid, and a framework will be brought back to the Committee.

The Director of Nursing noted that she is now a representative on the 'Long COVID Strategic Oversight Board' and updates will be brought back to the Committee.

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

6. GOVERNANCE MATTERS

6.1 Annual Internal Audit Report 2021/22

The Director of Finance & Strategy reported that conclusions of the Annual Internal Audit Report 2021/22 is very positive.

It was advised that the report details progress made regarding the Risk Management Improvements Programme and the review of the Board Assurance Framework. Also detailed within the report is the Organisational Duty of Candour Report, which has been delayed due to the pandemic, pressures on the systems and delays to the adverse events processes; every effort is being made to bring that back on track.

It was reported Information Governance & Security is an area of significant improvement, and all actions are complete. It was also reported good progress has been made on the Clinical Governance Framework, despite the slight delay in the timeline.

It was confirmed the Annual Internal Audit Report 2021/22 was brought to the Committee for assurance, and not for approval, as stated in the cover paper.

A Wood, Non-Executive Member, questioned the actions and support around the backlog of activity within the Organisational Duty of Candour Report and asked if an update will be brought back to this Committee on progress of actions. The Director of Finance & Strategy advised that the backlog was due to gaps in the service as a result of staff leaving the organisation and high staff absences due to Covid. It was advised that the Organisational Duty of Candour Report 2021/22 will be concluded shortly and as part of that report a section will be built in around improving resilience. The Director of Nursing added that work has been ongoing around the adverse events process and also around streamlining the complaints process as much as possible. The Organisational Duty of Candour Report 2021/22 will be brought to this Committee as soon as possible.

Action: Associate Medical Director

The Committee took **assurance** from the report as part of the portfolio of evidence provided in support of its evaluation of the internal control environment and the Governance Statement.

6.2 Board Assurance Framework (BAF) - Quality and Safety

The Director of Nursing reported that the quality & safety component of the BAF has been reviewed and updated. The risk level remains unchanged at high, and there have been no changes to the risk level or ratings of the linked risk. The BAF will be replaced by the Corporate Risk Register, and this new means of reporting will come to the Committee at the September meeting.

The Committee considered the questions set out in the paper and **approved** the updated quality and safety component of the BAF.

6.3 Board Assurance Framework (BAF) - Strategic Planning

The Director of Finance & Strategy reported that the Strategic Planning BAF has been assessed as moderate, and it is expected that this risk level will reduce as we progress through the milestone plan for strategy development.

The Committee **approved** the current position in relation to the Strategic Planning risk of moderate.

6.4 Board Assurance Framework - Digital and Information

The Associate Director of Digital & Information highlighted the two linked risks which have been removed from the Digital & Information BAF and are detailed in the paper. The current risk level for this BAF has been assessed as high, with the target score remaining at moderate.

M Black, Non-Executive Member, questioned why the cyber attack risk has been reduced. The Associate Director of Digital & Information reported that there has been the introduction of new technology for that specific risk, and work is being conducted in relation to the network and security audit to reframe some of the cyber attack risks.

The Committee took **assurance** from the content and current assessment of the Digital & Information BAF.

7. STRATEGY/PLANNING

7.1 Edinburgh Cancer Centre Reprovision - Regional Service Model Discussion

C Dobson introduced S Cosens, S Harrow and C Reid from NHS Lothian, who joined the meeting to speak to this item. S Cosens gave a presentation on the reprovision of the Edinburgh Cancer Centre, the slides for which will be shared with the Committee.

Action: Board Committee Support Officer

The Chair questioned the timelines once the Initial Agreement (IA) has been submitted to the Scottish Government. S Cosens advised that the Scottish Government are aware the IA will be submitted in August 2022, and that their Capital Investment Group is scheduled for 28 September 2022.

A Wood, Non-Executive Director, questioned if the decentralised radiotherapy model is an additionality. S Cosens advised that the demand in the future suggests that 10 linacs in the South East Region (Lothian, Fife, Borders and Dumfries & Galloway) are required, and that the decentralised model would suggest that at least two of these linacs would be together in another region. It was also reported that the impact of resources on other Boards in the region would be factored into service planning. S Cosens advised that the business case that is being submitted may include the radiotherapy satellite. Costings would be agreed through the South East Cancer Network (SCAN) where all the Health Boards come together to plan for cancer services

S Cosens explained that the Dumfries & Galloway Health Board send their oncology patients to the SCAN region and when specialist services are required, they are referred to the Edinburgh Cancer Centre, which is a continuation of the current service level provision. It was noted that this is a small number of patients.

The Chair commended the significant work of the whole team. S Cosens, S Harrow and C Reid were thanked for an excellent and informative presentation.

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

7.2 Data Sharing Agreement for Use Case Project with Data Loch

The Assistant Research, Innovation & Knowledge (RIK) Director joined the meeting and provided an update on the situation of Data Loch, as described in the paper.

A Wood, Non-Executive Member, requested clarity that the proposal is recommended and supported from an information governance perspective and questioned if there is an ethics process that is required. The Assistant RIK Director advised that the Information, Governance & Security Oversight Group recommended the proposal. It was noted that Data Loch is not a research project and is a service management project, which is subject to innovation governance oversight and data security & protection confidentiality. The Associate Director of Digital & Information reported that a detailed assessment will take place if there is a recommendation to proceed with the project.

Following a question from M Black, Non-Executive Member, the Assistant RIK Director reported that Fife benefits from being able to access two trusted research environments which offer slightly different services.

A Lawrie, Area Clinical Forum Representative, questioned if patient consent is sought for statistical data and if there is an opportunity for patients to opt out of their data being used. The Assistant RIK Director explained that the data will be subject to the NHS Code of Conduct and Data Protection Act around data confidentiality and security. It was noted that policies and protections are in place that ensure those policies are upheld within the information governance framework for Data Loch. It was also advised that the data sits within NHS Lothian's infrastructure and is subject to the same policies and frameworks as NHS Fife. The Associate Director of Digital & Information noted that Data Loch have carried out some strong engagement work to help inform the public's perception of handling data and the legislative position.

The Committee provided indicative **approval** to develop and implement a use case demonstration project with Data Loch.

7.3 Emergency / Resilience Planning

The Director of Public Health advised that the reporting arrangements for emergency/resilience planning is being refreshed. The paper describes the updates on progress to date and the initial recommendations from the internal audit findings.

It was advised that the cycle of reporting is on annual basis in terms of business continuity assurance, and that this was heavily disrupted due to the pandemic. It was reported that the organisation has been working to enhance command and control

structures throughout the pandemic and that the Business Continuity Plan has been tested thoroughly during this period.

A Wood, Non-Executive Member, asked if progress updates would be provided to the Committee on the future via resilience assurance reports. The Director of Public Health advised that progress updates will now be provided to the Executive Directors' Group on a quarterly basis, and that the terms of reference will be updated to reflect that change. An annual statement of assurance would come forward to the Board.

The Committee took **assurance** from the update and **noted** the focus of future resilience assurance reports will cover the following:

- Quarter 2: Testing and exercising
- Quarter 3: Business continuity assurance statement
- Quarter 4: Major Incident plan formal sign-off

8. QUALITY/PERFORMANCE

8.1 Integrated Performance and Quality Report (IPQR) Review Progress Report

The Associate Director of Planning & Performance highlighted the introduction of risk management into the IPQR and advised that work continues to be ongoing on the corporate risks, which will inform how the risk management information is presented in the IPQR. It was reported that corporate risks will be aligned to risk management within the IPQR, which will also be aligned to the improvement outcomes.

The Associate Director of Planning & Performance also mentioned that the metrics have all been reviewed within the IPQR and a few changes have been made. It was highlighted that screening indicators are still under discussion.

It was reported that the IPQR is now in its new format, and the new metrics have been included. It was noted that projections of activity are still a work in progress. The Scottish Government are still in discussions for agreement on projections with individual operational departments, and the projections will be included in the IPQR, once this work is complete.

Following a question from M Black, Non-Executive Member, the Associate Director of Planning & Performance provided clarity on the 'All delayed discharge bed days lost' within the operational performance metrics section of the paper.

M Black, Non-Executive Member, highlighted that there is no direction about the updating of Scottish Government directed national targets. The Associate Director of Planning & Performance agreed to take this forward outwith the meeting and respond directly back to M Black and the Committee if necessary.

Action: Associate Director of Planning & Performance

The Committee **noted** and **agreed** to the proposed update to the IPQR from the IPQR Review Group.

8.2 Integrated Performance and Quality (IPQR) Report

The Director of Nursing provided an update and gave an overview of the key points within the report.

A Wood, Non-Executive Member, questioned if the level of performance for cardiac arrest should be added to the operational performance metrics. A Wood also noted that cardiac arrest is one of the top extreme adverse events and questioned what percentage of cardiac arrests were avoidable. The Director of Nursing agreed to bring an update back to the Committee from the Resuscitation Committee who have been looking at work around deteriorating patients. Assurance was provided from the Associate Medical Director that the Resuscitation Committee are also looking at whole systems.

Action: Director of Nursing

Following a question from A Wood, Non-Executive Member, the Director of Nursing agreed to take forward with the Medical Director the agreement of a timeline for an update to be brought to the Committee on the Hospital Standard Mortality Rates (HSMR).

Action: Director of Nursing

The Director of Public Health highlighted inequalities, and 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. It was agreed to take this forward as an action.

Action: Director of Nursing/Associate Director of Planning & Performance

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

8.3 Healthcare Associated Infection Report (HAIRT)

The Director of Nursing spoke to the paper and highlighted the new Standards on Reduction of Healthcare Associated Infections (HAIs). A gap analysis will be carried out, and a paper will be brought back the Committee.

Action: Director of Nursing

It was reported that the reduction Standards for Clostridioides difficile Infection (CDI), Staphylococcus aureus Bacteraemia (SAB) and Escherichia coli Bacteraemias (ECB) have been extended to March 2024 due to the Covid response.

The Director of Nursing noted that the cleaning specification and Estates' work is still at green status, which is positive.

A Wood, Non-Executive Member, sought assurance on the resources for surgical site infection surveillance. The Director of Nursing advised that there are designated nurses for surgical site infection surveillance, however, due to the pandemic, those staff have been supporting other areas. This will be closely monitored to ensure that there is sufficient resource in place for when surveillance work returns.

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

8.4 No Cervix Incident – Lessons Learned

The Director of Public Health provided background information, as detailed in the paper, and provided assurance that the process has been completed and lessons learned

identified. The full report of the lessons learned session is available via Joy Tomlinson, Director of Public Health.

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

9. DIGITAL/INFORMATION

9.1 Update on Digital Strategy 2019-2024

The Associate Director of Digital & Information highlighted the key areas from the five key ambitions for Digital & Information and advised that progress remains strong. Delays in the implementation of HEPMA and paper-lite were reported, and those activities are now underway; it is expected initiation and early adoption will take place before the close of this digital strategy period, although there is recognition that implementation will be extended past that period.

The Associate Director of Digital & Information outlined the areas where delays have been recognised and will extend beyond delivery of the strategy period.

It was reported that there is a new Scottish Government consultation relating to the development of a National Data Strategy for Health & Social Care, and NHS Fife will receive further details in August 2022 to support our response.

Following a question from M Black, Non-Executive Member, assurance was provided that data availability and sharing between the Integrated Joint Board (IJB) and Primary Care is significant and will be encouraged as much as possible.

The Committee took **assurance** of suitable progress for the Digital and Information Strategy 2019-2024, despite challenges to complete the implementation of new capabilities within the remain term of the Digital Strategy.

10. PERSON CENTRED CARE / PARTICIPATION / ENGAGEMENT

10.1 Patient Experience & Feedback Report

The Director of Nursing spoke to the report and highlighted the key points.

It was noted that with additional staff in post, capturing live feedback from patients will be carried out. This will support improving processes around improving the patient experience.

The Committee **supported** the direction of travel indicated in the Report.

11. ANNUAL REPORTS

11.1 Clinical Advisory Panel Annual Report

The Associate Medical Director provided a brief update on the report.

A Wood, Non-Executive Member, questioned the financial details for referrals to the Independent Sector and asked if the services are being assessed. The Associate Medical Director provided assurance and advised that there is a process in place for

each provider, and that some of the services provided are for specific needs and may be the only option in the UK.

Following a question from M Black, Non-Executive Member, it was advised that addiction is just one of the services provided at The Priory, and that they also provide a service for those with severe and complex mental health needs. The Associate Medical Director agreed to provide M Black with more detail around the provision of addiction services in Fife outwith the meeting.

Action: Associate Medical Director

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

11.2 Director of Public Health Annual Report 2020-2021

The Director of Public Health highlighted the main points in the paper.

The Committee **considered** the emerging issues set out within the Director of Public Health Annual Report and **endorsed** the future opportunities listed for each priority.

12. FOR ASSURANCE

12.1 Delivery of Annual Workplan

The Clinical Effectiveness Manager outlined the updates to the annual workplan.

It was agreed to add the Annual Resilience Report to the workplan.

Action: Board Committee Support Officer

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

13. LINKED COMMITTEE MINUTES

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

13.1 NHS Fife Clinical Governance Oversight Group held on 19 April 2022 (confirmed)

13.2 Digital & Information Board held on 19 April 2022 (unconfirmed)

13.3 Fife Drugs & Therapeutic Committee held on 27 April 2022 (unconfirmed)

13.4 Fife IJB Clinical & Care Governance Committee held on 20 April 2022 (unconfirmed)

13.5 Research, Innovation & Knowledge Oversight Group held on 24 May 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/issues to escalate to the Board.

15. ANY OTHER BUSINESS

There was no other business.

Date of Next Meeting – Friday 2 September 2022 at 10am via MS Teams.

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

CLINICAL GOVERNANCE COMMITTEE – ACTION LIST

Meeting Date: Friday 2 September 2022

NO.	DATE OF MEETING	AGENDA ITEM / TOPIC	ACTION	LEAD	TIMESCALE	COMMENTS / PROGRESS	RAG
1.	01/07/22	**IPQR**	To bring an update back to the Committee from the Resuscitation Committee in relation to the level of performance for cardiac arrest.	**JO**	02/09/22	Dr McKenna will address this at the meeting.	
2.	01/07/22		To take forward with the Medical Director the agreement of a timeline for an update to be brought to the Committee on the Hospital Standard Mortality Rates (HSMR).	**JO**	02/09/22	No updated provided.	
3.	01/07/22		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.	**JO/SF**	02/09/22	No update provided.	
4.	01/07/22	**HAIRT**	To bring back a paper to the Committee in relation to the gap analysis to be carried out for the new Standards on reduction of healthcare associated infections.	**JO**	02/09/22	No update provided.	
5.	01/07/22	**Clinical Advisory Panel Annual Report**	To provide M Black with more detail around the provision of addiction services in Fife.	**HH**	02/09/22	No update provided.	
6.	03/11/21	**Clinical Governance Framework**	An update on the framework and delivery plan to be brought back to the Committee.	**GC**	~~29/04/22~~ ~~01/07/22~~ 31/10/22	23/06/22 – Deferred to 31 October 2022.	In progress / deadline not reached
7.	01/07/22	**Organisational Duty of Candour**	To arrange for a section to be built into the Organisational Duty of Candour Report 2021/22 around	**CM**	13/01/23	10/08/22 - There is an adverse events improvement plan underway with an update going	In progress / deadline not reached

NO.	DATE OF MEETING	AGENDA ITEM / TOPIC	ACTION	LEAD	TIMESCALE	COMMENTS / PROGRESS	RAG
			improving resilience. The 2021/22 report to be brought back to this Committee.			to Clinical Governance Oversight in August 2022. A proposal on addressing the backlog will likely be ready for the first CGC in 2023. Duty of Candour Interim Report expected before year end, with a view to concluding in Q1, 2023.	
8.	01/07/22	**Health & Safety Workplan**	To ask the Chair of the Health & Safety Subcommittee for an update in relation to a plan or opportunity for an assurance report to come to the Committee at regular intervals in terms of the delivery of the Health & Safety Workplan.	**JO**	02/09/22	08/08/23 - JO contacted Chair of H&S Subcommittee: Assurance Statement submitted to CGC on 29/04/22 and will be submitted annually.	Closed
9.	10/03/22	**Committee Development Session Topics**	Members and attendees were requested to suggest topics to be covered at a development session, twice a year, to delve deeper into topics relevant to the Committee's remit.	**All**	Second session to be arranged.	First session: Edinburgh Cancer Centre Reprovision- Regional Service Model, and Research & Development Session on 10/06/22. Second session: E-Coli Bacteraemia Infections and Cancer Delivery across Fife. HT is in process of co-ordinating availability for session in October 2022.	Closed
10.	13/01/22	**Adult Support and Protection Biennial Report 2018-2020**	Further detail to be provided on the number of reported self-harm cases and the link to the Psychological Therapies Services and Addiction Services waiting lists.	**NC**	~~01/07/22~~ 02/09/22	29/04/22 – It was advised that data is being collated and the paper will go to EDG on 5 May, before a full report is brought back to the Committee. This action has moved to the Public Health & Wellbeing Committee.	Closed

NO.	DATE OF MEETING	AGENDA ITEM / TOPIC	ACTION	LEAD	TIMESCALE	COMMENTS / PROGRESS	RAG
11.	01/07/22	**IPQR Review Progress Report**	To take forward and respond directly back to M Black and the Committee if necessary, regarding the updating of Scottish Government directed national targets.	**SF**	02/09/22	Complete.	Closed

ANNUAL STATEMENT OF ASSURANCE FOR
NHS FIFE CLINICAL GOVERNANCE OVERSIGHT GROUP

1. Purpose

1.1 To provide the NHS Fife clinical Governance Committee with the assurance that the Clinical Governance Oversight Group (CGOG) has fulfilled its remit during 2021/2022 to:

- Take an overview of the quality and safety of care provided across the Fife health system and how this impacts on patient/user experience and provide assurance to the NHS Fife Clinical Governance Committee and NHS Fife Board
- Ensure the Quality Reports to the Board, ASD and H&SCP reflect key performance indicators of quality, safety and patient experience in line with national requirements
- Maintain an awareness of evolving quality, safety and governance agendas, both internal and external to NHS Fife
- Oversee, and receive regular reports from local working groups when relating to identified priorities of work, and from participating groups in national programmes. To ensure learning is identified and shared across the organisation
- Identify key learning points from all areas and ensure these are communicated and embedded where appropriate across primary, secondary, and the Health and Social Care Partnership (HSCP)

1.2 This assurance statement summarises the key aspects of business covered which evidence delivery of the CGOG's remit. Please note that this assurance statement does not cover all aspects of business covered during 2021/2022.

2. Membership

2.1 During the financial year to 31 March 2022, membership of the CGOG comprised of:

Name	Roles / Designations
Dr Chris McKenna	Medical Director (Chair)
Janette Owens	Director of Nursing (Deputy Chair)
Lynn Barker	Associate Director of Nursing HSCP
Dr Sue Blair	Consultant in Occupational Medicine
Dr Robert Cargill	Associate Medical Director ASD (until Sept 2021)
Gemma Couser	Associate Director of Quality and Clinical Governance
Pauline Cumming	Risk Manager
Claire Fulton	Lead for Adverse Events
Scott Garden Ben Hannan	Director of Pharmacy (until Feb 2022) Director of Pharmacy (from Feb 2022)
Cathy Gilvear	Quality, Clinical & Care Governance Lead, HSCP
Dr Helen Hellewell	Associate Medical Director HSCP

Donna Hughes*	Head of Patient Experience
Aileen Lawrie	Associate Director of Nursing and Midwifery
Dr John Morrice	Associate Medical Director for Women and Childrens
Elizabeth Muir	Clinical Effectiveness Manager
Nicola Robertson	Associate Director of Nursing for Corporate
Geraldine Smith	Lead Pharmacist for Medicines Governance
Prof Morwenna Wood	Associate Medical Director for Emergency and Planned Care
Amanda Wong	Associate Director for Allied Healthcare Professionals

2.2 The CGOG may invite individuals to attend meetings for particular agenda items. Dr Gavin Simpson (Chair of the Fife Wide Deteriorating Patient Group and Resuscitation Committee) has routinely been in attendance at meetings. Other attendees, deputies and guests are recorded in the individual minutes of each meeting.

3. Meetings

3.1 The Group met on 4 occasions during the financial year to 31 March 2022, on the undernoted dates:

- 22nd April 2021
- 23rd June 2021
- 26th August 2021
- 15th February 2022
- The meeting scheduled for October 2021 and December 2021 were cancelled due to operational system pressures

3.2 The attendance schedule is attached at Appendix 1.

4. Business

4.1 The business of the group during 2021/2022 continued to be impacted by the need for NHS Fife to respond to the ongoing challenges of the coronavirus pandemic. This was particularly the case early in the year. Throughout this period the agenda was prepared to ensure focus on key items to ensure that assurance and oversight was provided by the Group.

Standing Agenda Items

4.2 At every meeting the Group considered the Integrated Performance and Quality Report (IPQR). Specifically focusing on the quality and safety metrics. This then focused the group to request more detailed overview of the improvement actions being progressed to address areas identified for improvement. In February 2022 the Group received a comprehensive reports of improvement work across:

- Prevention of In-Patient Falls
- Reducing Incidence of Harm for Pressures Ulcers
- Reducing Incidence of Harm for Cather Associated Unitary Tract Infection (CAUTI)

4.3 The Group welcomed the reports which were subsequently escalated to the Clinical Governance Committee for assurance.

4.4 Supplementing the IPQR, the HSCP Quality Report was also tabled at each meeting for review by the Group. In February 2022 the group received an update from Lynn Campbell (Associate Director of Nursing for Acute Services) and Gemma Couser (Associate Director of Quality and Clinical Governance) setting out the proposal to implement a quality dashboard for the Acute Service Division (ASD) with a view to developing a similar approach to the HSCP. The Group supported the development of the dashboard for ASD to provide staff in clinical areas to have access to key quality performance indicators.

4.5 At each meeting CGOG received an update in relation NHS Fife Policy and Procedures. Assurance was given to the Group in relation to policy and procedures being out of date. Compliance across the year ranged from 98%-100%. In addition the group received updates of any new policy or procedures in the pipeline.

4.6 In February 2022 the Group noted the lowest complaints performance in recent years. Janette Owens (Director of Nursing) provided CGOG with an overview of the redesign work underway to consider how to improve processes within the complaints team.

4.7 Minutes of Linked Groups noted at each meeting and points for escalation to Group raised as appropriate. An example of this is evidenced in April 2021 when the Falls Steering Group highlighted that there is an upward trend in falls with harm. It was noted that there were a number of factors contributing to this including environmental changes, social distancing etc. Lynn Campbell (Associate Director of Nursing, ASD) assured the group there that local improvement work had been initiated n areas with an increase in falls with harm.

Developments and Emerging Business

4.8 Development of the Clinical Governance Framework was presented to the Group at meetings throughout 21/22. The group noted that the impact of the ongoing operational challenges had impacted on the engagement work to develop the framework and as such noted the delay in concluding this work.

4.9 In June 2021 Dr Gavin Simpson (Chair of Deteriorating Patient Group) presented to the group a Fife wide proposal to move from Fife Early Warning Score (FEWS) to the National Early Warning Score 2 (NEWS2). The Group noted the benefits to patient care offered by the moving to NEWS2 including:

- Addition of the oxygen scoring element
- Opportunity to move areas currently using paper onto electronic recording
- Improved communication between department supporting handover with use of a consistent scoring system

4.10 The improved cardiac arrest rate over the past 5 years was noted by the Group and it was discussed that moving to NEWS2 would provide opportunity for further improvement. Questions were raised in relation to the scale of staff training programme required to support the move safely. Further to a considered and comprehensive discussion the group gave support to progress to NEWS2 and approval granted to escalated the case to the Executive Directors Group (EDG) for financial endorsement.

4.11 Early in 2021 the group received an update in relation to the National Hub for the Reviewing and Learning from the Death of Children and Young People. The National Hub aims to ensure that the death of every child and young person is reviewed to a

minimum standard; defined within a national data core data set. Within scope are all deaths of born children up to their 18th birthday or 26th birthday for those who continue to receive aftercare or continuing care at the time of their death.

4.12 Regular updates were provided to the Group in relation to developing a local system to ensure appropriate processes, assurance and governance would be implemented in response to this new national requirement. The CGOG reflected that the national guidance needed to align to existing processes for adverse events and death reviews (e.g. in mental health). The Group supported the proposal setting out the governance structure and local process and NHS Fife launched the new process from 1st October 2021. In addition the case was escalated to EDG for financial endorsement to secure resource to oversee this new requirement. The group discussed the importance of this work but clearly identified that this could not be delivered within existing resource. It was agreed that the CGOG would receive an update report and annual report from the governance group established to ensure compliance with the guidance. In addition an annual report would be provided to the Clinical Governance Committee.

4.13 In April 2021 the Group received assurance in relation to planning for an impending Adult Support and Protection Inspection (joint with Health Improvement Scotland and the Care Inspectorate) taking place between April and July 2021. Janette Owens (Director of Nursing) advised the group of the multi-professional and multi-agency planning to prepare for the inspection. In February 2022 the Group received a summary of the inspection findings particularly in relation to the clear strengths in partnership working to ensure the safety of adults.

4.14 At the February 2022 meeting the group received an overview of the Adverse Events Improvement plan which was presented over 7 broad workstreams:

- Adverse Events process
- Policy
- Training & Education
- Staff Support
- Patient & family involvement
- Team infrastructure
- Open Culture

4.15 The group welcomed this proposal and recognised the importance of staff involvement to engage with the development of the new process and policy. In particular the Group requested a focus on support for staff who are involved in adverse events. The delays in completion of adverse event reviews within target was also discussed and the requirement to review the process to improve was recognised. The multifaceted nature of the review was recognised by the group with support to progress this work.

5. Risk Management

5.1 The need to focus on risk was identified as an area of improvement and from February 2022 the agenda of the CGOG was refreshed to include the Quality and Safety Board Assurance Framework (Q&S BAF) as a standing agenda item.

6. Self-Assessment

7.1 The group has undertaken a self-assessment of its own effectiveness, utilising a questionnaire considered and approved by the Group's Chair. This was completed using Forms (an online portal). The output of this exercise provided the following key feedback:

- In 2021/2022 the group was provided with sufficient membership, authority and resource to perform its role effectively and independently
- The need to focus more explicitly on risk
- Reviewing the use of data from the IPQR to support quality discussions
- Recognition of the challenges presented by the ongoing pandemic and the impact on frequency of meeting
- Agreement to amalgamate the Adverse Events and Duty of Candour Group with the Clinical Governance Oversight Group in 2022/2023

7. Conclusion

7.1 As Chair of the Group during financial year 2021-2022, 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 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 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 Group and to all attendees. I would thank all those members of staff who have prepared reports and attended meetings.

Signed: Date: 30 August 2022

Dr Chris McKenna, Medical Director, Chair
On behalf of the Clinical Governance Oversight Group

Appendix 1 – Attendance Schedule

NHS Fife Clinical Governance Oversight Group Attendance Record

1st April 2021 to 31st March 2022

Member	Designation	22nd April 2021	23rd June 2021	26th August 2021	15th February 2022
Lynn Barker	Associate Director of Nursing, Health Social Care Partnership	✓	✓	✓	x
Dr Sue Blair	Consultant in Occupational Medicine	✓	x	✓	x
Andy Brown	Principal Auditor - Finance	x	x	x	x
Lynn Campbell	Associate Director of Nursing, Acute Services Division	✓	x	✓	✓
Gemma Couser	Associate Director of Quality & Clinical Governance	✓	✓	✓	✓
Pauline Cumming	Risk Manager	✓	x	✓	✓
Claire Fulton	Adverse Events Lead				✓
Scott Garden	Director of Pharmacy and Medicines	✓	x	x	x
Ben Hannan	Director of Pharmacy and Medicine				x
Cathy Gilvear	Quality, Clinical & Care Governance Lead, HSCP	✓	✓	✓	x
Dr Helen Hellewell	Associate Medical Director, HSCP	x	x	x	x
Donna Hughes	Head of Person Centre Care, NHS Fife	x	x		
Aileen Lawrie	Head of Midwifery/Nursing Women and Children's Directorate	✓	x	x	x
Dr Chris McKenna (Chair)	Medical Director, NHS Fife	x	✓	✓	✓
Dr Rob Cargill	Associate Medical Director for ASD	✓	✓		
Elizabeth Muir	NHS Fife Clinical Effectiveness Manager	✓	✓	✓	✓
Sally O'Brien	Head of Nursing				✓
Janette Owens	Director of Nursing	✓	✓	✓	✓
Gavin Simpson	Consultant Anaesthetics		✓		
Geraldine Smith	Lead Pharmacist, Medicines Governance & Education Training	x	✓	x	✓
Prof Morwenna Wood	Associate Medical Director for Emergency and Planned Care	x	x	x	x
Amanda Wong	Associate Director of Allied Health Professionals	x	x	✓	✓
John Morrice	Associate Medical Director for Women and Children's Services	x	x	x	x

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**2 September 2022**
Title:	**Board Assurance Framework - Quality & Safety**
Responsible Executive:	**Dr Chris McKenna, Medical Director**
Report Author:	**Pauline Cumming, Risk Manager**

1 Purpose

This report is presented to the Clinical Governance Committee for:

- Consideration & Approval

This report relates to an:

- Annual Operational Plan
- Emerging Issue
- Government Policy / Directive

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of this report is to update the Committee on the Quality and Safety component of the Board Assurance Framework (BAF).

The Committee plays a vital role in scrutinising the risks and where indicated, the Chair will seek further information from risk owners. The report provides the current position on the BAF since the last update on 1 July 2022. This will be the final report on the BAF before transitioning to a Corporate Risk Register, as outlined below at 2.3.

2.2 Background

The BAF brings together key information on the above risk, integrating objectives, risks, controls, assurances and additional mitigating actions. It should:

- identify and describe key controls and actions in place to reduce or manage the risk

- provide assurances based on relevant, reliable and sufficient evidence that controls are in place and are having the desired effect
- link to performance reporting to the Board and associated risks, legislation & standing orders or opportunities

The Committee is invited to consider the following on receipt of each update on the BAF:

- Does the risk score feel right?
- Do the current controls match the stated risk?
- Will the mitigating actions bring the risk down to its target level?
- If the mitigating actions are fully implemented, would the outcome be achieved?
- Does the assurance provided, describe how the controls are performing?
- Do the assurances come from more than one source including independent sources?
- Are limited resources being allocated appropriately i.e. on uncontrolled high risks or in otherwise well controlled areas of risk?

2.3 Assessment

The Committee can be assured that systems and processes are in place to monitor the organisation's performance in relation to quality and safety.

The BAF risk has been reviewed and updated, with the risk level remaining unchanged at High (15).The ratings and levels of the linked risks are unchanged. Details of the BAF risk and the linked risks are set out in Appendices 1 and 2.

As previously reported, the BAF is to be replaced with a Corporate Risk Register. Risks on the register will be categorised under the 4 strategic priorities:

1. To improve health and wellbeing
2. To improve the quality of health and care services
3. To improve staff experience and wellbeing
4. To deliver value and sustainability

Each risk will be assigned to one or more governance committee for assurance; these will be designated as a primary or secondary committee.

In anticipation of this development, the last report to the Committee indicated that clinical quality and safety risks for inclusion in the register were still to be confirmed, and would be reported to the next meeting on 2 September 2022. An update will be provided separately for members' consideration.

From November 2022, a report on the risks assigned for assurance will be provided to each meeting of the Committee.

The Board Integrated Performance & Quality Report provides further detail on quality and safety performance.

2.3.1 Quality/ Patient Care

Effective risk management underpins the delivery of high quality, person - centred care.

2.3.2 Workforce

Optimal staff health and well- being are integral to service quality and performance.

2.3.3 Financial

Please see Appendix 2 for specific financial impacts where applicable.

2.3.4 Risk Assessment/Management

Please refer to Appendices 1 and 2.

2.3.5 Equality and Diversity, including health inequalities

There are no equality and diversity issues associated with this component of the BAF.

2.3.6 Other impact

N/A

2.3.7 Communication, involvement, engagement and consultation

This paper was developed in consultation with the Associate Director of Quality and Clinical Governance.

2.3.8 Route to the Meeting

An earlier version of this paper was presented to the Clinical Governance Oversight Group on 16 August 2022 and EDG on 18 August 2022.

2.4 Recommendation

The Committee is invited to:

- **Consider** the questions set out above; and
- **Approve** the updated quality and safety component of the BAF

3 List of appendices

Appendix 1, NHS Fife Board Assurance Framework (BAF) Quality & Safety to NHS Fife CGC 020922 V 1.0
Appendix 2, BAF Quality & Safety - Linked Operational Risks to NHS Fife CGC 020922 V 1.0

Report Contact

Pauline Cumming
Risk Manager
Email pauline.cumming@nhs.scot

NHS Fife Board Assurance Framework (BAF)

Risk ID	Corporate Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Board Assurance Framework (BAF) - Quality & Safety																											
1674	Clinically Excellent, Person Centred	01 July 2022	02 September 2022	There is a risk that due to failure of clinical governance, performance and management systems (incluing information and information systems), NHS Fife may be unable to provide safe,effective, person centred care. Additionally, there is a risk that the effects of the COVID - 19 pandemic, including restricted capacity, reduced elective & non urgent services, and workforce pressures, will impact on the quality & safety of patient care and service delivery.	4 – Likely – Strong possibility this could occur	5 - Extreme	20	High Risk	3 – Possible – May occur occasionally – reasonable chance	5 - Extreme	15	High Risk	Failure in this area could have a direct impact on patients' health, organisational reputation and exposure to legal action. While it is recognised that several adverse events ranging from minor to extreme harm can occur daily, the proportion of these in relation to overall patient activity is very small.	Christopher McKenna Medical Director	Clinical Governance Christina Cooper	*Ongoing actions designed to mitigate the risk including:* Oversight and monitoring of strategy / framework / policy and procedure implementation and impact including: 1. Strategic Framework 2. Clinical Strategy 3. Clinical Governance Structures and operational governance arrangements 4. Clinical & Care Governance Strategy 5. Participation & Engagement Strategy 6. Risk Management Framework 7. Governance arrangements established to support delivery of the UK Coronavirus (COVID-19) action plan and Scottish Government Annual Delivery Plan 2022/23 8. Processes established for reporting and escalation of COVID-19 related incidents & risks 9. NHS Recovery Plan and Remobilisation These are supported by the following: 10. Risk Registers 11. Integrated Performance and Quality Report (IPQR), Performance reports dashboard data 12. Performance Reviews 13. Adverse Events Policy 14. Acute Adult Programme (formerly Scottish Patient Safety Programme (SPSP) 15. Implementation of SIGN and other evidence based guidance 16. Staff Learning & Development 17. System of governance arrangements for all clinical policies and procedures 18. Participation in relevant national and local audit 19. Complaints handling process 20. Using data to enhance quality control 21. HIS Quality of Care Approach & Framework, Sept 2018 22. Implementing Organisational Duty of Candour legislation 23. Adverse event management process 24. Sharing of learning summaries from adverse event reviews 25. Implementing Excellence in Care 26. Using Care Opinion feedback 27. Acting on recommendations from internal & external agencies 28. Revalidation programmes for professional staff 29. Electronic dissemination of safety alerts 30.Organisational Learning Group established in August 2021. 31.Implementiing the Adverse Event improvement Programme. 32. Reviewing and updating the Clinical and Care Governance Framework for delivery by 31/10/22. 33.Review of the Risk Management Framework and development of improvement programme is underway. 34. The Child and Young People Death Review Commissioning Group is well	1.Reviewing together of patient experience, complaints, adverse events and risk information to provide an overview of good practice, themes, trends, and exceptions to the norm 2.Weaknesses in the process for recording completion of actions from adverse event reviews including evidence of steps taken to implement and share learning from actions. 3.Weaknesses in related oversight and monitoring processes at operational level 4. Risk Management Improvement programme to be implemented	1. Give due consideration to how to balance the stabilisation and remobilisation of clinical services and take forward improvement work while managimg staff and public expectations, as we recover from the COVID-19 pandemic. 2. Continually review the Integrated Performance and Quality (IPQR) to ensure it provides an accurate, current picture of clinical quality / performance in priority areas. To incorporate a risk component from late summer 2022. 3. Refresh the extant Clinical Governance structures and arrangements to ensure these are current and fit for purpose as part of the review of the Clinical & Care Governance Framewrok. 4..Review the coverage of mortality & morbidity meetings in line with national developments and HIS guidance. 5. Review and refresh the current content and delivery models for key areas of training and development e.g. corporate induction, in house core, quality improvement, leadership development, clinical skills, interspecialty programmes, risk management, clinical effectiveness. 6. Review annually, all technology & Digital & Information systems that support clinical governance e.g. Datix / Formic Fusion Pro./ Labs systems. 7.Estabish via HIS, the plans for Board reviews against the Quality of Care Framework in order to prepare and understand our state of readiness for a review. 8. Further develop the culture of a person centred approach to care. 9. Executive commissioning of reviews as appropriate e.g. internal audit, external peer and 'deep dives' 10. Align the developing Clinical & Care Governance Framework with the NHS Fife Strategic Priorities, Corporate Objectives and the developing Population Health & Wellbeing Strategy. 11.Identify improvements within the adverse events process taking into consideration communication, roles, use of DATIX and lines of reporting. 12. Build a risk culture which ensures that there is engaged risk leadership and proactive measures with focus in place to address risks. 13. Build a risk culture which links the identification of risk to organisational objectives and strategic priorities. 14.Identify and implement an electronic system/ quality management system for managing policy and procedures to improve efficiency and assurance of document management. 15. Use the Essentials of Safe Care framework as the basis of an organisational self assessment to understand status quo and support development of C&CG Framework .	1. Assurance statements from clinical & clinical & care governance groups and committees 2. Assurances obtained from all groups and committees that: i. they have a workplan ii. all elements of the work plan are addressed in year 3. Annual Assurance Statement 4. Annual NHS Fife CGC Self assessment 5.I Reporting bi annually on adequacy of systems & processes to Audit & Risk Committee 6. External accreditation systems e.g.. Unicef - Accredited Baby Friendly Gold. UKAS Inspection for Labs 7. External agency reports e.g. GMC 8. Quality of Care review 9. Compliance and monitoring of policies & procedures to ensure these are up to date 10. Locally designed subject specific audits 11. National audits	1. Internal Audit reviews and evaluation reports on controls and process; including annual assurance and governance review / departmental reviewsto Audit & Risk Committee 2. External Audit reviews 3. HIS visits and reviews 4. Healthcare Environment Inspectorate (HEI) visits and reports 5. Health Protection Scotland (HPS) support and feedback 6. Health & Safety Executive visits and reports 7. Acute Adult Programme (formerly SPSP) visits and reviews 8. Scottish Govt Organisational DoC Annual Report 9. Scottish Public Service Ombudsman (SPSO) reports 10. Patient Experience and Feedback (PEaF) Quarterly Report which includes Care Opinion, compliments, and complaints report KPIs. 11. Specific National reporting 12. Mental Welfare Commission (MWC) reviews	1. Key performance indicators relating to corporate objectives e.g. person centred, clinically excellent, exemplar employer & sustainable 2. We require additional assurances that there is a system in place for oversight , monitoring of actions, and disseminating learning from a variety of sources e.g. audit, adverse events, SPSO, MWC reviews 3. We require additional assurances that there are systems in place for oversight of operational and strategic risks	Overall, NHS Fife has in place sound systems of clinical governance and risk management as evidenced by Internal Audit and External Audit reports and the Statement of Annual Assurance to the Board.	2 – Unlikely – Not expected to happen – potential exists	5 - Extreme	10	Moderate Risk	The organisation can identify the actions required to strengthen the systems and processes to reduce the risk level.

																established having met monthly since October 2021 Three posts to support the infrastructure of the death reviews process have been successfully recruited to. A Child &Young People Death Governance Group is in place and meets quarterly. The Year 1 report from the Child and Young People Death Commissioning Group will be submitted to the Clinical Governance Committee in November 2022.		16..Ensure linkages with Patient Relations Team to allow for shared learning and identification of organisational themes. 17. Further embed and monitor implementation of NHS Fife governance and reporting on the reviews of deaths of children and young people.										

Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
2214	Nursing and Midwifery Staffing Levels	Active Risk	High Risk	20	Owens, Janette
1904	Coronavirus Disease 2019 (COVID-19) Pandemic	Active Risk	High Risk	16	Tomlinson, Joy
2297	Cancer Waiting Times Access Standards	Active Risk	High Risk	15	Dobson, Claire
1296	Emergency Evacuation, VHK Phase 2 Tower Block	Active Risk	High Risk	15	McCormick, Neil
1907	Public Health Oversight of COVID-19 in Care Homes	Active Risk	High Risk	15	Tomlinson, Joy

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
43	Vascular access for haematology/Oncology	Active Risk	High Risk	16	Shirley - Anne Savage
528	Pandemic Flu Planning	Active Risk	Moderate Risk	12	Brown, George
637	SAB LDP standard	Active Risk	Moderate Risk	9	Cook, Julia
1652	Medical Capacity in Community Paediatric Service	Active Risk	Moderate Risk	12	Dobson, Claire
1670	Temperature within fluid storage room within critical care	Active Risk	Moderate Risk	12	Morgan, Belinda
356	Clinical Pharmacy Input	Closed Risk	High Risk	15	McKenna, Christopher
521	Capacity Planning	Closed Risk	Very Low Risk	1	Watts, Miriam
529	Information Security Risk	Closed Risk	High Risk	16	McGurk, Margo
1287	Overcapacity in AU1 Assessment Unit	Closed Risk	Very Low Risk	3	Shepherd, Angie
1297	Obsolete Equipment In Use – No Replacement Plan In Place (Graseby 3000 Series)	Closed Risk	Moderate Risk	10	Lowe, David
1366	T34 syringe drivers in the Acute Division	Closed Risk	Low Risk	6	Savage, Shirley-Anne
1502	3D Temperature Monitoring System (South Lab)	Closed Risk	Moderate Risk	12	Campbell, Ken
1514	Impact of the UK's withdrawal from the EU on the availability and cost of medicines and medical devices	Closed Risk	High Risk	15	Garden, Scott
1515	Impact of the UK's withdrawal from the EU on Nuclear Medicine and the ability to provide diagnostic and treatment service(s)	Closed Risk	High Risk	15	Anderson, Jane
1524	Oxygen Driven Suction	Closed Risk	High Risk	20	McKenna, Christopher
1667	Infusion pumps, volumisers and Syringe Divers in Paediatrics and Neonatal Units	Closed Risk	High Risk	25	Dobson, Claire

ID	Position of Risk (Risk Register)	Opened	Title	Description	Likelihood (initial)	Consequence (initial)	Risk level (initial)	Rating (initial)	Current Management Actions	Likelihood (current)	Consequence (current)	Risk level (current)	Rating (current)	Likelihood (Target)	Consequence (Target)	Risk level (Target)	Rating (Target)	Risk Owner	Handler	Previous Review Date	Next Review
2214	NHSFBD - Nursing Directorate Risk Register	21/10/2021	Nursing and Midwifery Staffing Levels	There is an established and continuing risk that safe nursing and midwifery levels cannot be achieved. NHS Fife is experiencing critical nursing and midwifery shortfalls, similar to other Boards across NHS Scotland. Vacancy rates, sickness absence levels and high activity related to consequences of the pandemic are aligned to the unprecedented demand on clinical services and on nursing and midwifery. There continues to be a heavy demand on supplementary staffing. Impact on quality of care remains a consequential concern.	5 - Almost Certain - Expected to occur frequently - more likely than not	4 - Major	High Risk	20	10/06/22: BAND 2-4 WORKFORCE: Continues to be developed. Associate Practitioner role (Band 4) to be progressed across NHS Fife once job description and so on agreed with the Health & Social Care Partnership (HSCP. EDUCATIONAL PROVISION: This has been agreed with Fife College and trainees will be appointed under Annex 21. Training period will take 9-15 months. NURSING & MIDWIFERY (N&M) WORKFORCE PLANNING GROUP: Group continues to drive N&M planning & development activity across NHS Fife. RECRUITMENT: 160 student nurses and midwives have been recruited to NHS Fife, coming into post from September 2022 onwards. Nurse Bank has recruited 850 staff in the financial year 2021-22. Health Care Support Worker(HCSW)recruitment: Over 70 Whole Time Equivalent(WTE) Band 2 -3 posts were successfully recruited into by March 22; funding provided by Scottish Govt(SG)for these substantive posts which are in addition to existing establishments, with a focus on expediting patient discharge from hospitals. International Recruitment (IR): NHS Fife welcomed the first IR nurses to Scotland following collaboration with Yeovil Hospital NHS Trust. To date we have an agreement to recruit 40 nurses and 3 radiographers and will have 23 international recruits in Fife by the end of June. Unfortunately, SG funding has not continued beyond March 2022 therefore the Directors of Acute Services and HSCP will be consulted for finance options to allow IR to progress beyond the current 43	5 - Almost Certain - Expected to occur frequently - more likely than not	4 - Major	High Risk	20	3 - Possible - May occur occasionally - reasonable chance	3 - Moderate	Moderate Risk	9	Owens, Janette	Robertson, Nicola	10/06/2022	31/08/2022

1904	NHSFBD – COVID-19 Risk Register	20/08/2020	Coronavirus Disease 2019 (COVID-19) Pandemic	As a result of the current global COVID-19 pandemic, there is a risk of significant morbidity and mortality in the Fife population due to a lack of immunity to this novel disease. This could 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, particularly among the elderly and those with underlying health risk conditions. The potential impacts for NHS Fife include increased deaths, increased pressure on healthcare and support services affecting service delivery, reduced capacity for non-urgent services, disruption to supply chains and high levels of employee absence due to personal illness and caring responsibilities.	5 - Almost Certain - Expected to occur frequently - more likely than not	5 - Extreme	High Risk	25	Update agreed at PHAC on 03/08/22:- COVID19 infection rates are more difficult to track at local and national level due to significant changes in testing patterns. There was a further increase in people testing positive during July. The ONS COVID-19 Infection survey in Scotland reported one in fifteen people in Scotland testing positive for the week ending 14th July the rate of increase is slowing. There are system-wide pressures due to a combination of factors including COVID19 staff absences. There is no evidence of increased severity of infection. A new sub-variant, BA.2.75 has been identified as of potential concern. COVID19 protective measures are reducing in use across the population and this is allowing high levels of COVID19 to continue to circulate. An autumn vaccination campaign is being planned which will enhance immune response but there remain concerns about the potential for vaccine escape.	4 - Likely - Strong possibility this could occur	4 - Major	High Risk	16	4 - Likely - Strong possibility this could occur	3 - Moderate	Moderate Risk	12	Tomlinson, Joy	Ward, Brenda	03/08/2022	05/10/2022
2297	Acute Services - ACUTE SERVICES DIVISION RISK REGISTER, NHSFBD - Cancer Services Risk Register, NHSFBD – COVID-19 Risk Register	25/03/2022	Cancer Waiting Times Access Standards	In view of increasing patient referrals and complex cancer pathways there is a risk that NHS Fife will see further deterioration of Cancer Waiting Times 62-day performance resulting in poor patient experience, impact on clinical outcomes and failure to achieve the Cancer Waiting Times Standard.	5 - Almost Certain - Expected to occur frequently - more likely than not	3 - Moderate	High Risk	15	11/07/2022 Daily tracking is unable to be carried out due to the increasing number and complexity of cancer referrals. Funding has been requested from SG for temporary additional Tracking support until March 2023. Await outcome. PTL meetings continue with an increased focus on escalation and action. Process changes have been made in the prostate pathway which have reduced waits between steps in the pathway. Further work is ongoing to improve this pathway. Scottish Government visited NHS Fife in June. Good engagement from Executive/management teams. Awaiting final report. Effective Cancer Management Framework Action plan agreed both locally and by Scottish Government and actions identified. A national SLWG is being set up to develop a 'Once for Scotland' approach to management of breaches standard operating procedure. This will be led by the NHS Fife Cancer Transformation Manager (Chair of national Cancer Managers' Forum) The Cancer Framework is in final edit stages and delivery plan is almost complete. Optimal Pathways and integrated care are included in the framework along with viewing CWT targets as a minimum standard The Single Point of Contact Hub is in development with a view to facilitating patients through their pathways with the intended aim of improving waits between steps to improve performance.	5 - Almost Certain - Expected to occur frequently - more likely than not	3 - Moderate	High Risk	15	4 - Likely - Strong possibility this could occur	3 - Moderate	Moderate Risk	12	Dobson, Claire	Nicoll, Kathleen	11/07/2022	10/10/2022

1907	1296
NHSFBD – COVID-19 Risk Register	CORPORATE RISK REGISTER, Corporate Directorate - Estates Risk Register
20/08/2020	22/08/2016
Public Health Oversight of COVID-19 in Care Homes	Emergency Evacuation, VHK Phase 2 Tower Block
As a result of the current global COVID-19 pandemic, there is a risk of significant morbidity and mortality. It is recognised that adults living in care homes often have multiple health and care needs and many are frail with varying levels of dependence. Many are inevitably at greater risk of poorer outcomes if they were to contract COVID-19 due to conditions such as frailty, multiple co-morbidity, pre-existing cardio-respiratory conditions or neurological conditions. Care homes are environments that have proved to be particularly susceptible to Coronavirus and require whole system support to protect residents and staff. The potential impacts for care home include increased morbidity and mortality, increased pressure on care home staff, high levels of employee absence due to personal illness and caring responsibilities. The COVID-19 vaccination has proved to be effective at reducing the most severe impacts of the virus. This continues to be monitored closely.	There is a risk that a second stage fire evacuation, or complete emergency evacuation, of the upper floors of Phase 2 VHK, may cause further injury to frail and elderly patients, and/or to staff members from both clinical and non-clinical floors.
5 - Almost Certain - Expected to occur frequently - more likely than not	4 - Likely - Strong possibility this could occur
5 - Extreme	5 - Extreme
High Risk	High Risk
25	20
Update agreed at PHAC meeting 03/08/22:- The risk status level remains unchanged. Whilst the recent increase in care home outbreaks and activity has settled there is slight concerns around the number of deaths. The next phase of vaccination is due out soon and it was noted that there may be waning immunity in those who were vaccinated early in the pandemic alongside concerns over new sub-variants within this vulnerable population group.	JR - 01/08/2022 - works have delayed and completion now due end of August
5 - Almost Certain - Expected to occur frequently - more likely than not	3 - Possible - May occur occasionally - reasonable chance
3 - Moderate	5 - Extreme
High Risk	High Risk
15	15
4 - Likely - Strong possibility this could occur	1 - Remote - Can't believe this event would happen
3 - Moderate	5 - Extreme
Moderate Risk	Low Risk
12	5
Tomlinson, Joy	McCormick, Neil
Ward, Brenda	Ramsay, Jimmy
03/08/2022	01/08/2022
05/10/2022	31/08/2022

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**2 September 2022**
Title:	**Board Assurance Framework - Strategic Planning**
Responsible Executive:	**Margo McGurk, Director of Finance**
Report Author:	**Susan Fraser, Associate Director of Planning and Performance**

1 Purpose

This is presented to the Clinical Governance Committee for:

- Consideration & Approval

This report relates to a:

- Board Assurance Framework

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The Board Assurance Framework (BAF) is intended to provide accurate and timely assurances to EDG and ultimately to the Board that the organisation is delivering on its strategic objectives in line with the following:

- NHS Fife Strategic Framework
- NHS Fife Clinical Strategy
- Fife Health & Social Care Integration Strategic Plan

EDG has a vital role in scrutinising the risk and where indicated, EDG will seek further information from risk owners.

This report provides the committee with the next version of the NHS Fife BAF 5 on 2 Sept 2022.

2.2 Background

This BAF brings together pertinent information on the above risk, integrating objectives, risks, controls, assurances and additional mitigating actions.

- Identifies and describes the key controls and actions in place to reduce or manage the risk

- Provides assurances based on relevant, reliable and sufficient evidence that controls are in place and are having the desired effect

- Links to performance reporting to the Board and associated risks, legislation & standing orders or opportunities

The Committee is invited to consider the following:

- Does the risk score feel right?
- Do the current controls match the stated risk?
- Will the mitigating actions bring the risk down to its target level?
- If the mitigating actions are fully implemented would the outcome be achieved?
- Does the assurance provided describe how the controls are performing?
- Do the assurances come from more than one source including independent sources?
- Are limited resources being allocated appropriately i.e., on uncontrolled high risks or in otherwise well controlled areas of risk?

2.3 Assessment

This BAF reflects the changes that have happened over the COVID period and included the strategic planning for the new Population Health and Wellbeing Strategy for NHS Fife. The current risk level is assessed and remains as **Moderate**, the expectation is that as we progress through the milestone plan activity in terms of the new strategy development and, as the recently recruited additional PMO capacity embeds, that this risk level should reduce.

Following discussion at previous committees, previous risks have remained on the BAF until the new Strategy is produced. The risks have been reviewed and updated. The BAF and risk also describes how:

- the Strategic Priorities form the focus of strategic planning direction going forward for NHS Fife.

- Work is progressing in the development of the Population Health and Wellbeing Strategy with revised timescales. Further engagement work has been commissioned and will take place over the next few months. Milestone plan to December 2022 has been produced.

- The Annual Delivery Plan 2022/23 was submitted on 29 July 2022 with a feedback meeting with the Scottish Government taking place on 22 August 2022. The Planned Care section of the ADP was submitted on 12 August 2022 with a financial template supporting the long waiting times recovery plan.

The committee are asked to note the current risk level against progress made in the development of the Population Health and Wellbeing Strategy and the robust planning through SPRA.

2.3.1 Quality/ Patient Care

Quality of Patient Care underpins the work undertaken by Strategic Planning and the development of the Population Health and Wellbeing Strategy.

2.3.2 Workforce

Workforce planning is aligned to the work undertaken by Strategic Planning through SPRA and the development of the Population Health and Wellbeing Strategy.

2.3.3 Financial

Financial planning is aligned to the work undertaken by Strategic Planning.

2.3.4 Risk Assessment/Management

Risk Assessment and Management is an integral part of the work undertaken by Strategic Planning.

2.3.5 Equality and Diversity, including health inequalities

Equality and Diversity is part of the work undertaken by Strategic Planning.

2.3.6 Other impact

n/a

2.3.7 Route to the Meeting

This paper was discussed at EDG on 18 August 2022 in advance of discussion at other committees.

2.4 Recommendation

The Committee is invited to:

- **Approve** the current position in relation to the Strategic Planning risk of Moderate.

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

NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Board Assurance Framework (BAF) - Strategic Planning																											
1675	Clinically Excellent, Exemplar Employer, Person Centred, Sustainable	03/10/2022	3 October 2022	There is a risk that the development and the delivery of the new NHS Fife Population Health and Wellbeing strategy is not adequately supported by the required planning and programme management capacity, capability and governance arrangements. Key Risks from previous BAFs will remain until committees are content they are covered in renewed PHW Strategy. 1. Community/Mental Health redesign is the responsibility of the H&SCP/IJB which hold the operational plans, delivery measures and timescales 2. Governance of the transformation programmes remains between IJB and NHS Fife. 3. Regional Planning - risks around alignment with regional plans are currently reduced as regional work is focussed on specific workstreams 4. Clinical Strategy does not reflect that the strategic direction of the organisation following the COVID-19 pandemic.	4 – Likely – Strong possibility this could occur	4 – Major	16	High Risk	3 – Possible – May occur occasionally – reasonable chance	4 – Major	12	Moderate Risk	Following period of COVID-19, portfolio management is being put in place. Programme management approach being refreshed through Strategic Planning Resource Allocation (SPRA) process.	Margo McGurk Director of Finance and Strategy	Clinical Governance. Christina Cooper.	*Ongoing actions designed to mitigate the risk including:* 11/8/22 1. Workshop has been held with PH to discuss DoPH report and focus for NHS Fife strategy. Next step is Grand Round on 31/8/22 with clinicians from across Fife to discuss next steps. Supported by MD, DoP and DoN 2. Joint engagement progressing with focus groups being planned. Opportunity to benefit from wider engagement process in HSCP. 3. Annual Delivery Plan submitted to SG but still in draft form.	EDG Portfolio Board will provide the required leadership and executive support to enable strategy development - now in place.	PHW Portfolio Board is now meeting monthly. TOR signed off. Governance route will be Public Health and Wellbeing Committee Time period for Strategy has been amended to start from 23/24 rather than 22/23. Annual Delivery Plan for 22/23 providing interim strategic direction. Work will continue during 2022 to ensure delivery of Strategy for 23/24. Responsible Person: Director of Finance Timescale: 31/03/2023	1. Minutes of meetings record attendance, agenda and outcomes. 2. Reporting of key priorities to governance groups from the SPRA process. .	1. Internal Audit Report on Strategic Planning (no. B10/17) 2. Governance committee scrutiny and reporting. .	Governance of new arrangements will be agreed to deliver the required assurance. This gap have now been closed.	Corporate Objectives now finalised for 22/23. Draft Annual Delivery Plan has been submitted in July 22 with draft Planned Care plan submitted on 12/8/22. ADP Q2 update on deliverables to be submitted in October 22.	2 – Unlikely – Not expected to happen – potential exists	4 – Major	8	Moderate Risk	Position is improving as Portfolio Board and Public Health and Wellbeing Committee is in place.

Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
	Nil currently identified				

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
	Nil applicable				

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**2 September 2022**
Title:	**Board Assurance Framework - Digital and Information**
Responsible Executive:	**Dr Chris McKenna – Medical Director**
Report Author:	**Alistair Graham – Associate Director of Digital and Information**

1 Purpose

This is presented to the Clinical Governance Committee for:

- Assurance

This report relates to a:

- Local Policy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The Board Assurance Framework (BAF) is intended to provide assurances to the Committee and ultimately to the Board, that the organisation is delivering on its Digital and Information strategic objectives as contained in the following:

- NHS Fife Strategic Framework
- NHS Fife Clinical Strategy
- Fife Health & Social Care Integration Strategic Plan
- NHS Fife Digital & Information Strategy 2019 - 24

In addition, the BAF recognises the opportunity to integrate digital capability as part of the development of the Population Health and Wellbeing Strategy.

The Committee has a key role in scrutinising the risk and where necessary, the chair should seek further information. The Committee is required to consider the following:

- Does the risk score feel right?
- Do the current controls match the stated risk?
- Will the mitigating actions bring the risk down to its target level?
- If the mitigating actions are fully implemented would the outcome be achieved?
- Does the assurance provided, describe how the controls are performing?
- Do the assurances come from more than one source including independent sources?
- Are limited resources being allocated appropriately i.e. on uncontrolled high risks or in otherwise well controlled areas of risk?
- Is there anything missing you would expect to see in the BAF?

This report provides an update on NHS Fife BAF in relation to Digital & Information (D&I) as at 8 August 2022.

2.2 Background

This BAF brings together pertinent information on the above risk, integrating objectives, risks, controls, assurances and additional mitigating actions.

- Identifies and describes the key controls and actions in place to reduce or manage the risk
- Provides assurances based on relevant, reliable and sufficient evidence that controls are in place and are having the desired effect
- Links to performance reporting to the Committee and associated risks, legislation & standing orders or opportunities

2.3 Assessment

The Committee can be assured that systems and processes are in place to monitor D&I performance and continue to work on the risks as and when resource/funding becomes available.

The high-level risks are set out in the BAF, together with the current risk assessment and the mitigating actions.

Changes since the last report to the Committee are as follows: -

New Linked Operational Risks:

During the period risk 1500 – Cyber Resilience Risk has been added as a linked risk. This risk represents the overarching corporate risk and is underpinned by 4 additional risks that have been updated to align with the 4 Objectivies of the Cyber Resilience Framework and Network and Information Security Directive.

Those objectivies are defined as:-

- Manage Security Risk

- Protect Against Cyber Attack
- Detect Cyber Security Events
- Respond and Recover

Previously Linked Operational Risks:

No change to the linked operational risks

Other Changes

No other changes noted in the period

The BAF's current risk level has been assessed as High, with the target score remaining Moderate.

In support of the transition to the Corporate Risk Register (CRR) it has been proposed that BA risks 1677 and linked risk 1500, the corporate risk associated with Cyber Resilience, are included as candidates for the CRR.

2.3.1 Quality/ Patient Care

No negative impact on quality of care (and services).

2.3.2 Workforce

No change

2.3.3 Financial

Digital & Information continue to identify and quantify the key financial exposures that present risks to be able to operate within the agreed budget. D&I looks to identifying additional funding allocations and changes to operating models to mitigate the levels of financial exposure. A number of opportiunities for Cost Improvement Plans (CIPs) are in development.

Further financial planning and business case propositons for remaining items relating to the Digital & Information Strategy will be prepared and presented throughout 2022-23.

2.3.4 Risk Assessment/Management

Please see attached risks and BAF.

2.3.5 Equality and Diversity, including health inequalities

N/A

2.3.6 Other impact

N/A

2.3.7 Communication, involvement, engagement and consultation

External stakeholders are engaged where appropriate.

2.3.8 Route to the Meeting

The BAF reflects the consideration and activities from the: -

Digital & Information Board

Information Governance & Security Steering Group

2.4 Recommendation

Assurance – the content and current assessment of the Digital & Information BAF is provide to the Committee for assurance. The BAF's current risk level has been assessed as High, with the target score remaining Moderate.

3 List of appendices

The following appendices are included with this report:

- Appendix 1 - BAF Digital & Information June 2022
- Appendix 2 - Digital & Information linked operational risks

Report Contact
Alistair Graham
Associate Director of Digital & Information
Email alistair.graham1@nhs.scot

NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Board Assurance Framework (BAF) - Digital & Information																											
1677	Clinically Excellent, Exemplar Employer, Person Centred, Sustainable	08/08/2022	3 October 2022	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 deliver sustainable and integrated services that are safe, secure and compliant with governance frameworks and associated legislation.	4 – Likely – Strong possibility this could occur	5 - Extreme	20	High Risk	3 – Possible – May occur occasionally – reasonable chance	5 - Extreme	15	High Risk	Failure in this area could have a direct impact on patients care, organisational reputation and exposure to legal action. While it is recognised that several adverse events ranging from minor to extreme can occur daily, the proportion of these in relation to overall activity is very small and reporting to competent authorities is minimal.	CMK Medical Director	Clinical Governance Christina Cooper (CGC)	*Ongoing actions designed to mitigate the risk including:* 1. Consistent alignment of the D&I Strategy with the NHS Fife Corporate Objectives and developing Health & Wellbeing Strategy 2. Digital & Information Board Governance established and supporting prioritisation with ongoing review 3. Information Governance & Security Governance Groups implemented with improvement and assurance activity plans reviewed and monitored by Steering Group. 4. Caldicott - register maintained and reviewed 5. Review of financial impact of D&I Strategy as part of annual deliver planning and areas of exposure quantified and presented via SPRA process 6. Operational governance lead through SLT focusing on operation controls (finance & resource), lifecycle management, policy/procedure implementation a workforce development 7. Risk management arrangements underpinned by: Policy & Process, Adverse event management, Asset Management Controls, Monitoring and Detection, Defence in Depth security measures and technology; all of which are receiving a higher percentage of budget allocation. 8. Directive on security of network and information systems (NIS) & Cyber Essentials Compliance – Action Plan developed prioritising a series of Cyber workshops informing technical controls and organisational response to Cyber attacks 9. Additional resilience planning and disaster recovery work underway to update alignment to current operating priorities 10. FOI, SAR, records management, DPA improvements being lead through IG&S Steering and Operational Groups 11. Senior Management Team consideration of policy and procedure impact and associated implementation 12. Monthly risk reviews with Operational Leads and escalation/reporting to Governance Groups as necessary 13. Performance Review 14. Participation in national and local audit e.g. NISD Audit 15. Commitment to ensure appropriate implementation of Cyber Defence Measures, including support of national centralised cyber incident reporting and coordination protocols. 16. Staff Learning & Development, both Digital staff and the wider organisation including leadership skills. 17. Business Case development to include costed resilience by design and ongoing support activities. 18. Enhancing monitoring of our digital systems.	Lack of formal quantification of the financial impact of the remaining items associated with the Digital Strategy, Business Cases in development. Level of financial and resource exposure linked to COVID response items. Lack of long term financial, lifecycle and workforce planning. Lack of evidence of assurance now that systems to maintain ongoing monitoring of compliance and control are established: GDPR/DPA 2018 - Improvements noted in IG&S Assurance Report (Target March 2022) Lack of consideration and commitment to unification of business process on strategic applications and the associated remove of duplicate or legacy systems Lack of training and education resource to ensure our staff and patients are digitally ready - Business Case in consideration Lack of resilience of key digital systems and technical recovery procedures and regular failover (DR) testing. - Plan to address agreed with EDG - April 2021- project now in initiation – Oct 2021 Governance and procedures do not fully follow ITIL professional standards - Internal Audit Findings responded to	1. Improving and maintaining strong governance, risk management and operating procedures following Information Technology Infrastructure Library (ITIL) professional standards within early adoption of continuous improvement assessment. (ITIL implementation - Phase 1 Agreed - Phase 2 underway) 2. Organisation to consider the gaps in current operating financial commitments as a result of COVID response and assessment of financial implementation of Digital Strategy presented through SPRA process. 3. Develop long term financial, lifecycle and workforce planning - plan to address is in development 4. Work to become fully compliant with GDPR, DPA 2018, NIS Directive, Information Security Policy Framework and thereafter maintain compliance.	Second line of Assurance: 1. Reporting to D&I SLT, D&I Board, Information Governance & Security Steering Group (IG&SG), EDG & Clinical Governance groups and committees. 2. Annual Assurance Statements for the D&I Board and IG&S Steering Group. 3. Locally designed subject specific audits. 4. Compliance and monitoring of policies & procedures to ensure these are up to date via D&I Senior Management Team. 5. Reporting bi annually on adequacy of risk management systems and processes to Audit & Risk Committee. 6. Monthly SIRO report 7. SGHSCD Annual review 8. SG Resilience Group Annual report on NIS & Cyber compliance 9. External Assurance on Delivery Plan by Scottish Government 10. Update to Assessment following June 2019- Digital Maturity Assessment 11 Periodic Benchmarking for areas of focus	Third line of Assurance : 1. Internal Audit reviews and reports on controls and process; including annual assurance and governance review / departmental reviews. 2. External Audit reviews. 3. Formal resilience testing / DR testing using an approved scope and measured success and mechanism for lessons learned and action plans. 4. Alignment to Cyber Resilience Framework 5. NISD Audit Commissioned by the Competent Authority for Health. 6. Benchmarking with NHS Scotland's Boards	1. The remaining deliverables as stated in the D&I Strategy have yet to undergone business case assessment against delivery. Findings presented via SPRA and FCIG. 2. Continual development of data assured performance is ongoing across all D&I Domains. Development of workplans aligned to risk continually developed. 3. Assurance reports are consistently provided to D&I SLT monthly and development of data/KPI reports to Governance Groups continue to be developed. These reports will ensure trend and analysis to highlight potential vulnerabilities and provide assurances (including assurances that confirm compliance with GDPR, DPA 2018, NIS Directive, the Information Security Policy Framework is being maintained). 4. Implementation of improvements as recommended in Internal and external Audit ongoing. Adverse Events review to be included 5. Improvements to SLA's (in line with 'affordable performance')is that output still awaited from 4 to provide assurance or otherwise 6. Assurance on patients' readiness/equality impact in the adoption of digital care provision 6. Assurance on organisational readiness for further Digital Adoption	Overall, NHS Fife Digital has in place a sound systems of 1. Governance - agreed ToR and reporting 2. Improving security defences and risk management as evidenced by Internal Audit and External Audit reports 3. Investment has been made to support NIS, GDPR and Cyber resilience and some tools which will improve visibility of the Network. 4. Clear articulation of digital aspiration via the Digital Strategy 2019-2024 5. Extended corporate governance including EDG attendance 6. Meeting visibility through provision of minutes and delivery plans to EDG/CGC 7. Investment in substantive resources for IG&S, Programme Management office and architecture service.	2 – Unlikely – Not expected to happen – potential exists	5 - Extreme	10	Moderate Risk	1. Difficulty in securing investment in people, tools and maintaining systems that are resilient and always within support cycles. 2. Fully implementing resistance to attack through 'resilience by design', well practised response plans and recovery procedures. 3. Reduce the 'human factor' through ongoing 'user base education' and improving organisational digital readiness. 4. Enhanced controls and continuing improvements to systems and processes for improved usage, monitoring, reporting and learning are continually being put in place. Aim for Moderate Risk as target rather than Low Risk is due to the fact that likelihood whilst unlikely may still happen and consequence will be extreme due to level of fines that may be imposed, reputational damage and patient harm.

Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
2192	Risk that Digital & Information Service Management activities are not aligned to ITIL	Active Risk	High Risk	20	Graham, Alistair
1422	Unable to meet NIS & Cyber Resilience Framework compliance	Active Risk	High Risk	16	Graham, Alistair
1500	Cyber Resilience Risk	Active Risk	High Risk	16	Potter, Carol
1934	Loss of Cloud based Email & Collaboration Services	Active Risk	High Risk	16	Young, Allan
537	Failure of the Network causing widespread loss of access to IT systems	Active Risk	High Risk	15	Young, Allan
885	Digital & Information Financial Position	Active Risk	High Risk	15	Graham, Alistair

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
226	Security of data being transferred off/on site	Active Risk	High Risk	16	Graham, Alistair
1338	NHS Fife at increased cyber attack risk due to legacy systems / application versions	Active Risk	Moderate Risk	12	Graham, Alistair
1393	Patch Management Risk	Active Risk	Moderate Risk	8	Young, Allan
1504	Lack of a central IT location to store guidance documents	Active Risk	High Risk	20	McKenna, Christopher
1576	Risk of not meeting Software as a Medical Device full compliance	Active Risk	Moderate Risk	9	McKenna, Christopher
1746	O365 May Cause Disruptive Network Overhead	Active Risk	Moderate Risk	9	Young, Allan
1932	T4 - User error in use of O365 products (including those supporting system)	Active Risk	Moderate Risk	12	Fowles, Malcolm
1996	Office 365 - Unknown Financial Consequence and so risk to licence availability	Active Risk	Moderate Risk	12	Graham, Alistair
529	Information Security Risk	Closed Risk	High Risk	16	McGurk, Margo
913	MIDIS replacement	Closed Risk	Moderate Risk	9	Donovan, Lesly
1424	End of support lifecycle for Microsoft Server Products	Closed Risk	High Risk	16	Young, Allan
1927	Deliberate unauthorised data access or misuse by insiders (staff, contractors etc.)	Closed Risk	Moderate Risk	12	Fowles, Malcolm
1928	T2 - Deliberate unauthorised access or misuse of O365 Email by outsiders (e.g. hackers)	Closed Risk	Moderate Risk	12	Young, Allan
1929	T7 - Inadequate or absent audit trail	Closed Risk	High Risk	25	Young, Allan

ID	2192	1422	1500
Position of Risk (Risk Register)	NHSFBD - Digital and Information Directorate Risk Register	NHSFBD - Digital and Information - Information Technology Risk Register, NHSFBD - Digital and Information Directorate Risk Register	CORPORATE RISK REGISTER, NHSFBD - Digital and Information Directorate Risk Register
Opened	15/09/2021	19/02/2018	04/12/2018
Title	Risk that Digital & Information Service Management activities are not aligned to ITIL	Unable to meet NIS & Cyber Resilience Framework compliance	Cyber Resilience Risk
Description	There is a risk (As supported by IA ReportB23-21) that the lack of governance and procedures aligned to the maintenance of ITIL standards will result in increased periods of system unavailability and adverse impact to clinical and corporate functions in NHS Fife	There is a risk that not enough resource or funding will be available to implement requirements for the full NIS and Cyber Essentials legislation and standards.	There is a risk that NHS Fife will be overcome by a targeted and sustained cyber attack, that may impact the availability or integrity of digital and information we require to operate a full Health Service. This risk is under-pinned by 4 other risks aligned to the main objectives of NISD. (Manage, Protect, Detect, Respond and Recover)
Likelihood (initial)	5 - Almost Certain - Expected to occur frequently - more likely than not	5 - Almost Certain - Expected to occur frequently - more likely than not	4 - Likely - Strong possibility this could occur
Consequence (initial)	4 - Major	4 - Major	4 - Major
Risk level (initial)	High Risk	High Risk	High Risk
Rating (initial)	20	20	16
Current Management Actions	8/8/22 - Recruitment to key roles now completed. Team will now commence the implementation of management practices based on priority. Training and cultural investment being prepared.	01/06/22 - Action plan still being progressed in line with NISD recommendations / priorities using appropriate resources vs 'run' commitments. Latest audit shows compliance increased from 69% to 76%, but more work and funding will be required to achieve 80%+.	12/08/2022 - Considerable focus continues in 2022 with heightened threat level. Current live incident with NHS Supplier being managed. Actions include education within the organisation, improvements to NISD compliance and improvements to backup solution.
Likelihood (current)	5 - Almost Certain - Expected to occur frequently - more likely than not	4 - Likely - Strong possibility this could occur	4 - Likely - Strong possibility this could occur
Consequence (current)	4 - Major	4 - Major	4 - Major
Risk level (current)	High Risk	High Risk	High Risk
Rating (current)	20	16	16
Likelihood (Target)	2 - Unlikely - Not expected to happen - potential exists	2 - Unlikely - Not expected to happen - potential exists	2 - Unlikely - Not expected to happen - potential exists
Consequence (Target)	3 - Moderate	4 - Major	3 - Moderate
Risk level (Target)	Low Risk	Moderate Risk	Low Risk
Rating (Target)	6	8	6
Risk Owner	Graham, Alistair	Graham, Alistair	Potter, Carol
Handler	Young, Allan	Young, Allan	Young, Allan
Previous Review Date	05/08/2022	01/06/2022	05/08/2022
Next Review	01/09/2022	01/09/2022	09/10/2023

ID	Position of Risk (Risk Register)	Opened	Title	Description	Likelihood (initial)	Consequence (initial)	Risk level (initial)	Rating (initial)	Current Management Actions	Likelihood (current)	Consequence (current)	Risk level (current)	Rating (current)	Likelihood (Target)	Consequence (Target)	Risk level (Target)	Rating (Target)	Risk Owner	Handler	Previous Review Date	Next Review
1934	NHSFBD - Digital and Information - Information Technology Risk Register, NHSFBD - Digital and Information Directorate Risk Register	08/09/2020	Loss of Cloud based Email & Collaboration Services	There is a risk that NHS Fife users and services could be prevented from using Email and Collaboration solutions (such as Teams / SharePoint), also online MS Office Products due to a loss of connectivity to the Internet or Microsoft Azure Infrastructure, resulting in a negative impact upon services, collaboration and communication.	4 - Likely - Strong possibility this could occur	4 - Major	High Risk	16	July 2022 - Situation continues to be monitored. Work continues to find funding for secondary Internet connectivity.	4 - Likely - Strong possibility this could occur	4 - Major	High Risk	16	2 - Unlikely - Not expected to happen - potential exists	3 - Moderate	Low Risk	6	Young, Allan	Fowles, Malcolm	25/07/2022	01/11/2022
537	NHSFBD - Digital and Information - Information Technology Risk Register, NHSFBD - Digital and Information Directorate Risk Register	02/05/2006	Failure of the Network causing widespread loss of access to IT systems	There is a risk of localised or widespread extensive and persistent IT network failure caused by failure of any of Local Area Networks, Wide Area Network connections within NHS Fife. Thus resulting in clinicians / admin staff being unable to access data which is pertinent to patient care and administrative services being significantly hindered.	3 - Possible - May occur occasionally - reasonable chance	5 - Extreme	High Risk	15	7/8/22 - Implementation of additional resilience ongoing following additional funding received from SG. Orders placed and wait for delivery and installation of equipment. Longer term financial plan provided to FCIG.	3 - Possible - May occur occasionally - reasonable chance	5 - Extreme	High Risk	15	1 - Remote - Can't believe this event would happen	5 - Extreme	Low Risk	5	Young, Allan	Fowles, Malcolm	08/08/2022	17/10/2022
885	NHSFBD - Digital and Information Directorate Risk Register	31/10/2014	Digital & Information Financial Position	There is a risk that D&I will not be able to provide funding for new IT initiatives due to flatlined or reducing budgets. This is due to the need to ensure the current production infrastructure is appropriately maintained, support contracts paid for and vulnerable equipment upgraded in order to remain safe & secure. The D&I financial position is heavily reliant on non-recurring money issued to the Board by Scottish Government Digital Directorate. This funding is always subject to reduction and designed to support enablement and innovation within NHS Boards. However NHS Fife uses a significant proportion of this funding to run the operational digital service, thus restricting the Board's ability to embark on redesign / service developments, innovation and strategic aims. The D&I department is forced to carry persistent high/red risks due to ever-competing funding challenges, which impact the ongoing ability maintain safe operations.	4 - Likely - Strong possibility this could occur	5 - Extreme	High Risk	20	06/06/22 - SPRA outcome known. Risk still associated with financial commitments associated with the COVID response activity and for larger scale deliverables associated with the D&I Strategy. Business Cases in development.	3 - Possible - May occur occasionally - reasonable chance	5 - Extreme	High Risk	15	2 - Unlikely - Not expected to happen - potential exists	2 - Minor	Low Risk	4	Graham, Alistair	Marshall, Shelley	06/06/2022	15/08/2022

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**2 September 2022**
Title:	**Draft Corporate Risk Register & Dashboard**
Responsible Executive:	**Margo McGurk, Director of Finance and Strategy**
Report Author:	**Pauline Cumming, Risk Manager**

1 Purpose

This is presented to the Clinical Governance Committee for:

- Discussion & Assurance

This report relates to a:

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

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

As part of the refresh of the Risk Management Framework, it was agreed that the Board Assurance Framework (BAF) would be replaced with a renewed NHS Fife Corporate Risk Register (CRR).

2.2 Background

An iterative process to agree the content of the CRR has been underway over recent months. This has involved:

- reviews of risks on the extant Corporate Risk Register
- reviews of other active risks, including those linked to the BAF
- discussion within EDG, the governance committees and the Board
- engagement with Senior Leadership Teams and Operational Teams
- identification of new risks that require to be considered for inclusion

Risk Categorisation

It has been agreed that risks on the Corporate Risk Register will be categorised by mapping across to the 4 strategic priorities as follows:

- To improve health and wellbeing
- To improve the quality of health and care services
- To improve staff experience and wellbeing
- To deliver value and sustainability

2.3 Assessment

Proposed Corporate Risks

The aim has been to draw out and refocus the presentation of the corporate risks with the mitigation in place at a strategic level. Annex 1 presents a draft of the strategic risk profile as a dashboard set in the context of the risk appetite of the Board. Annex 2 sets out the draft Corporate Risk Register for review.

The plan is to create opportunities at each committee and Board session to carry out deep dives into high risks which are deteriorating or not improving over time. The dashboard will also feature in the executive summary of the IPQR.

It is recognised that the CRR must be dynamic and act as a tool to enable the management of risks that may affect delivery of our strategic priorities. Frequent review of existing risks and monitoring of the environment is necessary to ensure the risks captured represent the current profile of the organisation. Continual communication of risks within the organisation, with the Board and other stakeholders, is essential to allow for informed decision-making, to enable appropriate scrutiny and to provide assurance that the risk profile is being effectively managed. In this way, the corporate risk register content will be subject to continuing refinement and development.

The Risks and Opportunities Group will play a key role in supporting the development, monitoring and review of the corporate risk register, identifying risks and opportunities to the strategic priorities, and ensuring continuous improvement of the organisation's control environment, including appropriate containment of risks.

2.3.1 Quality/ Patient Care

Effective risk management enables risks to quality and patient care to be identified and appropriately managed.

2.3.2 Workforce

Effective management of workforce risks supports delivery of quality and patient care.

2.3.3 Financial

Effective management of financial risks supports delivery of quality and patient care.

2.3.4 Risk Assessment/Management

As detailed in the paper.

2.3.5 Equality and Diversity, including health inequalities
An impact assessment will be conducted.

2.3.6 Other impact
None

2.3.7 Communication, involvement, engagement and consultation
This paper has been developed following the range of engagement over time with EDG, SLTs, governance committees and Board.

2.3.8 Route to the Meeting
EDG 18/08/22.
The paper will be shared with all governance committees during September then a final version will be presented for approval at the September Board meeting.

2.4 Recommendation

The Committee is asked to:

- **comment** and **take assurance** from the work to date on developing the Corporate Risk Register and Dashboard reporting.

Report Contact
Pauline Cumming
Risk Manager
Email pauline.cumming@nhs.scot

Working examples for discussion

Strategic Risk Profile

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	4	1	-	-	◀ ▶	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	◀ ▶	Moderate

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

Risk Improvement Trajectory & Deep Dive into deteriorating risks *(1 for each strategic objective)*

To improve health and wellbeing	Risk Improvement Trajectory
Risks which have improved	
Risks which have deteriorated	
Risks which have not moved	
Risks which have reached acceptable level of tolerance	
Total	

Deep Dive

Risk

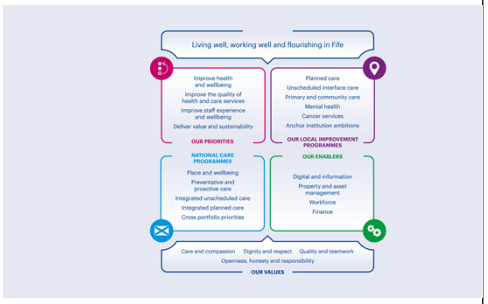
Risk Level and Score

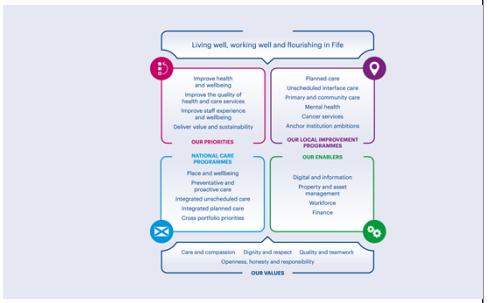
Risk Mitigation

Anticipated Timeline to Risk Reduction / Tolerate and Monitor

Corporate Risk Register contains individual risk details

M	Strategic Priority	Risk	Mitigation	Risk Level	Target Risk / Date	Risk Level Trend	Risk Owner	Primary Committee
1		**Population Health and Wellbeing Strategy** There is a risk that the ambitions and delivery of the new organisational Strategy do not deliver the most effective health and wellbeing and clinical services for the population of Fife.	EDG has established a Portfolio Board, reporting to the Pubic Health and Wellbeing Committee to deliver the required system leadership and executive support to enable effective strategy development. The Portfolio Board commissions and monitors the delivery of key mielstone activity associated with the delivery of an effective new strategy.	Mod 12	Mod 8		Chief Executive	Public Health & Wellbeing
2		**Health Inequalities** There is a risk that if NHS Fife does not develop and implement an effective strategic approach to contribute to reducing health inequalities and their causes, health and wellbeing outcomes will continue to be poorer, and lives cut short in the most deprived areas of Fife compared to the least deprived areas, representing huge disparities in health and wellbeing between Fife communities.	Public Health and Wellbeing Committee established, with the aim of providing assurance that NHS Fife is fully engaged in supporting wider population health and wellbeing for the local population. Public health department and wider partners ongoing programme of work on reducing health inequalities relating to Public Health Priorities, Health Promotion, Vaccination, Screening, and Dental Public Health (ongoing). Leadership and partnership working to influence policies to 'undo' the causes of health inequalities in Fife.	High 20	Mod 10		Director of Public Health	Public Health & Wellbeing
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.	Delivery plans are being developed for the autumn/winter vaccination campaign. The proposed start date is early September 2022; some planning is pending JCVI decisions. Implementation of new treatments for individuals at higher risk of adverse outcomes. Public communications programme to raise awareness of infection prevention and control measures across the region population cross the population.	High 16	Mod 12		Director of Public Health	Clinical Governance

4		**Policy obligations in relation to environmental management and climate change** There is a risk that if we do not put in place robust management arrangements and the necessary resources, we will not meet the requirements of the 'Policy for NHS Scotland on the Global Climate Emergency and Sustainable Development, Nov 2021.'	Robust governance arrangements have been put in place including an Executive Lead and Board Champion appointed Regional working group and representation on the National Board Active participation in Plan 4 Fife	Mod 12	Mod 10		Director of Property & Asset Management	Public Health & Wellbeing
5		**Optimal Clinical Outcomes** There is a risk that recovering from the legacy impact of the ongoing pandemic, combined with the impact of the cost-of-living crisis on citizens, will increase the level of challenge in meeting the health and care needs of the population both in the immediate and medium-term.	The Board has agreed a suite of local improvement programmes, as detailed in the diagram below to frame and plan our approach to meeting the challenges associated with this risk. The governance arrangements supporting this work will inform the level of risk associated with delivering against these key programmes and reduce the level of risk over time. 	High 15	Mod 10		Medical Director/ Director of Public Health	Clinical Governance

6		**Whole System Capacity** There is a risk that significant and sustained admission activity to acute services, combined with challenges in achieving timely discharge to downstream wards and/or provision of social care packages, that the management of Acute hospital capacity and flow will be severely compromised.	The combination of application of our OPEL process on a daily basis and the improvement work through our Integrated Unscheduled Integrated Care and Planned Care programmes provides the operational and strategic response to the challenges posed through this risk. 	High 20	Mod 9		Director of Acute Services	Clinical Governance
7		**Access to outpatient, diagnostic and treatment services** There is a risk that due to demand exceeding capacity, compounded by COVID -19 related disruption and stepping down of some non-urgent services, NHS Fife will see a deterioration in achieving waiting time standards. This time delay could impact clinical outcomes for the population of Fife.	Recovery Plans developed outlining additional activity and resources required to reduce backlog and meet ongoing demand. Speciality level plans in place outlining local actions to mitigate the most significant areas of risk. The governance arrangements supporting this work will inform the level of risk associated with delivering against these key programmes and reduce the level of risk over time. 	High 16	Low 4 3-4 years		Director of Acute Services	Clinical Governance

8		**Cancer Waiting Times** There is a risk that due to increasing patient referrals and complex cancer pathways, NHS Fife will see further deterioration of Cancer Waiting Times (CWT) 62-day performance.	Effective Cancer Management Framework Action plan agreed both locally and by Scottish Government and actions identified. A national Short Life Working Group (SLWG) is being set up to develop a 'Once for Scotland' approach to management of breaches standard operating procedure. This will be led by the NHS Fife Cancer Transformation Manager (Chair of National Cancer Managers' Forum). The Cancer Framework and delivery plan is almost complete. Optimal Pathways and integrated care are included in the framework along with viewing CWT targets as a minimum standard. The governance arrangements supporting this work will inform the level of risk associated with delivering against these key programmes and reduce the level of risk over time.	High 15	Mod 12		Director of Acute Services	Clinical Governance
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		Medical Director	Clinical Governance
10		**Primary Care Services** There is a risk that due to a combination of the demand on services, workforce availability and current funding and resourcing of Primary Care, it may not be	A Primary Care Governance and Strategy Oversight Group has been established. The group brings together both the transformation and sustainability initiatives for all four of the independent	High 16	Mod 8		Medical Director/ Director of Health & Social Care	Clinical Governance

		possible to deliver sustainable quality services to the population of Fife into the medium-term.	primary care contractors, whilst also overseeing any critical aspects of governance. It is co-chaired by the Medical Director and the Director of Health and Social Care. The group will provide assurance to NHS Fife Board and the Integration Joint board through the appropriate sub committees. The establishment of this group will allow governance and scrutiny of all aspects of primary care delivery and to provide a focus for improving patient care for the population of Fife					
11		**Workforce Planning and Delivery** There is a risk that if we do not implement effective strategic and operational workforce planning, we will not deliver the capacity and capability required to effectively deliver services.	Development and implementation of the Workforce Strategy to support the Clinical Strategy, workforce elements of the Annual Delivery Plan, Population Health & Wellbeing Strategy and Strategic Framework; alongside the Workforce Plan for 2022 to 2025. Implementation of the Health & Social Care Workforce Strategy to support the Health & Social Care Strategic Plan for 2019 to 2022, the integration agenda and the development of the H&SCP Workforce Strategy and Workforce Plan for 2022 to 2025. Implementation of the NHS Fife Board Strategic and Corporate Objectives, particularly the "exemplar employer / employer of choice" and the associated values and behaviours and aligned to the ambitions of an anchor institution.	High 16	Mod 8		Director of Workforce	Staff Governance
12		**Staff Health and Wellbeing** There is a risk that if due to a limited workforce supply and system pressure, we are unable to maintain the health and wellbeing of our existing staff we will fail to retain and develop a skilled and sustainable workforce to deliver services now and in the future.	Working in partnership with staff side and professional organisations across all sectors of NHS Fife to ensure staff engagement opportunities are maximised. Scoping a Staff Experience and Engagement Framework that sets out our key ambitions and commitments for improving staff experience, which will help to develop a	High 16	Mod 8		Director of Workforce	Staff Governance

			culture that values and supports our workforce.					
13		**Delivery of a balanced in-year financial position.** There is a risk that the Board may not achieve its statutory financial targets in 2022/23 due to the ongoing impact of the pandemic combined with the very challenging financial context both locally and nationally.	Financial Improvement and Sustainability Programme (FIS) board established to provide oversight to the delivery of Cost Improvements Plans and approve pipeline schemes to be taken to implementation.	High 15	Mod 8		Director of Finance & Strategy	Finance, Performance & Resources
14		**Delivery of recurring financial balance over the medium-term** There is a risk that NHS Fife will not deliver the financial improvement and sustainability programme actions required to ensure sustainable financial balance over the medium-term.	Strategic Planning and Resource Allocation process will continue to operate and support financial planning The FIS Programme will focus on medium-term productive opportunities and cash releasing savings The Board will maintain its focus on reaching the full National Resource Allocation (NRAC) allocation over the medium- term	High 15	Mod 8		Director of Finance & Strategy	Finance, Performance & Resources
15		**Prioritisation & Management of Capital funding** There is a risk that lack of prioritisation and control around the utilisation of limited capital and staffing resources will affect our ability to deliver the PAMS and to support the developing Population Health and Wellbeing Strategy.	Infrastructure developments prioritised and funded through the NHS Board capital plan. Regular Property and Asset Management Strategy (PAMS) report submitted to FP&R, NHS Board and Government.	Mod 12	Low 6		Director of Property & Asset Management	Finance, Performance & Resources

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 robotic being planned	Mod 12	Low 6		Director of Property & Asset Management	Clinical Governance
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 2022 with heightened threat level to improve our resilience to attack and ability to recover quickly.	High 16	Low 6		Medical Director	Clinical Governance
18		**Digital & Information** 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.	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	Mod 10		Medical Director	Clinical Governance

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**2 September 2022**
Title:	**Proposal to Develop Assistant Practitioner Role**
Responsible Executive:	**Janette Owens, Director of Nursing**
Report Authors:	**Janette Owens, Director of Nursing**

1 Purpose

This is presented to the Clinical Governance Committee for:

- Assurance

This report relates to an:

- Emerging issue
- 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 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 Fife 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.

Average sickness absence level for the year 2021/22 for the Nursing and Midwifery job family was 8.9% for non-Registered Nurses and 6.7% for Registered Nurses. These rates have led to continuing and sustained pressures within the profession.

Turnover rates for 2021-2022 have been reported at the highest level: 10.8% as of 31st March 2022. However, this is following a 2-year period of lower-than-expected turnover rates. The position continues to be reviewed to determine whether this is a continuing trend. There is a concern, that because of the age profile in nursing, an increased number of registered nurses will opt to retire.

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, to undertake work to support the expansion and development of the Band 2-4 nursing, midwifery and allied health professions (NMAHP) workforce.

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 development of the Framework is underway. The Commission set timelines for the programme of work in three phases:

- **PHASE 1:** Band 4 nursing HCSWs. The Level 4 HCSW within nursing teams in acute care was given as the priority in phase one. In addition, the CNOD requested NES to prioritise level 3 and 4 within community nursing. The Phase 1 report was published in January 2022, with the Development and Education Framework for Levels 3 and 4 Nursing Healthcare Support Workers published on **March 29, 2022.** The overview of the Development Framework for Level 4 is appended to this report (Appendix 1)

- **PHASE 2:** Band 2 nursing plus all nursing, midwifery and allied health professions (NMAHPs) Band 2 – 4. This Framework has been drafted with consultation on the Framework concluding on July 29, 2022. This work is being taken forward as part of the Nursing and Midwifery Workforce Task and Finish Group, chaired by the CNO and the Chief Executive of NHS Lanarkshire. Level 2 – 4 NMAHP development is one of 5 subgroups of the Task and Finish Group, due to be completed by **November 2022**

- **PHASE 3:** Healthcare Science – Bands 2 – 4. This phase will be commenced in the near future.

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 (March 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 7/ 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

A Steering Group has been established to govern the process and provide direction, to encourage a collaborative work environment and to monitor progress. Members of the

Steering Group include the Director of Nursing, Director of Acute Services, Director of Health and Social Care, Employee Director, Director of Finance and Director of Workforce.

A Project Management approach is being adopted to ensure that all strands of activity are interconnected across services, supporting equity of access to education and development.

At an operational level, and to take this work forward, a 'Clinical Assistant Practitioner Workforce Group' is driving the further development of the clinical AP workforce across NHS Fife. The scope of this group, which reports into the Steering Group and the Nursing and Midwifery Workforce Planning Group, is to provide tactical and operational leadership to the Clinical Assistant Practitioner development and implementation across NHS Fife.

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 have been developed and our JE 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	12 weeks accelerated underpinning knowledge (1 day per week)
SCQF Level 7	Professional Development Award online)
SCQF Level 8	Professional Development Award (online)

The Trainee will be supported by a Practice Development Nurse, who has been recruited specifically to support Assistant Practitioners, and 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.

There are already excellent examples of Band 4 NMAHP staff working well in Fife:

- Maternity Care Assistants: complete a Certificate in Higher Education (SCQF 7) through the University of the West of Scotland
- Theatre practitioners: complete SVQ3 theatres and PDA modules
- Rehab HCSW: complete SVQ3 and relevant profession specific modules

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 will be utilised.
Involved in decisions	Discussion is taking place with staff side colleagues to enhance staff engagement and communication
Treated fairly and	Fair and equitable recruitment processes will be in place

consistently	
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. A presentation was provided at the private Board meeting on 17/08/2022.
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.

2.12 Next Steps: Recruitment

To take this development forward, at pace, and to ensure staff have been identified to commence educational programmes in November advertisement of posts should commence week of 5th September. It is recommended that consideration is given to 25 recruits from Acute Services and the HSCP for the first cohort.

It is recognised that several processes will have to run in parallel – the analogy of building a plane when you are flying it. A linear process will not provide development of the role at 'pace', but oversight from the Steering Group, and project management by the CAPWG will ensure robust governance is in place.

3. Recommendations

Assurance
The Governance Committee is 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.

4. List of Appendices:

1. NES Level 4 Assistant Practitioner Development Framework Level 4 – Overview
2. NES RPL Guiding Principles
3. Service Needs Analysis Tool

REPORT CONTACT: Janette Owens, Director of Nursing

LEVEL 4
Assistant Practitioner

Development Framework Level 4 – Overview

Career Framework Level	Pillars of Practice	Broad sphere of Responsibility/ Role	Qualifications and experience expected for practitioners at this level of career framework	SCQF
LEVEL 4 **Assistant Practitioner**	**Clinical Practice** **Facilitation of Learning** **Leadership** **Service Improvement**	Has developed clinical skills which are more specialised than senior support workers and specific to an area of practice Actively involved in supporting others to learn, for example HCSWs, senior HCSWs and students Expected to have strong leadership and service improvement skills, for example working on improvement projects such as information for people receiving care, liaising with other departments and services Deliver less routine delegated activities care, treatment or interventions for people receiving care in support of and supervised (direct or indirect) by healthcare practitioners as part of a multi-professional/multi-agency team. This will be dependent on an individual's needs and area of practice relevant to each profession and context of care delivery	Can evidence previous relevant experience using Recognition of Prior Learning (see appendix 2) Normally at or working towards a SCQF Level 7 or 8 qualification in a health or social care related subject (See appendix 3) At this level specific training, guidance or qualifications may be required by relevant professional bodies or legislation Numeracy and literacy qualifications are required at this level of practice (see appendix 3)	**7-8**

Career Framework Level	Pillars of Practice	Aspects of Practice	Examples of Sphere of Responsibility/Role	Key Knowledge, Skills and Behaviours
LEVEL 4 **Assistant Practitioner**	**Clinical Practice**	**Person-centred safe, effective and care**	**Within own practice area:** Following the initial assessment by a healthcare practitioner*, take responsibility for planned, assigned care or treatment including defined clinical or therapeutic interventions within the care environment, recognising and understanding their role boundaries and limitations Working within current evidence base, agreed protocols and guidelines, adapt approaches and activities regarding care interventions, technical skills and programmes under the direction and supervision (direct or indirect) of a healthcare practitioner Carry out routine elements of an individual's assessment, treatment or intervention following protocols and evidence-based practice, guidelines/protocols and evaluate outcomes (actual or potential) Within the boundaries of their role, are able to use their own initiative and utilise clinical knowledge and skills at a more complex level than a senior HCSW Demonstrate critical thinking and problem-solving skills related to needs and activities and take action within the agreed parameters of the role Work as part of a multidisciplinary/multi–agency team Apply knowledge of infection prevention and	Has an in-depth knowledge and understanding of their scope of practice, job role and related activities Has a comprehensive skill base related to their practice. Any interventions carried out will be achieved through additional, focused training and education Understands and gains valid consent prior to action or providing care, and records this appropriately **Ability to:** Apply knowledge and demonstrate appropriate understanding of: - ✦ Infection control policies and procedures ✦ Appropriate standards for confidentiality, records and record-keeping ✦ Data Protection Act, Caldicott Guidelines and local policies regarding confidentiality and access to medical records. ✦ HCSW Code and Induction Standards ✦ Health and safety ✦ Moving and handling ✦ Standard infection control precautions ✦ COSHH regulations ✦ Risk management ✦ Equality and diversity policies ✦ Safeguarding legislation and policies

			control, leading by example and supporting others to comply with infection prevention and control policies Apply knowledge and skill related to undertaking/assisting as directed with specific complex care interventions and procedures Develop and maintain own knowledge and skills to provide safe and effective person-centred care with direction from a healthcare practitioner and can support others to do so Provide accurate information and adapt communication approaches which support individuals and carers to make informed choices Understand and act on factors that contribute to and impact on wellbeing and actively promote health improvement/promotion, understanding health inequalities and the impact on health outcomes Recognise and respond to change and/or concerns in a person's condition/care and/or treatment, using knowledge and skill to understand the situation and promptly report and/or escalate any changes to a registered practitioner Recognise and respond to issues with equipment or the environment ensuring the safety of those in their care Communicate both routine and complex/sensitive information to individuals,	Signs of harm and abuse What to do if you suspect harm or abuse ✦ HCSW Code of Conduct Understand and apply knowledge of legislation, and policies specific to their area of practice Develop knowledge on how and why their care provision and that of others in the multidisciplinary/multi-agency team, impacts on the person's journey Demonstrate risk assessment skills in relation to the person receiving care Demonstrate application of best practice within the practice setting Demonstrate underpinning knowledge that enables integration of theory relating to practice in relevant settings Understand and apply the concepts of accountability and responsibility and be confident to accept or decline delegated responsibility from a healthcare practitioner

			carers, relatives and other healthcare professionals/services/agencies using a range of effective communication methods including health literacy approaches Understand the communication needs of others and adapts communication accordingly Plan and prioritise activities and duties in consultation with healthcare practitioners and use a framework to support decision making when delegating interventions and activities Provide person centred, safe and effective care, that is responsive to individual preferences, needs and values, ensuring consent is given to proceed. Problem solves and takes action regarding individuals care or technical complications through awareness/understanding of policy and legislation **Where appropriate** and in line with local, national, and regulatory guidelines and policy, prepare, administer and record medication[1] Demonstrate and apply knowledge and skills in providing person centred, safe and effective care, treatment or intervention in collaboration with families and carers	

[1] **Resource guide to support the safe administration of medicines by HCSWs and Carers in health and social care settings (CNOD Dec 21).**

			Identify and measure the impact of conditions/care needs on individuals/family/carers and can support the implementation of strategies/tools to facilitate effective self-management, sign posting or providing information Maintain full, accurate and legible records and is proficient in using and supporting others to use digital systems and platforms e.g., email, electronic patient records Understand, follow and apply local process and procedure in reporting incidents and adverse effects Understand risk and adhere to local policies, protocols and guidelines, supporting others to do likewise e.g., workforce policies, clinical policies and guidance Recognise and act on health and safety issues Demonstrate, apply and share knowledge and understanding of clinical, scientific, administrative and technical activities required in the practice area	

- it is recognised that there may be some specific roles where an initial assessment is carried out by a senior HCSW or assistant practitioner

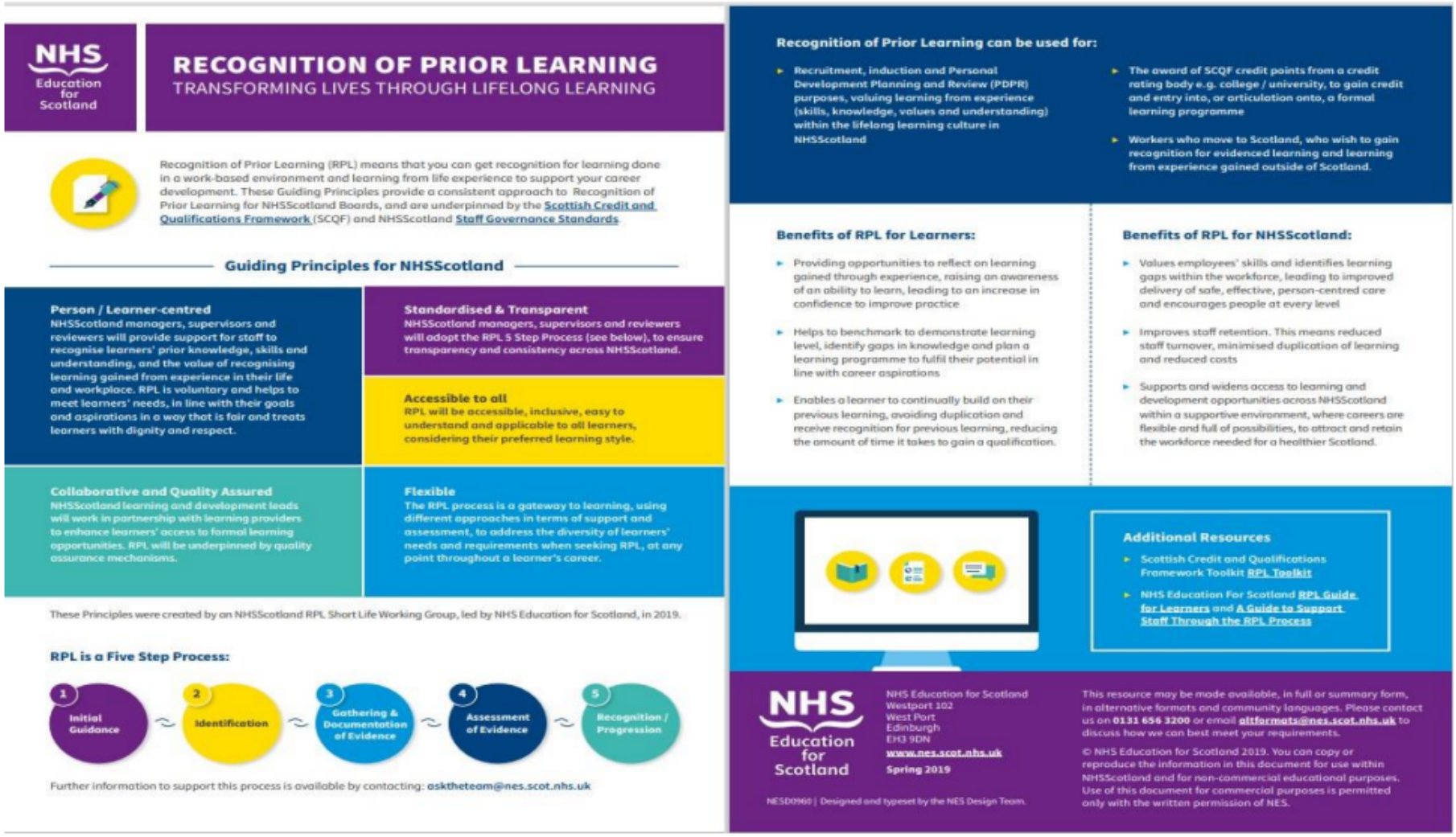
Career Framework Level	Pillars of Practice	Aspects of Practice	Examples of Sphere of Responsibility/Role	Key Knowledge, Skills and Behaviours
LEVEL 4 **Assistant Practitioner**	**Facilitation of Learning**	**Learning, Teaching and Assessment**	**Within own practice area:** Be responsible and accountable for keeping own knowledge and skills up to date through reflective practice and continuing professional development Within the boundaries of role, and seeking support where necessary, facilitate learning for individuals, families and carers Promote a positive learning environment by participating in the support and experience of all learners Act as a positive role model to others Give, ask for and receive feedback in an open, honest and constructive manner to facilitate learning and development for all learners	**Ability to:** Use reflection to enhance self-awareness, gain new insights and develop resilience when faced with adverse situations Recognise the personal impact of any difficult situations and have strategies to enable personal learning and development, recognising the limits of their competence and personal strengths Demonstrate application of a variety of methods to ensure learning has taken place, e.g., 4 stage approach to teaching a clinical skill, or use of Chunk & Check/Teach Back

Career Framework Level	Pillars of Practice	Aspects of Practice	Examples of Sphere of Responsibility/Role	Key Knowledge, Skills and Behaviours
LEVEL 4 **Assistant Practitioner**	**Leadership**	**Teamwork and Development**	**Within own practice area:** Act as a positive role model at all times Contribute to multi-professional/multi agency working, actively promoting, participating and respecting the contribution of others Develop effective team working skills and can negotiate with and influence others Contribute to team objectives in relation to leading service development initiatives	**Ability to:** Work effectively in a multi-disciplinary/multiagency team and participate in team development initiatives Demonstrate critical thinking and problem-solving skills and take action regarding people's care- or treatment through an awareness of policy and legislation Demonstrate effective organisational and time management skills practice in an anti-discriminatory and inclusive manner with individuals and colleagues Demonstrate and apply an understanding of the impact of leadership theories and activities in relation to compassion, civility, kindness and human factors

Career Framework Level	Pillars of Practice	Aspects of Practice	Examples of Sphere of Responsibility/Role	Key Knowledge, Skills and Behaviours
LEVEL 4 **Assistant Practitioner**	**Service Improvement**	**Guidelines and evidence-based practice**	**Within own practice area:** Contribute to the design, development, implementation and evaluation of service and quality improvement initiatives and range of quality assurance activities, including involvement in data collection Access, assess and apply relevant guidelines Apply knowledge and skills in using information technology systems	**Ability to:** Understand and apply evidence-based practice and identify and assesses risk in relation to care provision and quality care outcomes Demonstrate and apply knowledge of relevant guidelines Recognise the importance of responding to individuals' feedback and comments appropriately including resolving complaints in a timely manner and effectively at local level, escalating as appropriate Demonstrate effective application of quality improvement methodologies and tools Identify risk in relation to care provision and service improvement

RPL Guiding Principles

Appendix 2



NHS Education for Scotland

RECOGNITION OF PRIOR LEARNING

TRANSFORMING LIVES THROUGH LIFELONG LEARNING

Recognition of Prior Learning (RPL) means that you can get recognition for learning done in a work-based environment and learning from life experience to support your career development. These Guiding Principles provide a consistent approach to Recognition of Prior Learning for NHSScotland Boards, and are underpinned by the Scottish Credit and Qualifications Framework (SCQF) and NHSScotland Staff Governance Standards.

Guiding Principles for NHSScotland

Person / Learner-centred
NHSScotland managers, supervisors and reviewers will provide support for staff to recognise learners' prior knowledge, skills and understanding, and the value of recognising learning gained from experience in their life and workplace. RPL is voluntary and helps to meet learners' needs, in line with their goals and aspirations in a way that is fair and treats learners with dignity and respect.

Standardised & Transparent
NHSScotland managers, supervisors and reviewers will adopt the RPL 5 Step Process (see below), to ensure transparency and consistency across NHSScotland.

Accessible to all
RPL will be accessible, inclusive, easy to understand and applicable to all learners, considering their preferred learning style.

Collaborative and Quality Assured
NHSScotland learning and development leads will work in partnership with learning providers to enhance learners' access to formal learning opportunities. RPL will be underpinned by quality assurance mechanisms.

Flexible
The RPL process is a gateway to learning, using different approaches in terms of support and assessment, to address the diversity of learners' needs and requirements when seeking RPL, at any point throughout a learner's career.

These Principles were created by an NHSScotland RPL Short Life Working Group, led by NHS Education for Scotland, in 2019.

RPL is a Five Step Process:

1. Initial Guidance
2. Identification
3. Gathering & Documentation of Evidence
4. Assessment of Evidence
5. Recognition / Progression

Further information to support this process is available by contacting: asktheteam@nes.scot.nhs.uk

Recognition of Prior Learning can be used for:

- Recruitment, induction and Personal Development Planning and Review (PDPR) purposes, valuing learning from experience (skills, knowledge, values and understanding) within the lifelong learning culture in NHSScotland
- The award of SCQF credit points from a credit rating body e.g. college / university, to gain credit and entry into, or articulation onto, a formal learning programme
- Workers who move to Scotland, who wish to gain recognition for evidenced learning and learning from experience gained outside of Scotland.

Benefits of RPL for Learners:

- Providing opportunities to reflect on learning gained through experience, raising an awareness of an ability to learn, leading to an increase in confidence to improve practice
- Helps to benchmark to demonstrate learning level, identify gaps in knowledge and plan a learning programme to fulfil their potential in line with career aspirations
- Enables a learner to continually build on their previous learning, avoiding duplication and receive recognition for previous learning, reducing the amount of time it takes to gain a qualification.

Benefits of RPL for NHSScotland:

- Values employees' skills and identifies learning gaps within the workforce, leading to improved delivery of safe, effective, person-centred care and encourages people at every level
- Improves staff retention. This means reduced staff turnover, minimised duplication of learning and reduced costs
- Supports and widens access to learning and development opportunities across NHSScotland within a supportive environment, where careers are flexible and full of possibilities, to attract and retain the workforce needed for a healthier Scotland.

Additional Resources

- Scottish Credit and Qualifications Framework Toolkit RPL Toolkit
- NHS Education For Scotland RPL Guide for Learners and A Guide to Support Staff Through the RPL Process

NHS Education for Scotland
Westport 102
West Port
Edinburgh
EH3 9DN
www.nes.scot.nhs.uk
Spring 2019

NESD0960 | Designed and typeset by the NES Design Team.

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

NHS Fife

Assistant Practitioner Service Needs Analysis Tool

This tool aims to support practice in identifying the requirements for any new Assistant Practitioner role.

SERVICE NEEDS ANALYSIS TOOL

Section A – Patient /Client Needs

Changes in demography and patterns of health and illness, reducing inequality, an ageing skilled and experienced workforce are only some of the factors that impact on future service needs and delivery. This information is therefore important in assessing the need for Assistant Practitioner roles (Band 4) and building a robust case in support of your proposals.

1. **What are the challenges that currently exist in meeting patient needs?**

2. **How would you propose to meet these using a Clinical Health Care Support Role?**

Section B – Service Needs

3. **What does the current model of care look like, including current skill mix? How is it delivered and by whom?**

4. **What are the gaps in the current model of care? What will be the proposed new skill mix?**

5. **Identify the gaps you expect the Assistant Practitioner to meet.**

Communication with Stakeholders

6. **Who are the stakeholders who need to be involved in considering these options?**

7. **How will you engage and involve key stakeholder i.e. patients/carers, staff, service planners, to ensure ownership and support for the new role?**

Workforce Planning

8. **Has the new role been considered in the funding of the wider context of workforce planning, service planning and business planning?**

9. **How does the role contribute to the priorities of the organisation in terms of service delivery?**

10. **Could service gaps be addressed by using existing roles or staff? Please give a rationale?**

New role development, enhancing registrant role etc

11. **How will funding implications be addressed?**

12. **Who will be responsible for developing the business case for sustaining the new role?**

Section C –Clinical Health Care Support Worker/Assistant Practitioner Role

This section will help to determine the type of role that is required, what the person needs to be able to do, the parameters of the role, skills, knowledge and education required and levels of accountability and responsibility.

Define New Model of Care and Health Care Support Worker/ Assistant practitioner role

13. What new care practices and care delivery strategies can be employed to achieve identified goals? What evidence-based data supports these changes?

14. Are changes to current roles and responsibilities required to implement new care practices and care delivery strategies?

15. What knowledge/skills will be required to deliver desired service/outcomes for patients?

16. **Which professionals already have the required knowledge/skills?**

17. **Would the new role enhance ability to achieve goals for meeting patient health care needs? How do you know this?**

Parameters of accountability

18. **Have you defined specific areas of accountability for the individual/s taking on this role?**

19. **Do you have team roles and systems that support the individual's accountability e.g. scheme of delegation?**

20. **How will audit of individual practice be conducted?**

21. **Do you have mechanisms in place for support and supervision?**

22. **Have the scope of practice and the limitations of the new role been clearly identified, in line with the organisation's risk management policy and procedures and vicarious liability?**

23. **Have the activities of the new post holder been identified, and a job description constructed?**

24. **Who will cover the role in case of absence/sickness?**

25. **Who will the practitioner be accountable and responsible to on a daily basis?**

26. **Has professional, criminal, civil and employer accountability been agreed with the whole team and organization so that it is clear to whom the new role is accountable and responsible to?**

Governance arrangements

27. **How can patient safety be assured within this role e.g. risk assessment, clinical decision making, treatment delivery, agreed standards/guidelines, protocols?**

28. **Have clinical and professional accountability and supervision been agreed?**

29. **What arrangements have been made to support the new role in terms of supervision?**

30. **What mechanisms are in place to ensure individuals maintain their skills and competence?**

31. **Have the skills and competences required for the new or enhanced role been identified? Have they been mapped to any existing national standards?**

Adapted with permission from NHS Lothian

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**2 September 2022**
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 to the Clinical Governance Committee for:

- Assurance

This report relates to the:

- Integrated Performance & Quality Report

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

- Safe
- Effective
- Person Centred

2 Report Summary

2.1 Situation

This report informs the Clinical Governance (CG) Committee of performance in NHS Fife and the Health & Social Care Partnership against a range of key measures (as defined by Scottish Government 'Standards' and local targets). The period covered by the performance data is (with certain exceptions due to a lag in data availability) up to the end of June 2022.

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 will streamline 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 Personal Development Plan & Review (PDPR), in the Staff Governance section. Further additions relating to Adverse Events (Clinical Governance) and Establishment Gap (Staff Governance) will follow in due course.

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 will be introduced from 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.

The Clinical Governance aspects of the report cover HSMR, Falls, Pressure Ulcers, HAI and Complaints. A summary of the status of these is shown in the table below.

Performance is also reported for Adverse Events but measures that will enable assessment of performance are under development.

Measure	Update	Local/National Target	Current Status
HSMR	Quarterly	1.00 (Scotland average)	Above Scottish average
Falls [1]	Monthly	6.91 per 1,000 TOBD	Not achieving
Pressure Ulcers [1]	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) [2]	Monthly	50%	Not achieving

[1] 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.

[2] Ongoing challenges relating to COVID and staffing levels within the Patient Relations Department has meant that closure performance of Stage 2 Complaints fell significantly during FY 2021/22. An improvement target of 50% by March 2023, rising to 65% by March 2024 has been agreed by the Director of Nursing.

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

Risk Management is considered and will be included in future IPQRs as we capture the key issues from the ADP.

2.3.5 Equality and Diversity, including health inequalities

Not applicable.

2.3.6 Other impact

None.

2.3.7 Communication, involvement, engagement and consultation

The NHS Fife Board Members and existing Standing Committees are aware of the approach to the production of the IPQR and the performance framework in which it resides.

The Clinical Governance extract of the August IPQR will be available for discussion at the meeting on 2 September.

2.3.8 Route to the Meeting

The IPQR was ratified by EDG on 18 August and approved for release by the Director of Finance & Strategy.

2.4 Recommendation

The CG Committee is requested to discuss and take Assurance from this report.

3 List of appendices

IPQR

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

Fife Integrated Performance & Quality Report

CLINICAL GOVERNANCE

Produced in August 2022

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 the addition of some key indicators, removal of other indicators, updating of the Indicator Summary and applying Statistical Process Control (SPC) where appropriate. A Risk section will be introduced in due course.

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 for the Clinical Governance Committee comprises of the following sections:

a) **Indicatory Summary**
Provides a summary of performance against National Standards and local KPI's. These are listed showing current performance, comparison with 'previous' and 'previous year' and a benchmarking indication against other mainland NHS Boards, where appropriate. There is also an indication of 'special cause variation' based on SPC methodology.

b) **Projected & Actual Activity**
Comparing projected Scheduled Care activity to actuals for Patient TTG, New Outpatients and Diagnostics.

c) **Assessment**
Summary assessment for indicators of continual focus or those that are currently experiencing significant challenges.

d) **Performance Assessment 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
18 August 2022

Prepared by:
SUSAN FRASER
Associated Director of Planning & Performance

a. Indicator Summary

Section	Measure	Target 2022/23	Reporting Period	Current Period	Current Performance	SPC Outlier	Vs Previous	Vs Year Previous	Trend	Benchmarking
Clinical Governance	Major & Extreme Adverse Events	N/A	Month	Jun-22	47	○	▼	▼		
	HSMR	N/A	Year Ending	Mar-22	1.02	●	◀▶	◀▶		YE Mar-22
	Inpatient Falls	6.91	Month	Jun-22	6.94	○	▲	▼		
	Inpatient Falls with Harm	1.65	Month	Jun-22	1.47	○	▲	▼		
	Pressure Ulcers	0.89	Month	Jun-22	1.47	○	▼	▼		
	SAB - HAI/HCAI	18.8	Month	Jun-22	13.8	○	▼	▼		QE Mar-22
	C Diff - HAI/HCAI	6.5	Month	Jun-22	10.4	○	▼	▼		QE Mar-22
	ECB - HAI/HCAI	33.0	Month	Jun-22	51.9	○	▼	▼		QE Mar-22
	Complaints Closed - Stage 1	80%	Month	Jun-22	57.1%	○	▼	▼		2020/21
	Complaints Closed - Stage 2	50%	Month	Jun-22	3.4%	○	▲	▼		2020/21
Operational Performance	IVF Treatment Waiting Times	90%	Month	Jun-22	100.0%	●	◀▶	◀▶		
	4-Hour Emergency Access	95%	Month	Jun-22	74.9%	○	▼	▼		Jun-22
	Patient TTG % <= 12 Weeks	100%	Month	Jun-22	54.3%	●	▼	▼		Mar-22
	New Outpatients % <= 12 Weeks	95%	Month	Jun-22	55.4%	●	▲	▼		Mar-22
	Diagnostics % <= 6 Weeks	100%	Month	Jun-22	68.2%	●	▲	▼		Mar-22
	18 Weeks RTT	90%	Month	Jun-22	73.2%	●	▲	▲		QE Mar-22
	Cancer 31-Day DTT	95%	Month	Jun-22	100.0%	○	▲	◀▶		QE Mar-22
	Cancer 62-Day RTT	95%	Month	Jun-22	84.5%	○	▼	▲		QE Mar-22
	Detect Cancer Early	29%	Year Ending	Sep-21	23.2%	●	▲	▲		2020, 2021
	Freedom of Information Requests	85%	Month	Jun-22	90.5%	●	▼	▲		
	Delayed Discharge % Bed Days Lost (All)	N/A	Month	Jun-22	11.4%	●	▲	▲		QE Mar-22
	Delayed Discharge % Bed Days Lost (Standard)	5%	Month	Jun-22	7.2%	○	▲	▲		QE Mar-22
	Antenatal Access	80%	Month	Mar-22	82.1%	●	▼	▼		CY 2021
Finance	Revenue Resource Limit Performance	(£10.4m)	Month	Jun-22	(£6.2m)	●	▼	–		
	Capital Resource Limit Performance	£27.4m	Month	Jun-22	£5.7m	●	–	–		
Staff Governance	Sickness Absence	4.00%	Month	Jun-22	6.24%	○	▼	▼		YE Mar-22
	Personal Development Plan & Review (PDPR)	80%	Year Ending	Jun-22	31.4%	●	▼			
Public Health & Wellbeing	Smoking Cessation (FY 2022/23)	473	YTD	Apr-22	16	●	–	▼		QE Dec-21
	CAMHS Waiting Times	90%	Month	Jun-22	67.8%	○	▲	▼		QE Mar-22
	Psychological Therapies Waiting Times	90%	Month	Jun-22	76.3%	○	▼	▼		QE Mar-22
	Drugs & Alcohol Waiting Times	90%	Month	Apr-22	86.7%	●	▲	▼		QE Dec-21
	COVID Vaccination (Booster 1 or Dose 3)	80%	Month	Jul-22	78.9%	●	▲	–		Jul-22
	Immunisation: 6-in-1 at Age 12 Months	95%	Quarter	Q/E Mar-22	93.5%	○	▼	▼		QE Mar-22
	Immunisation: MMR2 at 5 Years	92%	Quarter	Q/E Mar-22	89.6%	○	▲	▲		QE Mar-22

Performance Key

- on schedule to meet Standard/Delivery trajectory
- behind (but within 5% of) the Standard/Delivery trajectory
- more than 5% behind the Standard/Delivery trajectory

SPC Key

- ○ SPC chart, 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

b. 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	Month End			Quarter End	Quarter End	Quarter End
		Jun-22	Jul-22	Aug-22	Sep-22	Sep-22	Dec-22	Mar-23
TTG Inpatient/Daycase Activity (Definitions as per Waiting Times Datamart)	Projected	3,036	1,012	1,012	1,029	3,053	3,087	3,087
	Actual	2,878	884			884	0	0
	Variance	-158	-128					
New OP Activity (F2F, NearMe, Telephone, Virtual) (Definitions as per Waiting Times Datamart)	Projected	18,567	6,201	6,220	6,385	18,806	19,132	19,166
	Actual	20,951	6,266			6,266	0	0
	Variance	2,384	65					
Urgent	Actual	10,868	3,460			3,460	0	0
Routine	Actual	10,083	2,806			2,806	0	0
Elective Scope Activity (Definitions as per Diagnostic Monthly Management Information)	Projected	1,491	497	497	497	1,491	1,491	1,491
	Actual	1,547	477			477	0	0
	Variance	56	-20					
Upper Endoscopy	Actual	575	185			185	0	0
Lower Endoscopy	Actual	182	45			45	0	0
Colonscopy	Actual	736	234			234	0	0
Cystoscopy	Actual	54	13			13	0	0
Elective Imaging Activity (Definitions as per Diagnostic Monthly Management Information)	Projected	11,988	3,996	3,996	3,996	11,988	11,988	11,988
	Actual	13,471	4,350			4,350	0	0
	Variance	1,483	354					
CT Scan	Actual	4,083	1,322			1,322	0	0
MRI	Actual	2,936	979			979	0	0
Non-obstetric Ultrasound	Actual	6,452	2,049			2,049	0	0

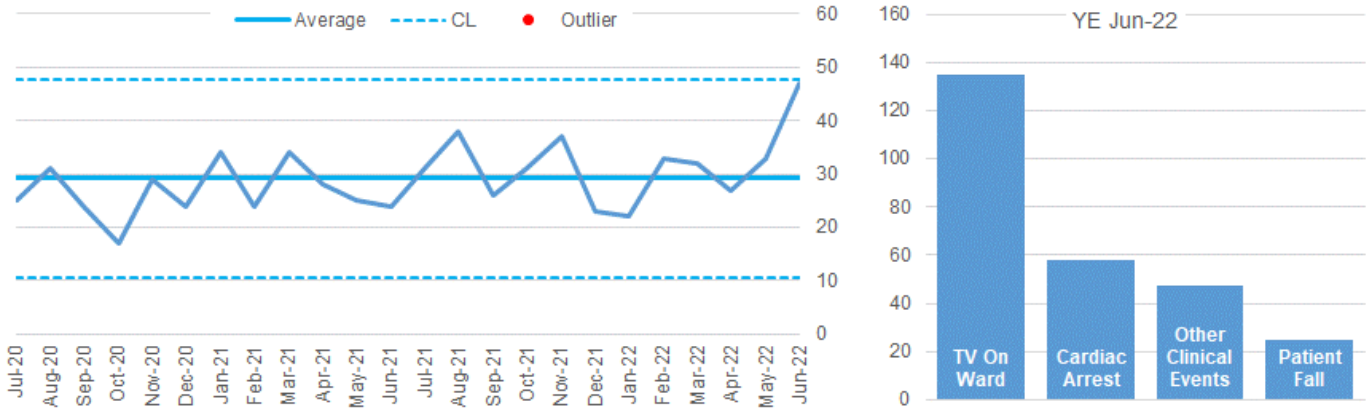
c. Assessment

CLINICAL GOVERNANCE		Target	Current
HSMR		**1.00**	**1.02**
Hospital Standardised Mortality Ratio (HMSR) is not intended for use in a pandemic situation. However, the increased HSMR that was observed in 2020 has subsequently reduced. Data for 2021 and Q1 of 2022 demonstrates a return to a typical ratio for NHS Fife.			
Inpatient Falls	*Reduce all patient falls rate by 10% in FY 2022/23 compared to the target for FY 2021/22*	**6.91**	**6.94**
While the overall performance across NHS Fife has remained similar the breakdown between divisions shows a higher rate of within the acute division compared to within the H&SCP. While trends will have to be monitored over a period of time there is no doubt that the current challenges in nurse staffing and high agency use as well as continued environmental factors related to COVID are having an impact. Focus on this in clinical teams continues by sharing the data and considering local action for improvement. The Falls steering group have not met due to clinical challenges, although work continues virtually. Of the 154 falls recorded in second quarter of 2022, 9 resulted in major/extreme harm, 14 moderate harm and the remainder minor. A full review of each fall is undertaken to support reflection and learning.			
Pressure Ulcers	*Reduce pressure ulcer rate by 25% in FY 2022/23 compared to the rate in FY 2021/22*	**0.89**	**1.47**
The data for overall Hospital Acquired Pressure Ulcer Incidents continues to show random variation, with a reduction in grade 3 and 4 pressure ulcers over the past 5 months. This data continues to be shared and discussed at a number of forums with pockets of improvement work taking place across the organisation. The constitution of the Tissue Viability Steering Group is also under review and following recent consultation with members an options appraisal has taken place and follow up discussions are to be arranged regarding the structures for meetings and reporting into the Tissue Viability Steering Group. The Acute and Community Tissue Viability Teams are under review and discussions are taking place about the possible integration of the services.			
SAB (MRSA/MSSA)	*We will reduce the rate of HAI/HCAI by 10% between March 2019 and March 2023*	**18.8**	**13.8**
NHS Fife continues to address its SABs and is currently ahead of the trajectory to achieve the 10% reduction by March 2023. 3 PICC Line associated SABs have been identified and 3 PWID SABs in 2022 to date. Positively, following a single PVC SAB in March and there have been no further PVC related SABs and no Renal haemodialysis line related SABs this year.			
C Diff	*We will reduce the rate of HAI/HCAI by 10% between March 2019 and March 2023*	**6.5**	**10.4**
NHS Fife is below national average for CDI and continues work aiming to achieve the 10% reduction target by March 2023, although there have been 13 health care associated CDI to date in 2022. Reducing the incidence of CDI recurrence is pivotal to achieving the HCAI reduction target and continues to be addressed. There have been only 2 recurrences of infection in 2022.			
ECB	*We will reduce the rate of HAI/HCAI by 25% between March 2019 and March 2023*	**33.0**	**51.9**
NHS Fife is above the target to achieve the ambitious 25% reduction of HCAI ECBs by March 2023. Reducing CAUTI HCAI ECB incidence remains the quality improvement focus to achieve our targets, there have been 18 CAUTIs in 2022 to date. Enhanced surveillance in place aiming to identify other areas for quality improvement.			
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%**	**3.4%**
There remain challenges in investigating and responding to Stage 2 complaints within the national timescales, primarily due to staffing and capacity issues across all services and a temporary pause of the complaints process within one directorate. We continue to see an increased volume of complaints, the majority being complex or covering multiple specialities/services. The Patient Relations team continues to face capacity and staffing challenges, exacerbated by vacancies and staff absence, some of which is long-term. This is having a negative effect on meeting timeframes, due to the increased workload on staff (who are managing multiple caseloads) and individual ability to manage day-to-day ad-hoc work. In order to address these challenges, existing processes have been reviewed in order to streamline workloads and generate efficiencies. Additional staff have also been redeployed to support with drafting complaint responses.			

d. Performance Exception Reports

Adverse Events

Major and Extreme Adverse Events



All Adverse Events

	Month	2021/22									2022/23		
		Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
ALL	NHS Fife	1417	1454	1399	1395	1440	1496	1499	1295	1466	1236	1394	1283
	Acute Services	626	614	610	649	632	596	611	512	674	528	602	590
	HSCP	740	802	747	691	749	836	853	733	725	655	744	651
	Corporate	51	38	42	55	59	64	35	50	67	53	48	42
CLINICAL	NHS Fife	1007	956	967	951	1016	970	940	901	1055	852	1002	903
	Acute Services	566	549	538	569	581	535	564	462	614	482	539	521
	HSCP	411	386	402	352	406	394	361	410	402	348	441	361
	Corporate	30	21	27	30	29	41	15	29	39	22	22	21

Commentary

Overall the number of adverse events reported in May and June was in keeping with monthly averages. A significant increase in events of cardiac arrest were reported. The events increased to 14 in May and 11 in June in comparison to the monthly average of 5.5 in the preceding 10 months. This increase is reflected in the sharp increase in major and extreme events across these months as all cardiac arrests are reported as major outcome in terms or harm.

Every cardiac arrest is reviewed at a monthly meeting of the CPR SBAR Review Group, the review group determines outcomes in relation to, if the cardiac arrest was unavoidable or avoidable. Decisions are then made as to whether a further investigation into the cardiac arrest is required either at an Emergency Bleep Meeting or at a Significant Adverse Event Review.

The cardiac review meetings will identify any themes or contributory factors which are contributing to this increase. This will help to inform any improvement actions required.

Quarter 1 Peri Arrest Audit Cardiac Arrest Review Outcomes Report April - June 2022 report will be shared at NHS Fife Deteriorating Patient Group, the data from the report will be used to drive an improvement plan for the organisation.

Focused improvement work continues in relation to falls, pressure ulcers and deteriorating patient. Adverse Events improvement work is ongoing. The proposal for suggested updates to the adverse events trigger list, review templates and the addition of a decision making tool for level of review will be presented at the Clinical Governance Oversight Group in August for discussion and agreement.

Key Deliverable	End Date
Adverse Event Process and Policy Review including 1) Review of policy 2) Increased focus on governance/assurance in relation to improvement actions from adverse events 3) training and education	Mar-23 On track

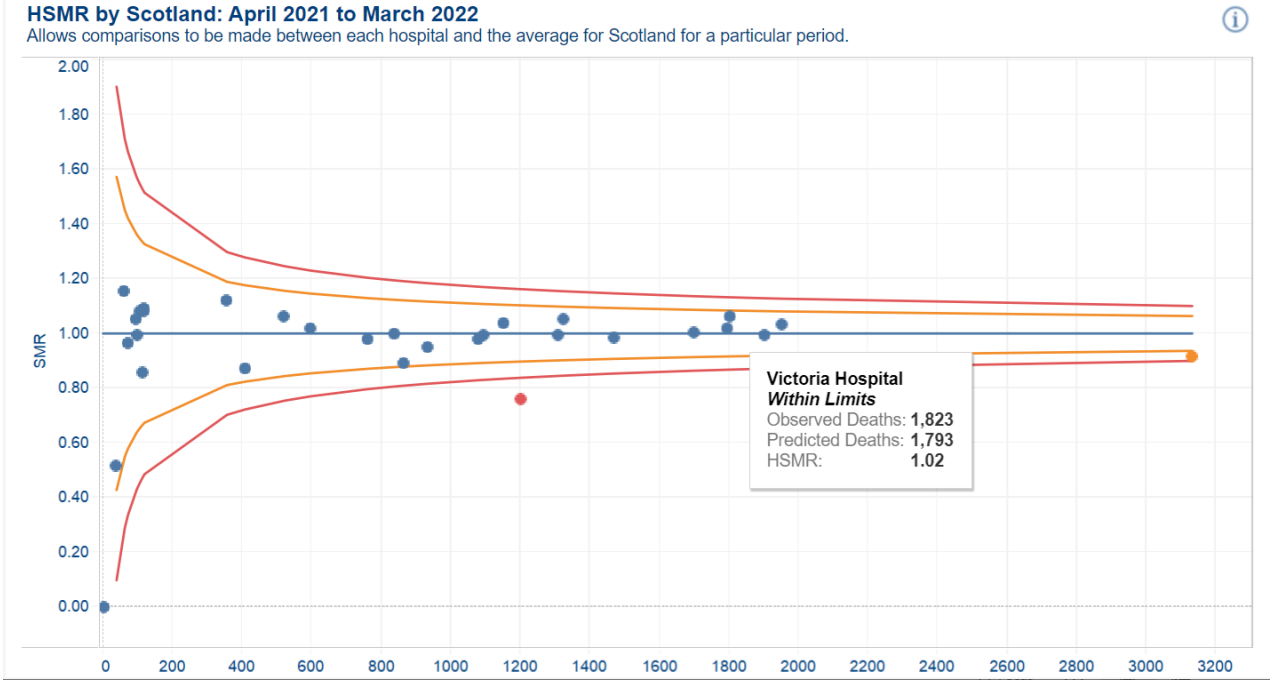
HSMR

Value is less than one, the number of deaths within 30 days of admission for this hospital is fewer than predicted. If value is greater than one, number of deaths is more than predicted.

Reporting Period; April 2021 to March 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.



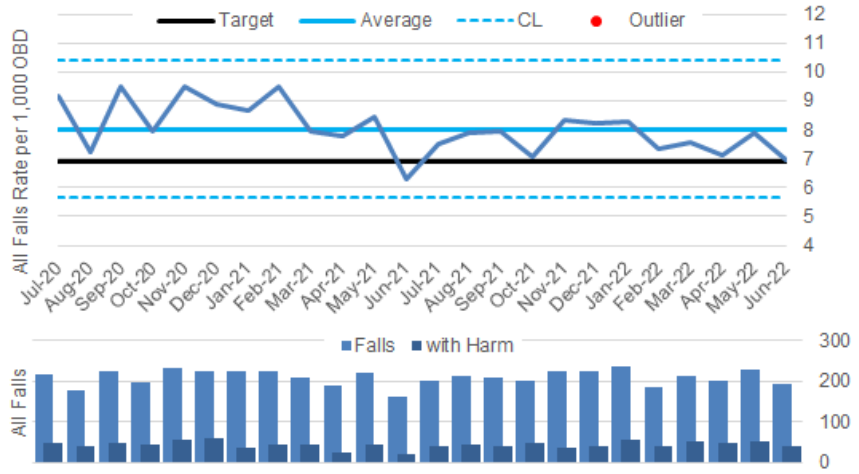
Commentary

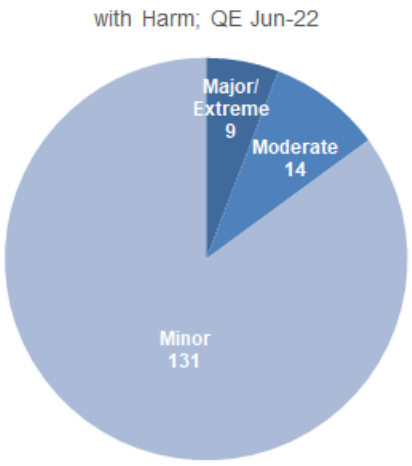
Hospital Standardised Mortality Ratio (HMSR) is not intended for use in a pandemic situation. However, the increased HSMR that was observed in 2020 has subsequently reduced. Data for 2021 and Q1 of 2022 demonstrates a return to a typical ratio for NHS Fife.

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

Local Performance





Performance by Service Area

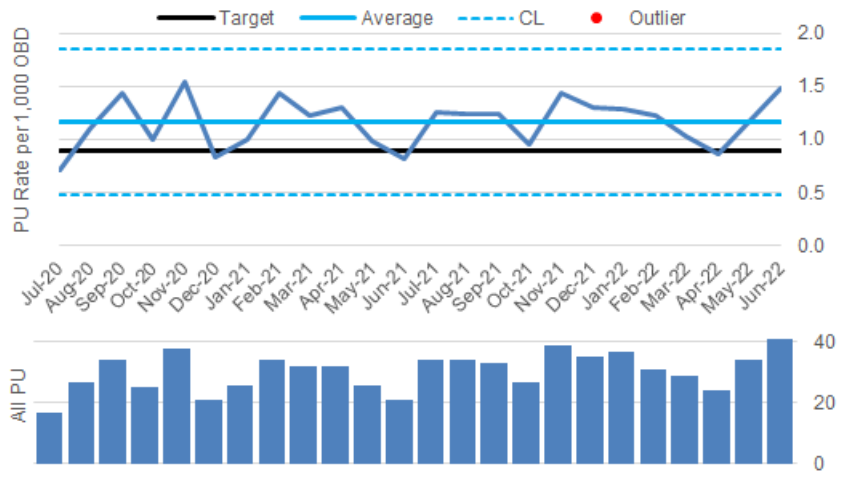
	2021/22									2022/23		
	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
NHS Fife	7.49	7.88	7.93	7.08	8.32	8.25	8.29	7.33	7.59	7.13	7.90	6.94
Acute Services	7.25	8.17	7.61	8.51	8.71	8.47	9.39	7.55	7.10	8.25	8.11	7.90
HSCP	7.70	7.63	8.21	5.85	7.97	8.06	7.34	7.16	8.01	6.14	7.72	6.08

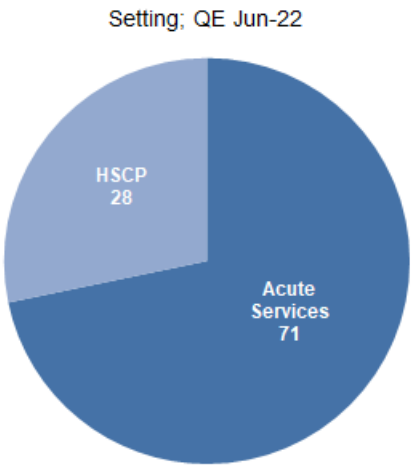
Key Deliverable		End Date
Reduction in number of Patient Falls in order to achieve specified reduction target in this FY		Mar-23 On track
Key Milestones	Refresh Falls Champions Register and Network	Sep-22 Not started
	Ensure that monthly falls data continues to be discussed and displayed in each ward setting along with associated improvement plans	Mar-23 On track
	Develop an Audit programme for 22/23	Jun-22 On track
	Review and refresh Falls Toolkit	Sep-22 Not started
	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	Mar-23 On track
	Explore feasibility of implementation of Falls module on Patient Trak	Mar-23 On track
	Explore QI resource to support clinical staff and enhance local improvement work	Oct-22 Not started

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

Local Performance





Performance by Service Area

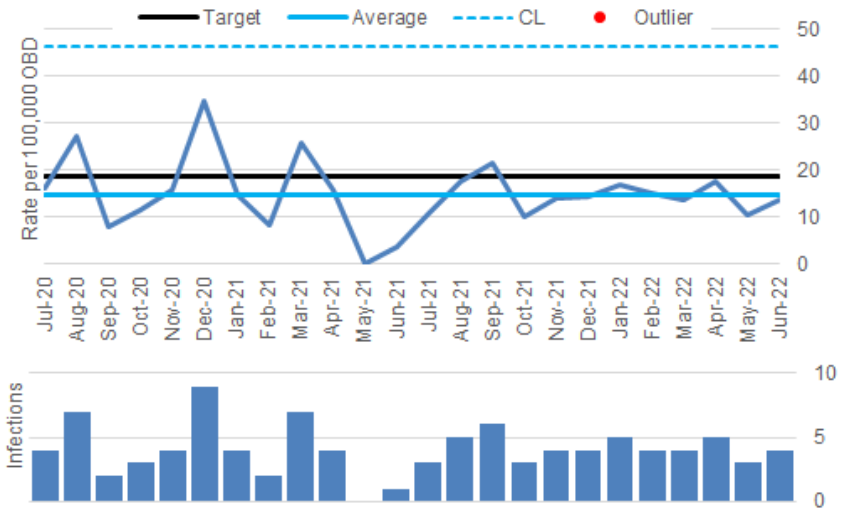
	2021/22									2022/23		
	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
NHS Fife	1.26	1.25	1.24	0.95	1.44	1.30	1.29	1.23	1.03	0.87	1.18	1.47
Acute Services	2.13	2.36	2.10	1.44	2.54	2.16	2.18	1.84	1.76	1.37	1.77	2.20
HSCP	0.49	0.27	0.49	0.53	0.49	0.55	0.52	0.72	0.40	0.41	0.66	0.82

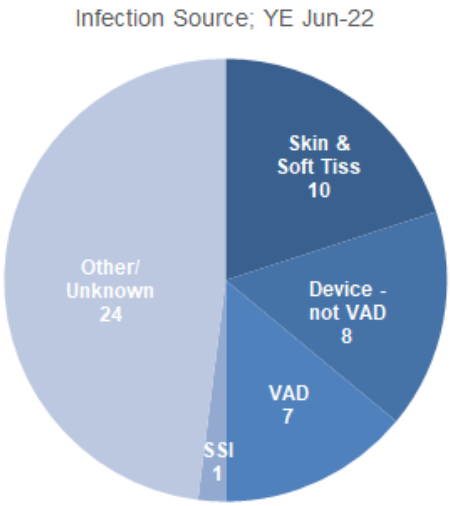
	Key Deliverable	End Date
	Reduction in number of Pressure Ulcers (PU) developed on case load across all health care setting in order to achieve specified reduction target in this FY	Mar-23 Off track
Key Milestones	Refresh PU Champions Register and Network	Oct-22 On track
	Ensure that monthly PU data continues to be discussed and displayed in each ward setting along with associated improvement plans	Dec-22 On track
	PU data discussed and shared with senior HSCP management team at QMASH meetings	Mar-23 On track
	PU Documentation Audit to support compliance	Mar-23 At risk
	Review LEARN summaries to support shared learning	Mar-23 On track
	Measurement against National Standards (Prevention & Management of PU)	Mar-23 On track
	Establish an operational TV group	Aug-22 On track
	Embed the revised HIS PU Standards (Oct 2020)	Oct-23 On track
	Develop and test electronic PURA and SSKIN bundle on Patientrack	Oct-22 On track
	Embed the use of the CAIR resource and Data and Insight Hub (ASD) for triangulation of data	Mar-23 On track
	Clinical teams with an increase in PU harms to identify and plan improvements	Mar-23 On track
	Develop a training and education plan	Oct-22 On track

SAB (HAI/HCAI)

Reduce Hospital Infection Rate by 10% (in comparison to FY 2018/19 rate) by the end of FY 2022/23

Local Performance





National Benchmarking

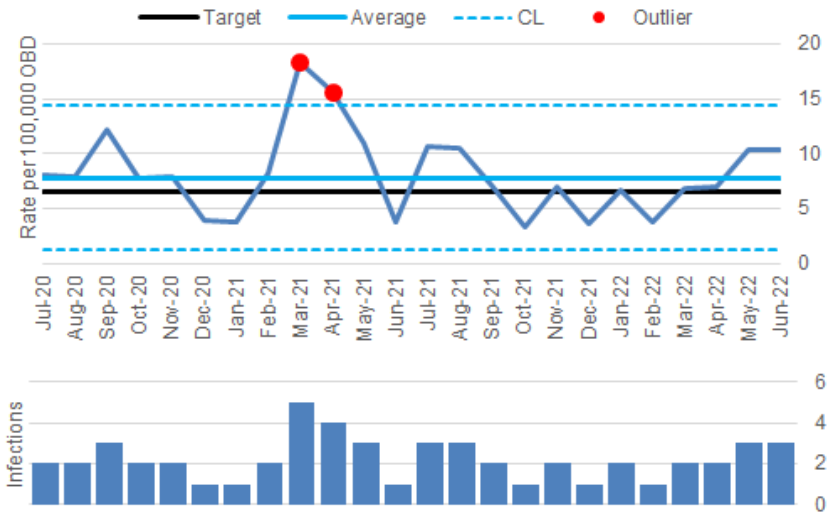
Quarter Ending	2020/21			2021/22			
	Sep	Dec	Mar	Jun	Sep	Dec	Mar
NHS Fife	18.7	20.6	17.8	6.3	16.6	12.7	15.2
Scotland	17.2	18.9	18.4	18.6	18.3	17.3	16.3

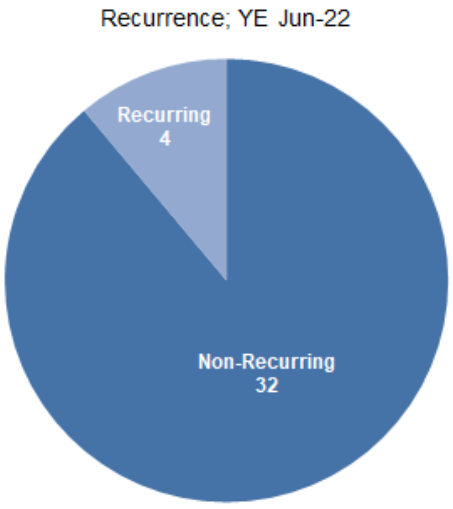
Key Deliverable	End Date
Local and national programme of surveillance; to undertake surveillance programmes which are compliant with mandatory national requirements and identify areas for improvement Optimise communications with all clinical teams in ASD & the HSCP	Mar-23 On track
Programme of audit; 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	Mar-23 At risk
IPC Education & training: Infection Prevention and Control knowledge and training for staff are fundamental for safe patient care	Mar-23 At risk

C Diff (HAI/HCAI)

Reduce Hospital Infection Rate by 10% (in comparison to FY 2018/19 rate) by the end of FY 2022/23

Local Performance





National Benchmarking

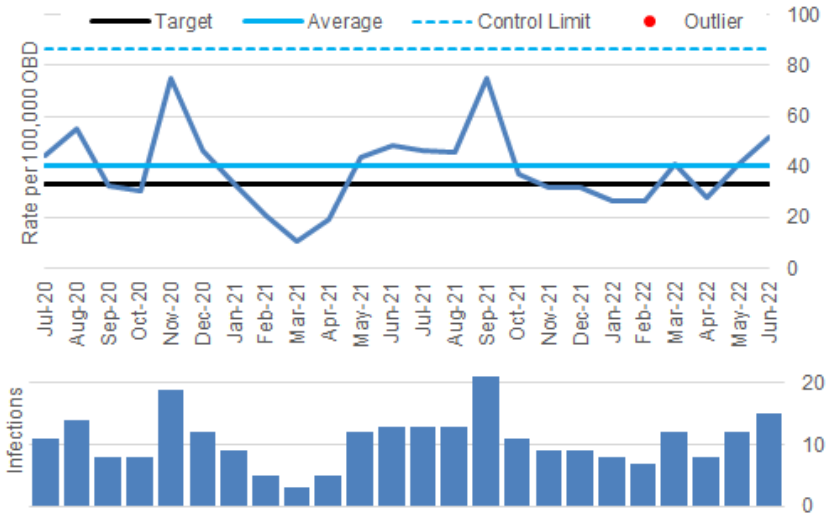
Quarter Ending	2020/21			2021/22			
	Sep	Dec	Mar	Jun	Sep	Dec	Mar
NHS Fife	9.3	7.7	14.0	10.0	9.5	4.6	7.0
Scotland	17.4	16.4	15.8	14.6	16.8	13.3	12.6

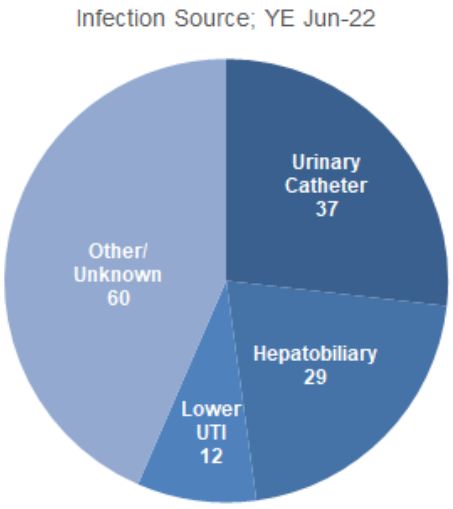
Key Deliverable		End Date
Local and national programme of surveillance; to undertake surveillance programmes which are compliant with mandatory national requirements and identify areas for improvement		Mar-23 On track
Key Milestones	Optimise communications with all clinical teams in ASD & the HSCP	Mar-23 On track
	Reduce overall prescribing of antibiotics	Mar-23 On track
	Reducing recurrence of CDI	Mar-23 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		Mar-23 At risk
IPC Education & training: Infection Prevention and Control knowledge and training for staff are fundamental for safe patient care		Mar-23 At risk

ECB (HAI/HCAI)

Reduce Hospital Infection Rate by 25% (in comparison to FY 2018/19 rate) by the end of FY 2022/23

Local Performance





National Benchmarking

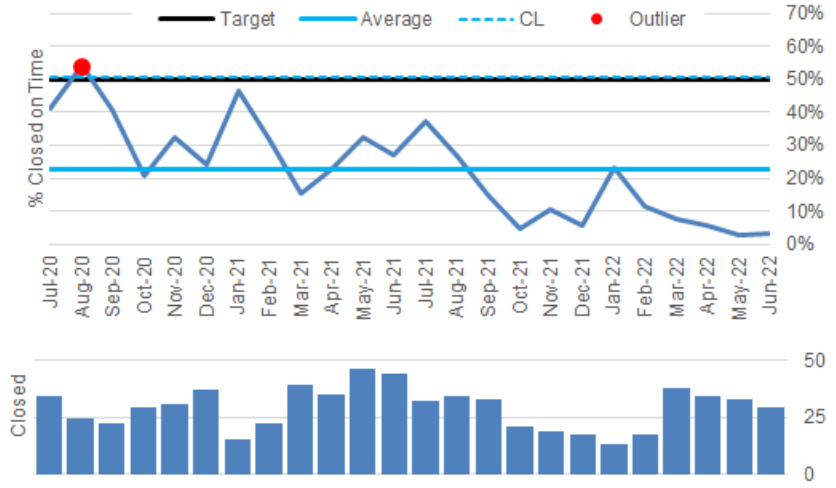
Quarter Ending	2020/21			2021/22			
	Sep	Dec	Mar	Jun	Sep	Dec	Mar
NHS Fife	45.3	50.3	21.6	37.6	60.3	33.6	31.6
Scotland	42.0	40.9	34.7	38.2	41.5	34.1	30.5

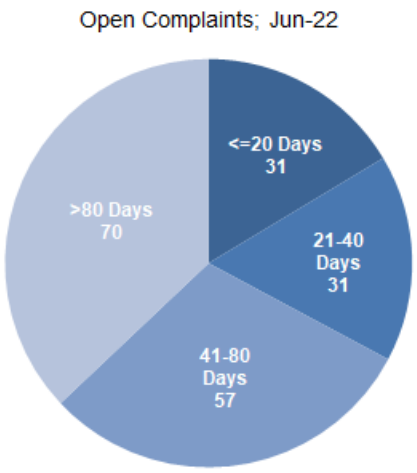
Key Deliverable		End Date
Local and national programme of surveillance; to undertake surveillance programmes which are compliant with mandatory national requirements and identify areas for improvement		Mar-23 On track
Key Milestones	Optimise communications with all clinical teams in ASD & the HSCP	Mar-23 At risk
	Ongoing work of Urinary Catheter Improvement Group (UCIG) eCatheter insertion & maintenance bundle on Patientrack- further rollout	Mar-23 On track
	Enhanced surveillance - led by Consultant Microbiologist	Mar-23 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		Mar-23 At risk
IPC Education & training: Infection Prevention and Control knowledge and training for staff are fundamental for safe patient care		Mar-23 At risk

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

Local Performance





Performance by Service Area

		2021/22									2022/23		
		JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
NHS Fife	% Closed on Time	37.5%	26.5%	15.2%	4.8%	10.5%	5.9%	23.1%	11.8%	7.9%	5.9%	3.0%	3.4%
	% Acknowledged (3 days)	96.9%	100.0%	100.0%	100.0%	100.0%	88.2%	84.6%	100.0%	89.5%	88.2%	90.9%	93.1%
Acute Services	% Closed on Time	26.1%	31.6%	21.7%	0.0%	16.7%	7.7%	30.0%	18.2%	3.6%	8.0%	0.0%	5.0%
HSCP	% Closed on Time	50.0%	16.7%	0.0%	20.0%	0.0%	0.0%	0.0%	0.0%	14.3%	0.0%	9.1%	0.0%

Key Deliverable	End Date
Adherence to the NHS Scotland Model Complaints Handling Procedures (DH 2017)	Mar-23 On track
Adherence to NHS Fife's Participation and Engagement Framework	Mar-23 On track
Rebrand Patient Relations to Patient Experience Team	Dec-22 On track

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**2 September 2022**
Title:	**Paper One: Healthcare Associated Infection Report (HAIRT) – Infection, Prevention & Control Priorities**
Responsible Executive:	**Janette Owens, Director of Nursing**
Report Author:	**Julia Cook, Infection Control Manager**

1 Purpose

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

This is presented to the Clinical Governance Committee for:

- Assurance

This report relates to a:

- National Health & Well-Being Outcomes

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

Update for Infection Prevention and Control for August 2022 committee to provide assurance that all IP&C priorities are being and will be delivered. This report is for information for the Committee update based on the most recent HAIRT circulated to the Infection Control Committee August 2022.

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 (2022) 13, published on the 11th May 2022, advised reductions standards for Healthcare Associated Infections for CDI, SAB and ECB as outlined in DL (2019) 23 are to be extended by one year as a result of the COVID-19 response. Please see below for new LDP Standards.

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

- New LDP standards are to reduce incidence of healthcare associated CDI by 10% from 2019 to 2023, utilising 2018/19 as baseline data.
- Outcome measure - achieve 10% reduction by 2022/23 in healthcare associated infection rate - rate of 6.5 per 100,000 total bed days.

***Staphylococcus aureus* Bacteraemia SAB**

- New LDP standards are to reduce incidence of healthcare associated SAB by 10% from 2019 to 2023, utilising 2018/19 as baseline data.
- Outcome measure to reduce the rate of SAB from 20.9 per 100,000 total bed days in 2018/19, 10% reduction target rate for 2022/23 is 18.8 per 100,000 total bed days.

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

- New LDP standards are to reduce incidence of healthcare associated ECB by 25% from 2019 to 2023, utilising 2018/19 as baseline data.
- Outcome measure to reduce the rate of ECB by 25% from 44.0 per 100,000 total bed days in 2018/19, target rate for 2022/23 is 33.0 per 100,000 total bed days.

2.3 Assessment

SAB

- During Q1 2022 (Jan-Mar), NHS Fife was below the national rate for healthcare associated infection (HCAI) and above for community associated infection (CAI).
- Vascular access devices (VAD) remain the greatest challenge for hospital acquired SABs, ongoing improvement work continues.
- There have been no further PWID related SABs since the previous report

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 23/5/22; some progress has been made with the PGDs and they should be available soon and the refresher training video will be re-shared with staff.

CDI

- During Q1 2022 (Jan-Mar), NHS Fife was below the national rate for HCAI & CAI.

- The cumulative total of CDIs from Jan-June 2022 (19 cases) is lower than during the same time period in 2021, when there were 27 cases.

Current CDI initiatives

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

ECB

- During Q1 2022 (Jan-Mar), NHS Fife was above the national rate for HCAI & CAI.
- Considering the time period Jan-Jun 2022, the number of ECBs (136 cases) has risen substantially, compared to the same time period the previous year (Jan-Jun2021), when there were 104 ECBs.
- There has been 1 trauma associated ECB to date in 2022.

Current ECB Initiatives

- The Infection Prevention and Control team continue to work with the Urinary Catheter Improvement Group (UCIG).
- This group aims to minimize urinary catheters to prevent catheter associated healthcare infections and trauma associated with UC insertion/maintenance/ removal and self-removal to establish Catheter Improvement work in Fife.
- Infection control surveillance alert the patients care team Manager by Datix when an ECB is associated with a traumatic catheter insertion, removal or maintenance.
- Monthly ECB reports and graphs are distributed within HSCP and Acute services
- Catheter insertion/Maintenance bundles now in MORSE for District nurse documentation
- Patientrack CAUTI bundles still to be implemented for Acute services/HSCP Acute services engagement and a HoN lead will be required to assist with the roll out of this bundle.
- CAUTI bundles are planned to be implemented within 5 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 lead for NHS Fife.

COVID-19 pandemic

The Scottish Government Test and Protect Transition Plan sets out changes to testing, that came into effect in May 2022, with testing only remaining in place for certain groups to protect high risk settings and support clinical care.

In Scotland, the number of nosocomial cases per week peaked in March/April 2022, and then risen again June, which also resulted in an increase in the number of clusters/incidents reportable to ARHAI Scotland across Scotland and NHS Fife.

Surgical Site Infection (SSI) Surveillance Programme

The CNO suspended the national SSI Surveillance programme in March 2020 in response to the COVID-19 pandemic, DL (2022) 13, published on the 11th May 2022 stated that resumption of the surveillance is due to commence in Q4 2022.

Caesarean Section SSI

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

Large Bowel Surgery SSI and Orthopaedic Surgery SSI

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

Outbreaks (May – June 2022)

- **Norovirus**

There has been **1** new ward closure due to a Norovirus outbreak and 1 bay as a suspected outbreak since last ICC report

- **Seasonal Influenza**

There has been NO new closures due to confirmed Influenza

- **COVID-19**

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

Hospital Inspection Team

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

Hand Hygiene

Ward Dashboard is no longer available to display Hand Hygiene audit, however results are still accessible via LanQIP dashboard as shown in the report card.

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 4 (Jan - March 2022) was **96.2%**.

National Cleaning Services Specification

The National Cleaning Services Specification – quarterly compliance report result for Quarter 4 (Jan - March 2022) shows NHS Fife achieving **Green** status.

Estates Monitoring

The National Cleaning Services Specification – quarterly compliance report result for shows Quarter 4 (Jan - March 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

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

2.3.6 Other impact

N/A

2.3.7 Communication, involvement, engagement and consultation

This paper has been considered by the Infection Control Manager

2.3.8 Route to the Meeting

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

This is a summary of the HAIRT submitted to the Infection Control Committee August 2022

2.4 Recommendation

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

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 3rd August 2022.

(Validated Data up to June 2022)

August 2022

Contents

Board Wide Issues

Key Healthcare Associated Infection Headlines

1.1 Achievements:

The IPCT have support and promoted both World Hand Hygiene Day and Biomedical Science day, with information stands at the VHK. Which provide a fantastic opportunity to engage and raise awareness of the importance of hand hygiene in reducing infection risks with patients, visitors and staff.

Three more of the IPCT have now successfully completed the University of Highland and Islands MSc module *The Built Environment (Infection Prevention and Control)* which provides attendees with the skills to deal with scenarios that might arise during the design, planning, construction and maintenance of healthcare facilities, and understand the role of these elements in relation to prevention and control of infection.

Representatives of the IPCT attended the Infection prevention Society (IPS) Scotland Branch Conference *Infection Control Matters,* the conference includes sessions from Professor Jennie Wilson, Professor Jacqui Reilly, Lesley Shepherd, Dr Anne Templeton, Elaine Ross and Dr Lucy Gozdzielewska.

Infection Prevention & Healthcare Facilities Management joint event *"Improving Services to Reduce Infections"*– Scotland's first-ever national-conference to not only address the challenge of reducing Healthcare-Acquired Infection but also the difficulties facing the facilities management teams in keeping our hospitals open and safe for business. This event brought together policy-makers, leaders and key-professionals from all elements of the Scottish healthcare structure.

***Staphylococcus aureus* Bacteraemia Prevention (SAB)**

During Q1 2022 (Jan-Mar), NHS Fife was below the national rate for healthcare associated infection (HCAI) and above for community associated infection (CAI).

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

During Q1 2022 (Jan-Mar), NHS Fife was below the national rate for HCAI & CAI.

***Escherichia coli* bacteraemia (ECB)**

During Q1 2022 (Jan-Mar), NHS Fife was above the national rate for HCAI & CAI.

1.2 Challenges:

NHS Fife received a DL (2022) 13 on 11th May 2022 stating that due to board pressures associated with the Covid-19 pandemic, the previously agreed standards and indicators for 2022 would be extended for a further year to 2023.

SABs

Vascular access devices (VAD) remain the greatest challenge for hospital acquired SABs, ongoing improvement work continues.

There have been no further PWID related SABs since the previous report.

ECBs

Considering the time period Jan-Jun 2022, the number of ECBs (136 cases) has risen substantially, compared to the same time period the previous year (Jan-Jun2021), when there were 104 ECBs. The number of HCAI (HAI + HCAI) cases has also risen during Jan-Jun 2022 (62 cases), in comparison to Jan-Jun 2021 when there were 47 cases.

CDI

The cumulative total of CDIs from Jan-June 2022 (19 cases) is significantly lower than during the same time period in 2021, when there were 27 cases. This improvement is also reflected in the number of Healthcare associated (HAI + HCAI + Unknown) CDIs; in Jan-June 2022 there were 13 cases, compared to 16 in Jan-June 2021.

Caesarean Section SSI/ Large Bowel Surgery SSI/ Orthopaedic Surgery SSI

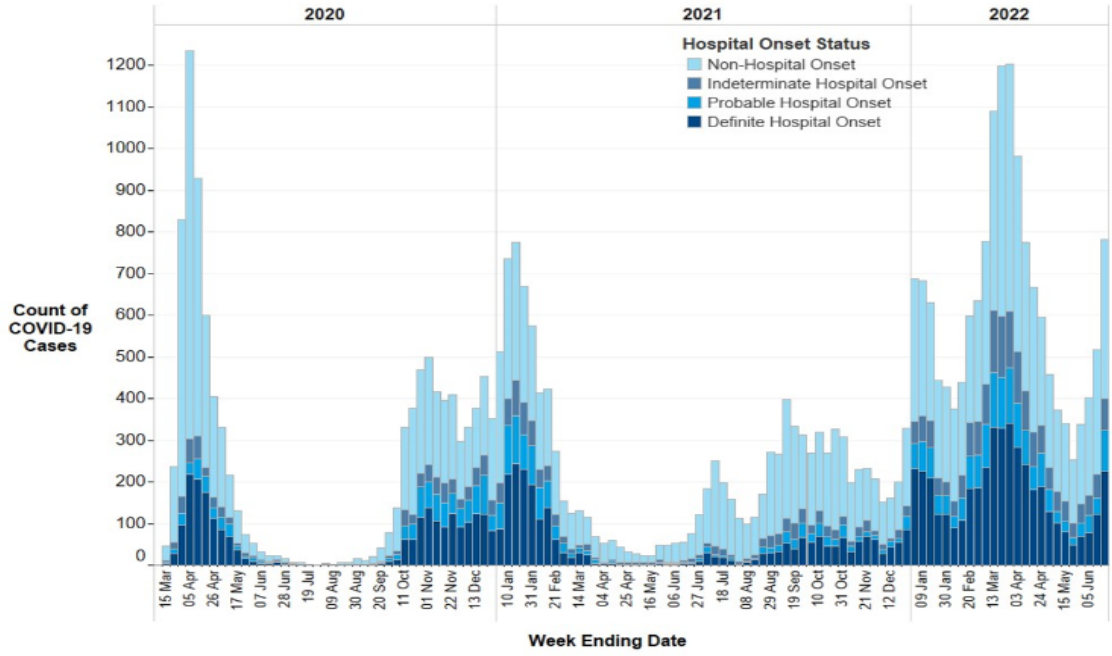
National surveillance programme for SSI 2021/22 has been paused due to the COVID-19 pandemic. However, a DL (2022) 13, published on the 11th May 2022 stated that resumption of the surveillance is due to commence in Q4 2022. Much preparation and extra resources will be required prior to this taking place. We are currently awaiting further instruction.

COVID-19

The Scottish Government Test and Protect Transition Plan sets out changes to testing, that came into effect in May 2022, with testing only remaining in place for certain groups to protect high risk settings and support clinical care.

In Scotland, the number of nosocomial cases per week peaked in March/April 2022, and then risen again June, which also resulted in an increase in the number of clusters/incidents reportable to ARHAI Scotland across Scotland and NHS Fife.

Figure 1: Epidemic curve of COVID-19 cases with first positive specimen of COVID-19 episode taken during an inpatient stay, by onset status: week-ending 01 March 2020 to week-ending 19 June 2022 (n=37,612). [1,2]

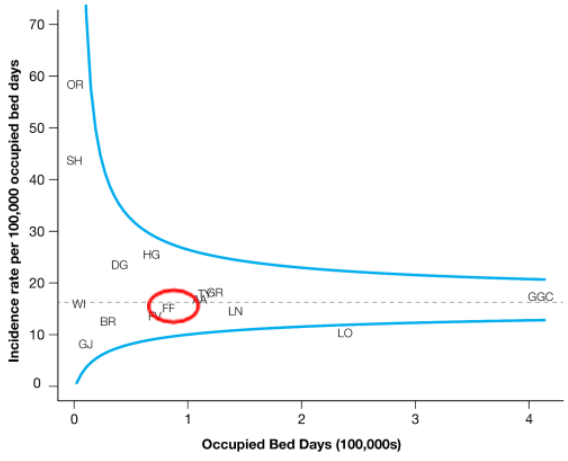
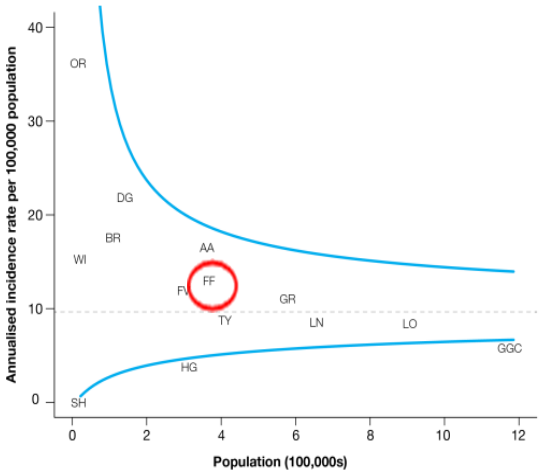


Surveillance

2. Staphylococcus aureus incorporating MRSA/CPE screening compliance

2.1 Trends – Quarterly

Staphylococcus aureus Bacteraemias (SABs)				
Local Data: Q2 2022 (April - June) **(Q2 2022 National comparison awaited)**				
In Q2 2022 NHS Fife had:	23 SABs	12 HCAI/HAI 11 CAI	This is **THE SAME** as:	23 Cases in Q1 2022

Q1 2022 (Jan-Mar) - ARHAI Validated data with commentary			
Healthcare associated SABs		**Community associated SABs infection**	
HCAI SAB rate: **15.2**	Per 100,000 bed days	CAI SABs rate: **13.0**	Per 100,000 Pop
No of HCAI SABs: 13		No of CAI SABs: 12	
This is **BELOW** National rate of 16.3		This is **ABOVE** National rate of 9.6	
			
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 will be extended by one year to 2023			
Standards application for Fife:	**SAB Rate Baseline 2018/2019**	**SAB 10% reduction target by 2022**	**SAB 10% reduction target maintenance by 2023**
SAB by rate 100,000 Total bed days	**20.9** per 100,000 TBDs	**18.8** 100,000 TBDs	**18.8** 100,000 TBDs
SAB by Number of HCAI cases	**76**	**68**	**68**
Current 12 Monthly HCAI SAB rates for Year ending March 2022 (HPS)			
SAB by rate 100,000 Total bed days	**12.8** per 100,000 TBDs		
SAB by Number of HCAI cases	**43**		

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 no further dialysis line related SABs since the most recent case on 15/10/21. The IPCT continues ongoing surveillance and provides support to the renal staff around VAD care.

As of **07/06/2022** the number of days since the last confirmed SAB is as follows:	
CVC SABs	47 Days
PWID (IVDU)	79 Days
Renal Services Dialysis Line SABs	235 Days
Acute services PVC (Peripheral venous cannula) SABs	82 Days

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

2.2 Current SAB Initiatives

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

- Collect and analyse SAB data on a monthly basis to understand the magnitude of the risks to patients in Fife.
- Provide timely feedback of data to key stakeholders to assist teams in minimising the occurrence of SABs where possible.
- Examine the impact of interventions targeted at reducing SABs.

- Use results locally for prioritising resources.
- Use data to inform clinical practice improvements thereby improving the quality of patient care.
- Liaise with Drug addiction services re PWID (IVDU) SABs. The most recent meeting took place on 23/5/22; some progress has been made with the PGDs and they should be available soon and the refresher training video will be re-shared with staff.

2.3 National MRSA & CPE screening programme

MRSA

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

NHS Fife achieved **98%** compliance with the **MRSA** CRA in Q2 (Apr-Jun) 2022

This was equal to Q1 2022 (98%) & **ABOVE** the compliance target of 90%.

The National Scottish average for Q2 has still to be published.

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

Quarter	Q2 2020 Apr-Jun	Q3 2020 Jul-Sept	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 Apr- Jun
Fife	98%	88%	98%	95%	98%	88%	93%	98%	98%
Scotland	87%	86%	82%	83%	84%	81%	82%	81%	N/k

CPE (Carbapenemase Producing Enterobacteriaceae)

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

NHS Fife achieved **98%** compliance with the **CPE** CRA for Q2 2022 (Apr-Jun)

This is slightly **DOWN** from 100% in Q1 2022

The National Scottish average for Q2 2022 is still to be published.

Quarter	Q2 2020 Apr-Jun	Q3 2020 Jul-Sept	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
Fife	95%	85%	98%	88%	90%	100%	98%	100%	98%
Scotland	80%	85%	79%	82%	83%	82%	80%	80%	N/k

MDRO CRA Patientrack Update

- Following a successful pilot of the electronic MDRO CRA in AU2, Patientrack has now added the CPE and MRSA assessments which were rolled out across the Board in September 2021
- The IPCT available for support to clinical teams
- Ongoing quality assurance will continue throughout 2022

3 Clostridioides difficile Infection (CDI)

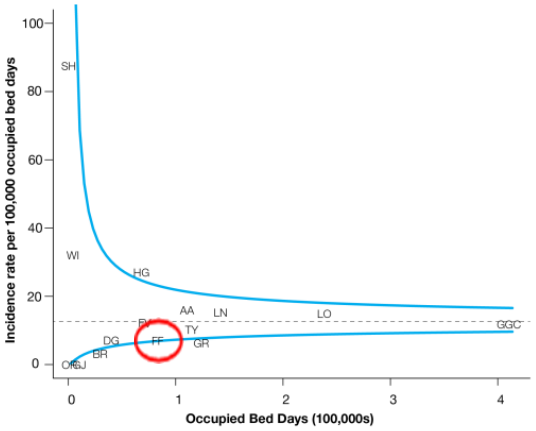
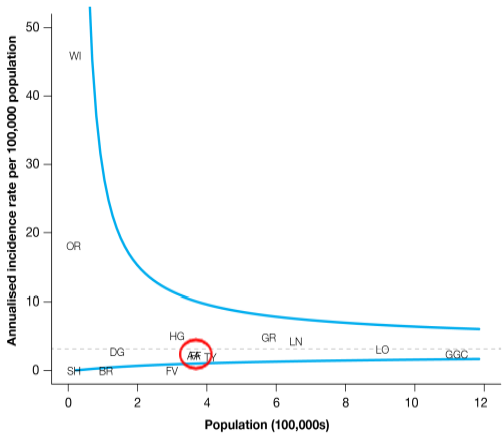
3.1 Trends

<table>
<tr><th colspan="5">Clostridioides difficile Infection (CDI)</th></tr>
<tr><th colspan="5">Local Data: Q2 Apr-Jun 2022

(Q2 2022 HPS National comparison awaited)</th></tr>
<tr><td rowspan="2">In Q2 2022
NHS Fife had:</td><td rowspan="2">12 CDIs</td><td>8 HCAI/HAI/Unknown</td><td rowspan="2">This is UP from</td><td rowspan="2">7 Cases in

Q1 2022</td></tr>
<tr><td>4 CAI</td></tr>
<tr><td colspan="5"></td></tr>
<tr><th colspan="5">Q1 (Jan-Mar) 2022 ARHAI validated data with commentary</th></tr>
<tr><td colspan="5">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.</td></tr>
<tr><th colspan="3">Healthcare associated CDIs</th><th colspan="2">Community associated CDIs infection</th></tr>
<tr><td>HCAI CDI rate: 7.0</td><td rowspan="2">Per 100,000 bed days</td><td>CAI CDIs rate: 2.2</td><td rowspan="2">Per 100,000 Pop</td></tr>
<tr><td>No of HCAI CDIs: 6</td><td>No of CAI CDIs: 2</td></tr>
<tr><td colspan="2">This is BELOW National rate of 12.6</td><td colspan="2">This is BELOW National rate of 3.2</td></tr>
<tr><td colspan="3"> 
</td><td colspan="2"> 
</td></tr>
</table>

NHS Fife was **WITHIN** the 95% confidence interval in the funnel plot analysis for HCAI & CAI.

New standards for reducing all Healthcare Associated CDI by 10% by 2022 (from 2018/2019 baseline). This standard will be extended by one year to 2023.			
Standards application for Fife:	**CDI Rate Baseline 2018/2019**	**CDI 10% reduction target by 2022**	**CDI 10% reduction target maintenance by 2023**
CDI by rate 100,000 Total bed days	**7.2** per 100,000 TBDs	**6.5** 100,000 TBDs	**6.5** 100,000 TBDs
CDI by Number of HCAI cases	**26**	**23**	**23**
Current 12 Monthly HCAI CDI rates for Year ending March 2022 (HPS)			
CDI by rate 100,000 Total bed days	**7.7** per 100,000 TBDs		
CDI by Number of HCAI cases	**26**		

3.2 Current CDI initiatives

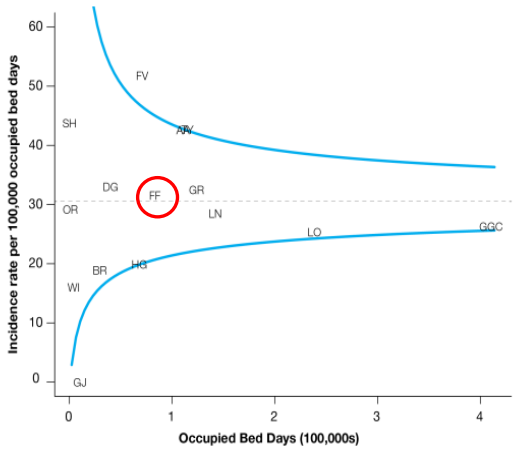
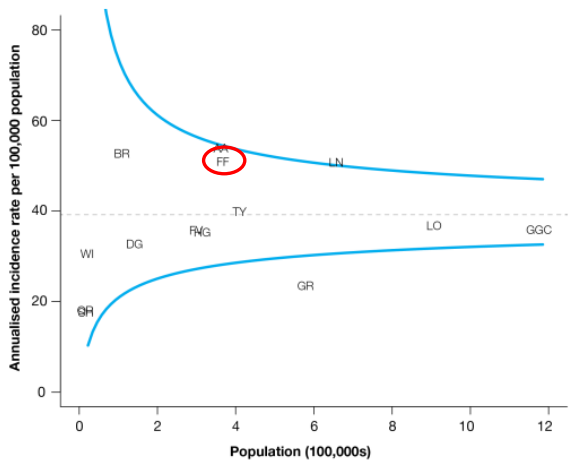
Follow up of all hospital and community cases continues to establish risk factors for CDI

- 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: Q2 (April – June) 2022 **(Q1 2022 HPS National comparison awaited)**				
In Q2 2022 NHS Fife had:	70 ECBs	35 HAI/HCAIs 35 CAIs	This is UP from	66 Cases in Q1 2022
Q2 2022 There were **12** Urinary catheter associated (1 of which was from a Suprapubic catheter) ECBs, which was significantly higher than during Q1 2022, when there were **7 CAUTIs** (2 of which were in patients who self- catheterise).				

Q1 (Jan-Mar) 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: **31.6**	Per 100,000 bed days	CAI ECBs rate: **50.9**	Per 100,000 Pop
No of HCAI ECBs: 27		No of CAI ECBs: 47	
This is **ABOVE** National rate of 30.5		This is **ABOVE** National rate of 39.2	
			
For HCAI & CAI ECBs: NHS Fife was **WITHIN** the 95% confidence interval in the funnel plot analysis			

Two HCAI reduction standards have been set for ECBs:

1) 25% reduction ECBs - 2021/2022		
New standards for reducing all Healthcare Associated ECB by 25% by 2021/22 (from 2018/2019 baseline).		
Standards application for Fife:	**ECB Rate Baseline 2018/2019**	**ECB 25% reduction target by 2022**
ECB by rate 100,000 Total bed days	**44.0** per 100,000 TBDs	**33.0** per 100,000 TBDs
ECB by Number of HCAI cases	**160**	**120**
Current 12 Monthly HCAI ECB rates for Year ending March 2022 (HPS)		
ECB by rate 100,000 Total bed days	**40.8** per 100,000 TBDs	
ECB by Number of HCAI cases	**137**	

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

2021-2017 NHS Fife's Urinary catheter Associated ECBs – HPS data Q1 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 Q2 2022	TBC	**33.3%**	
2022 Q1	17.6%	**0%**	* Locally calculated data- TBC by HPS when Q1 data published on Discovery
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 Q2	TBC	**35%**	
2022 Q1	21.2%	**33.3 %**	* Locally calculated data- TBC by HPS when Q1 data published on Discovery
2021 TOTAL	27.0%	**36%**	
2020 TOTAL	24.1 %	**23.0 %**	
2019 TOTAL	22.8 %	**28.0 %**	
2018 TOTAL	22.1%	**36.6 %**	
2017 TOTAL	18.3 %	**35.3 %**	
Data from NSS Discovery ARHAI Indicators			

4.2 Current ECB Initiatives

The Urinary Catheter Improvement Group (UCIG) work was commissioned following a raised ECB CAUTI incidence. The IPC Surveillance team continue to liaise with the Urinary Catheter Improvement Group last held on 22/07/2022. 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.

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.

Monthly ECB reports and graphs are distributed within HSCP and Acute services
There has been 1 trauma associated ECB to date in 2022.

CAUTI bundles have now been installed onto Patientrack in February 2022 and are awaiting to be trailed on a ward within VHK before 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.
Acute services engagement & a HON lead will be required to assist the roll out of this CAUTI bundle.

CAUTI bundles are planned to be implemented within 5 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 lead 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.
- Reporting of Hand Hygiene performance is based on data submitted by each ward via LanQIP
- A minimum of 20 observations are required to be audited per month per ward.
- Hand Hygiene audit results of all staff groups by individual ward, hospital or directorate within both the Acute services & HSCP should be viewed on Ward Dashboard.
- From October 2021 it was noted that Ward Dashboard is no longer widely available. However, Hand Hygiene audit results are still accessible via LanQIP dashboard as shown in the report card.

  Hand Hygiene compliance can be accessed for reporting purposes on LanQIP dashboard.

5.1 Trends

- Unable to report

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 4 (Jan-Mar 2022) was **96.2%**.
- 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	Q4 Jan-Mar 22	Q3 Oct-Dec 21
Fife	96.2% ↑	95.9%
Scotland	95.5%	95.3%

- The National Cleaning Services Specification – quarterly compliance report result for Q4 (Jan-Mar) 22 shows NHS Fife achieving **GREEN** status.

- **Estates Monitoring**

Estates Location	Q4 Jan-Mar 22	Q3 Oct-Dec 21
Fife	96.8↑	96.6
Scotland	96.7	96.4

- The Estates Monitoring – quarterly compliance report result for Quarter 4 (Jan-Mar) 22 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).

All Influenza patients admitted to ICU are also notifiable to HPS

May – end of June 2022

Norovirus

There has been **1** new ward closure (V6) due to a Norovirus outbreak and 1 bay (V31) as a suspected outbreak since last ICC report

Seasonal Influenza

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

Weekly national seasonal respiratory report- Week 27, **week ending 10th of July 2022**

In week 27, There were:

• 15 influenza cases: 10 type A (subtype unknown), three type A(H3), one type A(H1N1) and one type B.

• coronavirus (non-SARS-CoV-2), HMPV, rhinovirus and Mycoplasma pneumoniae were at Baseline activity level. Adenovirus, parainfluenza, and RSV remained at Low activity level.

7.2 COVID-19 pandemic

NHS Fife is currently managing the pandemic COVID-19 across all of its services.

Please note COVID-19 cases are being reported on the Scottish Government website.

COVID-19 incidents/clusters/outbreaks May – June 2022, there has been 17 new COVID-19 outbreaks/incidents reportable to ARHAI Scotland during this reporting period.

COVID-19 outbreaks/incidents reported to ARHAI Scotland March/April 2022				
Hospital	Ward	Total Patients	Deaths	Total Staff
HSCP				
Queen Margaret Hospital	Ward1 Ward 3 Ward 6	5 3 8	0 0 0	2 1 6
Glenrothes Hospital	Ward 2 Ward 3	5 7	1 0	2 0
Stratheden Hospital	Elmview	12	0	12
ASD				
Victoria Hospital	AU1	2	0	0
	Ward 23	2	0	0
	Ward 32	7	0	4
	Ward 32	3	0	6
	Ward 5	3	0	0
	Ward 44	18	0	6
	Ward 6	5	0	1
	Ward 9	5	0	1
	Ward 41	9	0	6
	Ward 43	10	0	4
	Ward 54	2	0	3

8. Surgical Site Infection Surveillance Programme

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

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

However, a further DL (2022) 13 was issued in May 2022, stating the planned resumption of SSI surveillance in Q4 2022. Further clarity is awaited.

8 a) Caesarean section SSI

All Caesarean Section surveillance has been postponed due to the COVID19 pandemic until further notice

8 b) Hip Arthroplasty SSI

All Orthopaedic surveillance has been postponed due to the COVID19 pandemic until further notice

8 c) Hemi arthroplasty SSI

All Orthopaedic surveillance has been postponed due to the COVID19 pandemic until further notice

8 d) Knees SSI

All Orthopaedic surveillance has been postponed due to the COVID19 pandemic until further notice

8 e) Large Bowel SSI

All large bowel surveillance has been postponed due to the COVID19 pandemic until further notice

9. Hospital Inspection Team

There have been no inspections during this reporting period

10. Assessment

- **CDIs**: The number of *Clostridioides difficile* cases has improved, so far, in 2022, compared to 2021, which is also reflected in the cumulative total of HCAIs. However, the number of HCAIs need to remain low to achieve the target set for 2022/2023
- 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 and dialysis line infections have been effective but remains a challenge, with local surveillance continuing
- 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
- Addressing Lower UTI related ECBs
- **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). SSI surveillance due to recommence Q4 2022. Increased resources and months of preparing will be required to successfully recommence surveillance.

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 categorized as:

Healthcare Associated (HCAI & HAI) or **Community** Onset (Community or Not known).

Please see HPS definition of Healthcare Associated & Community infections in 'References & Links'

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

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

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

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	4	4	8	3	0	3	15	10	25

Cleaning Compliance (%) TOTAL FIFE											
	Aug 21	Sep 21	Oct 21	Nov-21	Dec-21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22
Overall	96.0	95.6	95.8	95.7	96.2	96.1	96.4	96.1	96.2	95.9	95.8

Estates Monitoring Compliance (%) TOTAL FIFE											
	Aug 21	Sep 21	Oct 21	Nov-21	Dec-21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22
Overall	96.3	96.1	96.0	96.6	97.1	96.3	97.4	96.6	96.6	96.3	96.2

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

Cleaning Compliance (%) Victoria Hospital												
	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun
Overall	95.5	96.0	95.9	95.7	95.4	96.4	95.2	96.2	96.0	95.9	95.7	95.9

Estates Monitoring Compliance (%) Victoria Hospital												
	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar-22	Apr-22	May-22	Jun-22
Overall	96.5	96.8	96.8	96.5	97.3	97.7	96.3	98.0	98.0	97.4	97.2	97.0

Hand Hygiene Audits VHK: LanQIP Dashboard VHK

Compliance with Hand Hygiene Bundle - GWP5

Hospital	Ward	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Victoria Hospital	Accident and Emergency	96%	100%	100%	92%	95%	100%	92%	93%	96%	93%	100%	83%	100%	
	Admissions Unit 1	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%				
	Admissions Unit 2	100%	95%					100%		100%	100%	100%	100%	100%	100%
	Childrens Ward	95%	95%	95%	95%	100%	100%	100%	95%	100%	100%	95%	100%	100%	100%
	Day Intervention Unit	100%	100%	95%	100%	100%	100%	90%		100%	100%	100%	100%	100%	100%
	Dermatology	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	ENT			100%	100%	100%	100%	100%	95%	100%	100%	100%	100%	100%	100%
	Hospice	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	92%	100%	100%	100%
	Maternity Assessment	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Maternity Ward	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
	Neonatal Unit		100%	100%	100%	100%	100%	100%	100%						
	OPD	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		100%	100%
	Ophthalmology	100%	100%	100%	100%	100%	100%	100%	97%	100%	100%	100%	100%	100%	100%
	Orthodontics						100%								
	Renal Outpatients	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
	Special Care Baby Unit								100%	100%	100%				
	Surgical Pre-Assessment	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Urology Centre	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
	Ward 10	100%	85%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Ward 21	100%	100%	100%	100%	100%							100%	100%	100%
	Ward 22	100%	100%	100%	100%	100%	100%		100%	100%	100%	100%	100%	100%	100%
	Ward 23	100%	100%	100%	100%										100%
	Ward 31	100%	90%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Ward 32	96%	100%	100%	100%	100%	100%	96%	100%	100%	95%	100%	100%	100%	100%
	Ward 33	95%	100%	95%	100%	100%	100%	100%	95%	100%	100%	100%	100%	100%	100%
	Ward 34	100%	100%	100%											
	Ward 41	100%	95%	100%	100%	95%	95%	88%	100%	100%	100%	100%	100%		
	Ward 42	100%	100%	100%	100%	100%	100%	100%							
	Ward 43	100%	100%	95%	96%	100%	90%	95%	100%	100%	100%	95%	100%	95%	100%
	Ward 44	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	96%	100%
	Ward 51	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Ward 52	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Ward 53	100%					100%	100%							100%
	Ward 54	100%	96%	100%	100%	95%	100%	96%	100%	100%	100%	95%	100%	100%	100%
	Ward 6													100%	
	Ward 9	100%	100%	100%	100%	100%	100%	100%		100%	100%				

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

Cleaning Compliance (%) Queen Margaret's hospital												
	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22
Overall	96.3	97.0	96.3	96.7	97.0	96.9	97.5	97.8	96.0	97.2	97.1	96.4

Estates Monitoring Compliance (%)Queen Margaret's hospital												
	July 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22
Overall	94.6	95.3	95.5	95.7	97.0	97.4	96.4	96.5	96.6	96.0	95.4	96.6

Hand Hygiene Audits VHK: LanQIP Dashboard QMH

Compliance with Hand Hygiene Bundle - GWP5

Hospital	Ward	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Queen Margaret	CIU	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Colposcopy	100%	100%	100%			100%	100%		100%		100%	100%	100%	
	Dermatology	100%	85%	100%	100%	100%	100%	100%	100%	96%	100%	100%	100%	100%	100%
	DSU	95%	100%	100%	100%	87%	100%	95%	100%	95%	95%	95%	95%	95%	100%
	Endoscopy	100%	100%	100%	100%	100%		100%	100%	100%	100%	100%	100%	100%	100%
	Haematology Day Bed Unit	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	95%	100%
	OPD	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%	92%	100%	100%	100%
	Ophthalmology	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Plastics	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	96%
	Radiology	100%	100%	100%	90%	80%	100%	90%	100%	100%	100%	100%	95%	100%	100%
	Renal Outpatients	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Ward 2	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
	Ward 3	100%	100%	100%	100%	100%	100%	100%	96%	100%	100%	96%	100%	100%	100%
	Ward 4	76%	80%	85%	92%	85%	80%	76%	80%	88%	85%	90%	90%	72%	87%
	Ward 5	95%	96%	95%	95%	96%	95%	95%	96%	96%	96%	95%	95%	100%	96%
	Ward 6	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Ward 7	100%	100%	100%	100%	100%	100%	100%	100%		100%	100%	100%	100%	100%
	Ward 8	100%						100%	100%	100%	100%	100%	100%	100%	100%

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

Hand Hygiene Audits VHK: LanQIP Dashboard HSCP

Compliance with Hand Hygiene Bundle - GWP5

Hospital	Ward	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Adamson Hospital	MIU_OPD	95%	93%	90%	95%	93%	100%	100%	96%	95%	100%	100%			
	Tarvit Ward	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	95%
Cameron Hospital	Balcurvie	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Balgonie	100%	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Letham	96%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	SGSU		100%	96%	100%		100%	100%	100%	100%		100%		100%	100%
Glenrothes Hospital	Ward 1	100%	100%	100%	100%			96%	100%	100%					
	Ward 2	100%	95%	100%	100%	100%	93%	100%	100%	100%	90%	90%		100%	100%
	Ward 3	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Randolph Wemyss Memorial Hospital	CRU	100%	100%	100%	100%	80%	100%	100%	100%	100%	100%			100%	100%
STACH	MIU_OPD	100%	100%	100%	100%		95%	100%	100%	100%	100%	100%	100%		
	Renal Unit	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	95%	100%	100%	100%
	Ward 1	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Ward 2	92%	100%	100%	90%	90%	100%	100%	96%	100%	100%	100%	100%	100%	100%
Stratheden Hospital	Bayview	100%	100%	100%	100%	100%	100%	100%	95%	100%	100%	100%			
	Cairnie									100%	100%	100%	100%	100%	100%
	Dunino	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Elmview	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	IPCU	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Lindores	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Lomond	100%	100%	100%	100%	100%									
	Muirview	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Radernie	100%	100%	100%	100%	80%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Weston Day Hospital	100%	100%	100%	100%	100%	100%	93%	100%	100%	100%	100%	100%	100%	100%

Out of Hospital Infections

	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	2	4	2	0	10	10

Appendix 1 References and Links

References & Links
Understanding the Report Cards – Infection Case Numbers *Clostridioides difficile infections (CDI)* and *Staphylococcus aureus* bacteraemia *(SAB)* cases are presented for each hospital, broken down by month by Healthcare Associated (HCAI & HAI) & Community (Community/Unknown) onset. More information on these organisms can be found on the NHS24 website: *Clostridioides difficile*: https://www.hps.scot.nhs.uk/a-to-z-of-topics/clostridioides-difficile-infection/ *Staphylococcus aureus* : https://www.hps.scot.nhs.uk/a-to-z-of-topics/staphylococcus-aureus-bacteraemia-surveillance/ For each hospital, the total number of cases for each month are those, which have been reported as positive from a laboratory report on samples taken more than 48 hours after admission. For the purposes of these reports, positive samples taken from patients within 48 hours of admission will be considered confirmation that the infection was contracted prior to hospital admission and will be shown in the "out of hospital" report card. **Targets** There are national targets associated with reductions in C.diff and SABs and from 2019 for e.coli bacteraemias (ECBs). More information on these can be found on the Scotland Performs website: http://www.scotland.gov.uk/About/Performance/scotPerforms/partnerstories/NHSScotlandperformance **Understanding the Report Cards – Hand Hygiene Compliance** Hospitals carry out regular audits of how well their staff are complying with hand hygiene. Each hospital report card presents the combined percentage of hand hygiene compliance with both opportunity taken and technique used. **Understanding the Report Cards – Cleaning Compliance** Hospitals strive to keep the care environment as clean as possible. This is monitored through cleaning and estates compliance audits. More information on how hospitals carry out these audits can be found on the Health Facilities Scotland website: http://www.hfs.scot.nhs.uk/online-services/publications/hai/ **Understanding the Report Cards – *'Out of Hospital Infections'*** *Clostridium difficile infections* and *Staphylococcus aureus bacteraemia* cases can be associated with being treated in hospitals. However, this is not the only place a patient may contract an infection. This total will also include infections from community sources. The final Report Card report in this section covers '*Out of Hospital Infections*' and reports on SAB and CDI cases reported to NHS Fife which are not attributable to a hospital.
For HPS categories for Healthcare Associated Infections: **https://www.hps.scot.nhs.uk/web-resources-container/quarterly-epidemiological-commentary-for-the-surveillance-of-healthcare-associated-infections-in-scotland-methods-caveats/**

Appendix 2 Categories of Healthcare & Community Infections

Categories of Healthcare & community Infections

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

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

Hospital Acquired Infection (HAI):
Positive Blood culture obtained from patient who has been
-Hospitalised for >48 hours
If the patient was transferred from another hospital the duration of the in-patient stay is calculated from the date of the first hospital admission
OR
-The patient was discharged from hospital in the 48 hours prior to the positive blood culture being obtained
OR
-A patient receives regular haemodialysis as an outpatient

Community Infection
-Positive Blood culture obtained from a patient with 48 hours of admission to hospital who does not fulfil any of the criteria for the healthcare associated blood stream infections

Not known:
-Only to be used if the ECB is not a HAI and unable to determine if community or HCAI

Healthcare Associated Infection (HCAI):-
Positive blood culture obtained within 48 hours of admission to hospital and fulfils one or more of the following criteria:
-Was hospitalised overnight in the 30 days prior to the +ve blood culture being obtained.
OR
-Resides in a Nursing home, long term facility or residential home
OR
-IV,IM, Intra-articular or sub cut medication in the 30 days prior to the positive blood culture,
but EXCLUDING IV illicit drug use.
OR
-Underwent venepuncture in the 30 days before +ve BC
OR
-Underwent medical procedure which broke mucous or skin barrier i.e. biopsies or dental extraction in the 30 days before +ve BC
OR
-Underwent any care for chronic medical condition or manipulation of medical device by a healthcare worker in the community in the 30 days prior to the +ve BC being obtained i.e. podiatry or dressing of chronic ulcers, catheter change or insertion
OR
-Has a long term indwelling device (i.e. catheter, central line, drain (excluding a haemodialysis line)

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

HPS Linkage Origin Definitions

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

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

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

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

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

NHS Fife
Hayfield House
Hayfield Road
Kirkcaldy, KY2 5AH

www.nhsfife.org

facebook.com/nhsfife
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NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**2 September 2022**
Title:	**Paper Two: Healthcare Associated Infection Report (HAIRT) - Healthcare Improvement Scotland Infection Prevention and Control Standards (2022)**
Responsible Executive:	**Janette Owens**
Report Author:	**Julia Cook Infection Control Manager**

1 Purpose

To provide a gap analysis and assurance that all Infection Prevention and Control (IPC) priorities in line with the recently published and mandated Healthcare Improvement Scotland (HIS) IPC Standards (2022) are being, or will be, delivered throughout the organisation.

This is presented to the Clinical Governance Committee for:

- Assurance

This report relates to:

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

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of this report is to provide information to the Infection Control Committee (ICC), Clinical Governance Committee (CGC), NHS Fife Board and all other interested parties on the recently published HIS IPC Standards (2022) and gap analysis for the delivery of these Standards throughout the organisation. The Standards are included as Appendix 1.

Recommendations for issues that require further review and or action are also included.

2.2 Background

IPC is critical to keeping people safe when they are receiving health and social care. Effective IPC can help reduce the risk of infection and ensure the safety of people receiving care, staff and visitors. IPC is integral to quality health and social care delivery because anyone is at risk of developing an infection in these settings.

IPC standards are a key component in the drive to reduce the risk of infections in health and social care in Scotland. The Standards support organisations to quality assure both their IPC practice and approaches, and the IPC principles set out in the National Infection Prevention and Control Manual.

A single set of standards has been developed for use across health and adult social care. This will support the Once for Scotland approach and further integration of health and social care.

Standards underpin Healthcare Improvement Scotland's programme of inspection of the safety and cleanliness in acute and community hospitals. The Care Inspectorate inspects services using self-evaluation frameworks (which include IPC practice) that are informed by the standards and the National Infection Prevention and Control Manual.

These standards are informed by current evidence, best practice and stakeholder recommendations. They supersede Healthcare Improvement Scotland's HAI standards published in 2015.

2.3 Assessment

A full gap analysis can be found in Appendix 2. This provides assurance that NHS Fife is currently delivering on the majority of the 9 Standards.

Areas that require further review or action are:

Standard 1 – LEADERSHIP AND GOVERNANCE

- Local IPC have the necessary expertise, leadership skills and resources to support their organisation - IPCT structure agreed with HAI Executive and ICM – *vacancies in IPCT and Microbiology*.
- Health protection teams (HPT) have the necessary expertise, leadership skills and resources to support their organisation – *to be confirmed.*
- IPC Policy – *update to be published*
- Framework - *currently under review*
- The organisation demonstrates effective management of outbreaks, including Improvement plans - *required*

Standard 2 - EDUCATION AND TRAINING

- Evaluation of the provision, uptake and effectiveness of IPC training, including providing staff with opportunities to feedback on the education programme and training provided - *with online training via TEAMs, feedback form to be added*.
- IPC Education Strategy – *currently under review and out for final comment*.

Standard 3 - COMMUNICATION

- Equality and Human Rights colleagues have been contacted to enquire if there is a local service for information leaflets provided in alternative formats and languages

Standard 4 - ASSURANCE AND MONITORING SYSTEMS

- Availability of communications on assurance and monitoring information in staff and public areas, for example audit result charts and graphs. Audit results charts and graphs- *at entrance of each ward ?still in place in all areas*
- Incident Management Team meeting minutes with improvement plans, where required- *IMT minutes available, improvement plans are not currently a standard agenda item*

Standard 5 – OPTIMISING ANTIMICROBIAL SYSTEMS

- There are extant documents that are in need of review; the work of the Anti Microbial Team (AMT) has been severely curtailed during the COVID-19 pandemic and we are still catching up with our backlog
- Ability to monitor routine antimicrobial use, feedback on this to prescribers and target areas of poor practice is limited by competing demands on clinical AMT members and by a lack of available Pharmacy support
- Educational activity, monitoring of antimicrobial prescribing data, and targeted interventions for poor stewardship practice have been severely affected by both the demands on clinical staff of the COVID-19 pandemic and by a lack of available Pharmacy support for the work of the AMT.

Standard 6 - INFECTION PREVENTION AND CONTROL POLICIES, PROCEDURES AND GUIDANCE

- Risk assessments, with mitigating actions, are put in place and reviewed when staff are unable to adopt and implement the NIPCM - *Risk assessment would sit with clinical teams*
- When an audit programme is not undertaken within the agreed timescales the risks are discussed, agreed and recorded through internal governance structures, “Safe and Clean Care Audit programme” - *for clinical teams to undertake and escalate. Not in place in all areas despite launching 2019*
- Learning from instances where staff are unable to adopt and implement the NIPCM is shared
- Completed improvement plans following an outbreak or adverse event- *Not currently a standing agenda item for PAGs/IMTs*

Standard 7 – CLEAN AND SAFE CARE EQUIPMENT

- Nil

Standard 8 – THE BUILT ENVIRONMENT

- HAI-SCRIBE process in place- *need to agree escalation process and authorisation and recording of derogations*
- Learning from incidents, outbreaks and building maintenance projects is shared throughout the organisation and across sectors to support continuous quality improvement in IPC- *Area for further consideration*
- Evidence that learning has been shared within and across organisations- *Area for further consideration*

Standard 9 - ACQUISITION AND PROVISION OF EQUIPMENT

- The implementation of a loan policy - *Loan policy development being considered*

2.3.2 Workforce

Effective IPC is essential to the provision of a clean and safe working environment, and to overall staff health and wellbeing.

Significant focus on IPC Team professional development and recruitment, vacancies noted within IPCT and Microbiology.

Standard 5 - identifies further Pharmacy support required to fully deliver on this Standard.

2.3.3 Financial

No direct implications. However, actions to improve compliance with the Standards will require an investment of time and finance.

2.3.4 Risk Assessment/Management

IPC is critical to keeping people safe when they are receiving health and social care. Effective IPC can help reduce the risk of infection and ensure the safety of people receiving care, staff and visitors. IPC is integral to quality health and social care delivery because anyone is at risk of developing an infection in these settings.

Challenges and recommendations of any risks to NHS Fife delivering on the new HIS IPC Standards (2022) are discussed throughout this report

2.3.5 Equality and Diversity, including health inequalities

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

2.3.6 Other impact

N/A

2.3.7 Communication, involvement, engagement and consultation

This paper has been considered by the Infection Control Manager, IPCT, AMT Chair and HAI Executive

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.

- For presentation to ICT, ICC and AMT

2.4 Recommendation

Discussion – Examine and consider the implications of a matter.

Recommendations for the Standards are as follows:

Standard 1

- Local IPC & HPT, have the necessary expertise, leadership skills and resources to support their organisation – *to be confirmed.*
- IPC Policy – *updated to be published*
- Framework - *currently under review*
- The organisation demonstrates effective management of outbreaks, including: Improvement plans – *required to be implemented*

Standard 2

- With IPC online training via TEAMs, feedback form to be added.
- IPC Education Strategy – *currently under review and out for final comment*

Standard 3

- Confirmation on alternative formats and languages for patient information leaflets awaited.

Standard 4

- Availability of communications on assurance and monitoring information in staff and public areas, for example, audit result charts and graphs. Ensure these are available at the entrance of each ward
- Incident Management Team meeting minutes with improvement plans, where required- *consider adding improvement plans to the standard IMT agenda item*

Standard 5

- There are extant documents that are in need of review
- Review of current Pharmacy support for key deliverables of the AMT and Standard 5 required
- Recruitment to the Consultant Microbiologist vacancy would then reduce clinical burden on AMT lead and allow more time to be devoted to AMT work

Standard 6

- Risk assessments, with mitigating actions, are put in place and reviewed when staff are unable to adopt and implement the NIPCM - *Risk assessment would sit with clinical teams*
- Review framework and governance structures of Safe and Clean Care Audit programme with clinical teams
- Review processes to ensure learning from instances where staff are unable to adopt and implement the NIPCM is shared

- Completed improvement plans following an outbreak or adverse event- *consider adding as a standing agenda item for PAGs/IMTS*

Standard 7

- Nil

Standard 8

- Meeting to be confirmed with Estates and Facilitates and IPCT to review and strengthen the following:
    - HAI-SCRIBE process in place- *need to agree on escalation process and authorisation and recording of derogations*
    - Learning from incidents, outbreaks and building maintenance projects is shared throughout the organisation and across sectors to support continuous quality improvement in IPC
    - Evidence that learning has been shared within and across organisations

Standard 9

- The implementation of a loan policy - *loan policy development being considered*

3 List of appendices

The following appendix are included with this report:

Appendix 1: Green GAP analysis

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

NHS FIFE HIS IPC STANDARDS (2022) COMPLIANCE
MAY 2022 REVIEW

INTRODUCTION:

The prevention and control of infection is everybody's responsibility, with standards being one part of the drive towards a safer NHS Scotland.
The Healthcare Improvement Scotland (HIS) Healthcare Associate Infection (HAI) standards support reducing the risk of HAIs in health and care.

In 2015, HIS developed Healthcare Associate Infection Standards which complemented the National Infection Prevention and Control Manual. This document was updated in May 2022, HIS Infection Prevention and Control Standards. The implementation of both of these documents is mandatory across NHS Scotland. The guidance is considered best practice in other care settings, including care homes.

The 9 Standards (2022) are:

1. Leadership and governance
2. Education and training
3. Communication
4. Assurance and monitoring systems
5. Optimising antimicrobial use
6. Infection prevention and control policies, procedures and guidance
7. Clean and safe care equipment
8. The built environment
9. Acquisition and provision of equipment

HIS has committed to revising the Standards to ensure that there is a common and current benchmark of quality for organisations and services across health and social care as they work together to help prevent and manage the spread of infection. This work started in March 2021, with the Standards due for completion in early 2022.

This document provides an NHS Fife compliance check against the Standards (2022), as preparation is made for the introduction and implementation of the New Standards. The review has been undertaken, recognising the impact of COVID-19.

STANDARD 1: LEADERSHIP AND GOVERNANCE			
Standard Statement: The organisation demonstrates effective leadership and governance in IPC			
	CRITERIA	**NHS FIFE COMPLIANCE**	
1.1	Appropriate and responsive governance and accountability mechanisms are in place. Healthcare organisations have: • an executive lead with accountability for IPC and responsibility for overseeing and providing assurances on IPC within their organisation • an IPC manager with responsibility for leading local IPC teams and reporting IPC issues to the executive lead, and • local IPC and health protection teams (HPT) with the necessary expertise, leadership skills and resources to support their organisation.	Executive Director of Nursing is Board Lead for HAI ICM IPCT structure agreed with HAI Executive and ICM – vacancies in IPCT and Microbiology. HPTs to be confirmed	✓
1.2	The organisation has an IPC assurance and accountability framework that specifies, as a minimum: • defined roles and responsibilities • quality monitoring and assurance arrangements • reporting and escalation structures, and • an IPC risk management strategy with clear lines of responsibility.	IPC Policy – updated to be published Framework - Currently under review	-
1.3	The organisation has clear systems in place to ensure that it takes a strategic and co-ordinated approach to IPC. This includes, as a minimum: • compliance with IPC policies, procedures, guidance and standards with appropriate follow-up action where there is non-compliance • access to specialist IPC advice, guidance and support • implementation of staff induction, role-specific education and training programmes • ongoing and consistent data assurance and monitoring with improvement plans • prompt identification of people who are colonised or are at risk of developing an infection • accountability and responsibility arrangements for reporting adverse events, in line with the national adverse events framework and national reporting requirements, and • adherence to Duty of Candour regulations and responsibilities	HAI/ IPC policies and procedures discussed through ICC, EDG, CGC, SLTs, particularly high on agenda over past 2 years during pandemic IPCT available 7 days per week NHS Fife IPC Education Strategy National surveillance programme, IPQR IPCT/ICNET/trakcare HAIRT presented to CGC for discussion and assurance and to Board Duty of Candour discussed at PAGs & IMTS	✓

1.4	There are well-defined and locally agreed processes to enable: • an effective multidisciplinary and multiagency approach to IPC • cross-organisational support including access to specialist advice when indicated • compliance with mandatory HAI reporting, where required • staff to implement, monitor and improve their compliance with IPC policies, procedures, guidance and standards • accurate and prompt communications and information exchange following consent (where applicable) from the individual and within, and between, services and settings, and • communication and engagement with people that use services, staff, visitors and the public on matters related to IPC, including reducing specific risks.	IPCT: ICDs, ICM, deputy ICM, IPCNs, IPC surveillance nurses, AMR pharmacist Cross-organisational working with HPT/OH/H&S National surveillance programme, HIIAT/HIORT via ORT ARHAI Scotland NHS Fife IPCT programme of audit and clinical teams Safe and Clean Care Audit programme Communication Strategy Care Opinion Staff feedback	✓
1.5	The organisation demonstrates effective management of outbreaks, including: • preparedness • assessment of a person's care and safety • reporting, and • improvement plans.	Outbreaks managed as per chapter 3 of the NIPCM, reported to ARHAI Scotland, ICT, ICC, HAIRT. Improvement plans - required	✓ x
1.6	The organisation communicates and engages with people/the public on matters related to IPC, including information on reducing specific infection-related risks.	Framework in place for communication with people/Public – StaffLink for Staff and Social Media	✓
1.7	The organisation communicates and uses information, data and learning from a variety of internal and external sources to support good practice and continuous quality improvement in IPC.	Surveillance, national monitoring, PAGs, IMTs, lessons learned shared with HCT, ICT, ICC.	✓
1.8	The organisation ensures that there is continuous engagement with staff, visitors and people that use services and their representatives to capture feedback and inform service improvements.	Framework in place for communication with people/Public – StaffLink for Staff and Social Media. Care opinion	✓

Practical examples: healthcare and social care organisations			
	• An organisational assurance and accountability framework describing lines of accountability, roles and responsibilities, and reporting and escalation structures. • Implementation of an IPC risk management strategy with records demonstrating that risk registers are regularly reviewed and updated. • Improvement plans, underpinned by quality improvement methodology, that demonstrate implementation of the IPC standards. • Accessible documentation demonstrating evidence of staff and team performance, for example audit and improvement activity. • Organisational responses to assurance visits with appropriate action taken, where required, which are accessible. • Improvement work including improvement plans, data collection and review of data (for example feedback from people receiving care) and national benchmarking. • Completion of Reporting of Incidents, Diseases and Dangerous Occurrences. Regulations (RIDDOR) form, and notification to the Health and Safety Executive. • Duty of Candour monitoring including evidence of organisational openness, honesty and supportiveness. • Feedback from people receiving care and their representatives, and evidence of learning from complaints or feedback. • Executive board reports or minutes. • Infection control committee and internal clinical governance group reports Healthcare organisation use of risk assessment tools and risk registers. • Quarterly reports on current and emerging issues being used for quality improvement. • Outbreak management plans, including details of the incident management team, as instigated by the healthcare organisation. • IPC key performance indicators. • Healthcare Associated Infection Report Template (HAIRT).	IPC Framework – currently under review Risk register – presented at each ICC Action plan completion following Assurance visits/IPC audits. IPC Audit Programme & Clinical teams Safe and Clean Care Audits HIS Assurance Inspections- actions plans completed Surveillance, national monitoring , quarterly reports ECB, SAB, CDI, MDRO CR MRSA & CPE Managed under datix as part of Adverse Events Policy, although separate reporting system. H&S Team review. Duty of Candour discussed at PAGs & IMTS Care Opinion HAIRT; ICC and CGC ICC bi-monthly, Risk Register IPQR As per Chapter 3 NIPCM IPQR HAIRT	- ✓

STANDARD 2: EDUCATION AND TRAINING			
Standard Statement: Staff are supported to undertake IPC education and training, appropriate to their role, responsibilities and workplace setting, to enable them to minimise infection risks in care settings.			
CRITERIA		**NHS FIFE COMPLIANCE**	
2.1	The organisations training plan includes IPC training and education, in line with role, responsibility and workplace setting, which includes: • any local or national mandatory staff induction and training • information on current IPC policies, procedures and guidance, including the NIPCM • assessment of staff education and training requirements • tailored education and training, for example infection-specific management and insertion and maintenance of invasive devices, where required • allocation of dedicated time and resources for staff to access and undertake relevant IPC education and training, including refresher training • learning and sharing of IPC best practice across settings and sectors • application of quality improvement methodology for IPC, and • evaluation of the provision, uptake and effectiveness of IPC training, including providing staff with opportunities to feedback on the education programme and training provided.	Education strategy Training records held at local level IPCT have all attended QI sessions and apply to business as usual Tailored management and insertion and maintenance of invasive devices- PPD With online training via TEAMs, feedback form to be added.	✓
2.2	The organisation's training plan includes IPC education and training, in line with role, responsibility and workplace setting, to ensure that staff: • are supported to maintain role-appropriate levels of skill, knowledge and competency in IPC • have access to ongoing support, and • have access to continuous professional development in IPC.	IPC included in Mandatory training All staff have annual appraisals with IPC inc. as part of PDP SIPCEP	✓

2.3	Staff, in line with role, responsibility and workplace setting have access to clear guidance and support: • on their role and responsibilities in relation to IPC • to identify and address their own ongoing continuous professional development, education and training needs • on what to do when they experience barriers to implementing IPC measures • on career frameworks and development opportunities in IPC, where relevant, and • on infection-specific management, including outbreak management.	All IPCNs have undertaken or are undertaking Masters programme with UoD In place Staff feedback on their experiences on infection prevention and control, which inform learning activities. Turas learn PDP process in place for all staff	✓
2.4	As part of educational monitoring across the organisation, organisations use local and national IPC-related data and information to: • evaluate staff knowledge, skills, competency and confidence in IPC • identify areas for improvement in relation to staff IPC practice, and • improve staff IPC practice through further provision of education and training.	A range of training methods to give staff the opportunity to learn from each other's experiences in relation to infection prevention and control.	✓

Practical examples of evidence of achievement (NOTE: this list is not exhaustive)			
	• Training and development plans and records, for example induction, e-learning, completion of competencies, safety briefs, conference or study-day attendance. • Competency frameworks, appropriate to role and workplace setting. • Where appropriate to role, responsibilities and workplace setting, staff access and participate in quality improvement methodology education and training, for example modules provided by NHS Education for Scotland. • Where appropriate to role and workplace setting, staff access national learning platforms and systems for health and social care staff, for example Turas Learn, LearnPro, Scottish Social Services Council (SSSC) Learning Zone. • Availability of IPC-related information, which includes appropriate guidance, standards, manuals and audit tools and how they link to IPC practice. • Where appropriate to role, demonstration of staff having access to regular supervision, appraisal and support to identify training needs. • Dedicated learning time and support for staff included in the organisation's IPC education and training programme. • IPC education and training that is easy to access and delivered in formats appropriate for staff learning styles and workplace setting. • Use of adverse event reports to support training and education programmes. • Evaluation of training needs and training programmes. • Staff feedback being used to improve IPC education and training.	Held at ward level NES IPC framework NHS Fife QI training, NES QI Zone via TURAS Learn TURAS learn, SIPCEP NIPCM and Safe and Clean care Audit programme based on, "A National Monitoring Framework to Support Safe and Clean Care Audit Programmes"(2018) PDPs IPC Education Strategy – currently under review A range of training methods to give staff (face-to-face /TEAMs /Presentations /online learning etc) Learning summaries presented Staff feedback	✓

STANDARD 3: COMMUNICATION			
Standard Statement: The organisation implements robust communication systems and processes to enable person-centred decision making, continuity of care and effective IPC throughout a person's care experience.			
	CRITERIA	**NHS FIFE COMPLIANCE**	
3.1	All IPC related communications with people, and their representatives where appropriate, are documented in the person's care record and used to inform their plan of care	Discussion with patients / families recorded in notes. Care plans updated	✓
3.2	Staff are provided with clear, timely and responsive information and guidance on IPC to enable them to provide safe and effective care.	Staff meetings, staff use of StaffLink for updates and able to access IPC guidance/NIPCM updates	✓
3.3	Staff, IPC teams and HPTs have effective and appropriate communication: • when information and specialist advice for people receiving care is required • when there is a known or suspected outbreak or incident and • throughout the management process.	Good liaison and relationships with IPC teams and HPT. Escalation process for outbreaks/incidents	✓
3.4	Staff communicate and work collaboratively within and between, health and social care settings. Staff adhere to Governance arrangements including consent to share information: • support continuity of care and • minimise harm associated with infection, including when people are transferred between services.	As per ICT guide, SOPS followed for transportation, training and support given to staff	✓
3.5	People who are at risk of developing an infection, and their representatives where appropriate, are provided with high-quality and timely communication and information in a format that is right for them. This supports people to: • understand the impact, consequences and risks of having an infection • implement IPC precautions, where appropriate • understand what actions they can take to minimise the risk of developing an infection • understand what action the organisation is taking to minimise infection risks, and • make informed decisions and ask questions about their care.	Good communications between clinical teams and the patients/representatives. Patient information leaflets to support communications	✓
3.6	People that have become colonised or have developed an infection, and their representatives where appropriate, are: • promptly notified of their infection • provided with information in a language and format that is right for them • signposted to support on IPC-related care and procedures	Good communications between clinical teams and the patients/representatives. Patient information leaflets to support communications	✓

	• informed about any impact their infection may have on their care • given accessible and relevant information about minimising the infection risk to others, and • provided with opportunities to ask questions about their care.		
3.7	Where there is an IPC-related adverse event, the person, and their representatives where appropriate, are informed about this in line with organisational Duty of Candour and professional codes of conduct.	PAGs/IMTS – Duty of Candour standing agenda item	✓
3.8	There is continuous quality improvement of all IPC-related communication systems and processes. This includes: • monitoring the effectiveness of communications, and • evaluating and using feedback from staff, visitors and people receiving care and their representatives.	Communications strategy reviewed bi-annually Staff/patient/visitor feedback acted upon.	✓
Practical examples of evidence of achievement (NOTE: this list is not exhaustive)			
	• Availability of information provided in alternative formats and languages. • Timely communications and collaboration between health and social care settings detailing any infections, for example handovers, discharge summaries and admission letters. • Mechanisms for communication regarding IPC issues within, and between, health and social care settings, for example electronic staff communication systems. • Examples of person-centred communication with a person's representatives where a person has reduced capacity or is unable to make their own decisions. • Availability and use of information leaflets appropriate to individual need. • Duty of Candour monitoring. • Feedback from staff, visitors and people receiving care and their representatives, and evidence of learning from complaints or feedback. • Enquiries and responses to and from the IPC team. • Examples of completed care records/plans (anonymised) for communication between people receiving care and their representatives and healthcare staff about HAIs throughout a hospital episode. Examples include a person's MRSA status and cause of death.	National patient information leaflets available in alternative formats, NHS Fife Equality and Human rights has been contacted to enquire if there is a local service for leaflets Discharge/transfer sheets available Trackare/H&SC Clinical portal Individually available National leaflets available in alternative forms NHS Fife DoC annual report which goes to the Board and the IJB. DoC is picked up as part of adverse event process Learning summaries Available on request IPCT document advice in ICNET and patients' medical notes	-

STANDARD 4: ASSURANCE AND MONITORING SYSTEMS			
Standard Statement: The organisation uses robust assurance and monitoring systems to ensure there is a coordinated and rapid response to reduce the risk of infections and to drive continuous quality improvement in IPC.			
	CRITERIA	**NHS FIFE COMPLIANCE**	
4.1	The organisation has robust assurance and monitoring systems and processes in place with appropriate triggers; • mandatory national and local surveillance of infections and organisms, in line with national guidance. • access to multidisciplinary support from professionals and teams with specialist IPC knowledge and expertise. • that enable prompt detection, response and ongoing monitoring of any variance from normal local infection limits, including incidents and outbreaks, in line with national guidance • to respond to all infection-related incidents and outbreaks, in line with the NIPCM and • to help identify and plan areas for targeted learning and improvement.	IPCNs trained in use of ICNET; Surveillance and Audit nurses trained in use of systems. Surveillance triggers in line with appendix 13 of the NIPCM: PAGs, IMTs IPCT: ICDs, ICM, deputy ICM, IPCNs, IPC surveillance nurses, AMR pharmacist Cross-organisational working with HPT/OH/H&S	✓
4.2	The organisation reviews and evaluates assurance and monitoring activity to ensure • information gathered is used to help reduce infection risks. • appropriate action is taken where required to further reduce infection risk and • learning can be shared across settings and sectors.	Use of ICNET, surveillance nurses trained in use of systems Learning Summaries presented to ICC	✓
4.3	The organisation's assurance and monitoring system enables information and interpreted data to be communicated, in an accessible format to: • relevant health and social care teams and • people in receipt of care and their representatives and visitors	Surveillance reports completed by surveillance nurses and distributed to key stakeholders	✓
4.4	Staff that use assurance and monitoring systems: • have training needs assessed in line with their career and development frameworks appropriate to their role, responsibilities and workplace setting • undertake relevant and up to date training on the organisation's system	StaffLink, Turas training and appraisals used for all staff	✓
4.5	Performance is reported against local and national measures; • through internal reporting structures • to external partners and	Surveillance reports completed by surveillance nurses and distributed with key stakeholders	✓

	• publicly at board meetings.		
4.6	Review and report assurance and monitoring system data, including new, emerging and re-emerging infection related risks , in line with the NIPCM and is shared with external partners.	National surveillance programme HIIAT and HIORT reporting to ARHAI Scotland via ORT	✓
Practical examples of evidence of achievement (NOTE: this list is not exhaustive)			
	• Local and national reporting and escalation of infection surveillance, incidents and outbreaks. • Access and uptake of quality improvement training for staff, where appropriate, in relation to assurance and monitoring systems. • Audit and improvement plans. • Staff understanding of organisational monitoring, for example local standard operating procedures and guidance documents, with detail on how they would escalate. • Responses to trigger alerts with improvement plans. • Availability of communications on assurance and monitoring information in staff and public areas, for example audit result charts and graphs. • Completed Healthcare Infection Incident Assessment Tool (HIIAT) assessments, where required. • Minutes of meetings from internal governance groups, for example problem assessment groups, incident management teams, 'hot debriefs' and infection control and clinical governance committees. • Submission of data for national audit and surveillance programmes. • Incident Management Team meeting minutes with improvement plans, where required.	National surveillance programme HIIAT and HIORT reporting to ARHAI Scotland via ORT QI training undertaken IPCT agreed methodology for surveillance, agreement meeting with Consultant Microbiologist and Surveillance team to agree data before submission Escalation plan available. Trigger alerts investigated, improvement plans as appropriate. Audit results charts and graphs- at entrance of each ward (?still in place) HIIATs completed for PAGs and IMTs PAGs, IMTs, ICT, ICC, CGC – minutes available National Surveillance submitted IMT minutes available, improvement plans are not a standard item	-

STANDARD 5: OPTIMISING ANTIMICROBIAL SYSTEMS			
Standard Statement: The organisation demonstrates reliable systems and processes for antimicrobial stewardship to support optimal antimicrobial use.			
	CRITERIA	**NHS FIFE COMPLIANCE**	
5.1	All organisations can access appropriate antimicrobial expertise. **Healthcare organisations** have a core multiprofessional Antimicrobial Management Team, with defined roles and responsibilities, for the oversight and co-ordination of all aspects of antimicrobial use within the NHS board	AMT: • Consultant Microbiologist (chair) • Antimicrobial Pharmacist (deputy chair, currently on secondment to HIS) • Infection Control Manager • Infection Control Nurse • Consultant in Infectious Diseases • Consultant in Acute Medicine • Consultant Surgeon • Consultant Paediatrician • Clinical Effectiveness Pharmacist • Primary Care Development Pharmacist • Medicine Management Nurse • Head of Nursing for the Health and Social Care Partnership • General Practitioner Representative (Medical Director, Director of Pharmacy and Medicines, Director of Nursing support)	✓

5.2	All organisations support optimal antimicrobial use. **Healthcare organisations** implement and evaluate a planned programme of education for optimising antimicrobial use. The programme is provided to all staff involved in the prescribing, supply and administering of antimicrobials.	Educational modules are available to clinical staff regarding the safe and effective prescribing of vancomycin and gentamicin Material from the Scottish Antimicrobial Nursing Group is available to nursing staff to help them understand and develop their role in antimicrobial stewardship, available on TURAS learn and promoted by IPCT	✓
5.3	Healthcare organisations support optimal use of antimicrobials by ensuring that: • local antimicrobial policies are produced and updated at least every three years, or when indicated, in line with current national policy, guidance and best practice • local antimicrobial policies and guidance are accessible to all health and social care staff, and • staff who prescribe, supply and administer antimicrobials are alerted to any changes in antimicrobial practice policy and guidance.	Antimicrobial policies are reviewed on a three-yearly where possible, although there are extant documents that are in need of review; the work of the AMT has been severely curtailed during the COVID-19 pandemic and we are still catching up with our backlog Antimicrobial policies are available online to all NHS Fife staff, including via mobile app, on the Microguide platform. This is updated regularly and signposts to relevant Scottish Antimicrobial Prescribing Group guidance Urgent changes are communicated to prescribers via hospital-wide e-mail, and changes to guidance are published in real time by updating the content of the guidance in Microguide	- ✓ ✓

5.4	Healthcare organisations, through the Antimicrobial Management Team, maintain an annual programme for antimicrobial stewardship. This programme includes: • monitoring data, including all adverse events relating to antimicrobial use • providing feedback on prescribing practice to clinical teams • targeted quality improvement interventions to address poor clinical practice in the use of antimicrobials, and • reporting findings, including risk assessments, and improvement plans where appropriate, through internal governance structures.	Adverse events relating to antibiotic prescribing are monitored by the NHS Fife Pharmacy team and reported to the AMT as required The AMT reports to the NHS Fife ADTC and guidance is submitted both there and at the MSDTC Ability to monitor routine antimicrobial use, to feed back on this to prescribers, and to target areas of poor practice, is limited by competing demands on clinical AMT members and by a lack of available Pharmacy support	
5.5	To ensure that the healthcare organisation optimises its antimicrobial use through a quality improvement approach, the Antimicrobial Management Team: • works with the multidisciplinary team to support and promote antimicrobial stewardship across health and social care • participates in the implementation of an antimicrobial stewardship programme of education for optimising antimicrobial use • reviews antimicrobial prescribing and resistance data in line with the annual programme for local surveillance of antimicrobial use • feeds back the main findings of the review to clinical and management teams, and • responds to data that indicate poor antimicrobial stewardship with targeted improvement interventions.	The AMT includes representatives from all sectors of NHS Fife including the HSCP, Primary Care, and Secondary Care Educational activity, monitoring of antimicrobial prescribing data, and targeted interventions for poor stewardship practice have been severely affected by both the demands on clinical staff of the COVID-19 pandemic, and by a lack of available Pharmacy support for the work of the AMT	

Practical examples of evidence of achievement (NOTE: this list is not exhaustive)			
	• Availability of antimicrobial guidance, for example signposting to the Antimicrobial Companion and Scottish Antimicrobial Prescribing Group guidance. • Improvement plans to address areas for quality improvement and evidence of progress against improvement plans. • Support for staff to access education and training on optimal antimicrobial use. • Multidisciplinary working to support and promote antimicrobial stewardship. • Processes in place to access advice from local experts on the use of antimicrobials. • Audits on appropriate antimicrobial prescribing in line with current guidance and best practice with improvement plans. • Local antimicrobial policies that are produced and updated at least every three years. • Regular audit and surveillance, including improvement plans, of antimicrobial use in line with Scottish Antimicrobial Prescribing Group policy and guidance. • Feedback from the Antimicrobial Management Team provided to all teams involved in the prescribing, supply and administering of antimicrobials. • Antimicrobial stewardship reporting through internal governance structures. • Availability of organism- and body-system-specific treatment decision making aids, for example urinary tract infection, respiratory tract infection and MRSA. • Prescribing and resistance data have been used to inform continuous quality improvement. • Information exchange with multidisciplinary teams, for example through email, electronic portals and regular reporting of antimicrobial data. • Membership, terms of reference, minutes and annual programme/plan of the Antimicrobial Management Team.		

STANDARD 6: INFECTION PREVENTION AND CONTROL POLICIES, PROCEDURES AND GUIDANCE			
Standard Statement: The organisation uses evidence-based IPC policies, procedures and guidance.			
	CRITERIA	**NHS FIFE COMPLIANCE**	
6.1	The current version of the National Infection Prevention and Control Manual has been adopted, implemented and is accessible by all staff.	Available online and StafLink	✓
6.2	The organisation has, and implements an annual IPC work programme in line with national requirements and the NIPCM.	Annual work programme presented to ICC	✓
6.3	The organisation has systems and processes in place to ensure that: • staff are alerted to any changes in IPC policy, procedures and guidance, including the NIPCM that may impact practice • risk assessments, with mitigating actions, are put in place and reviewed when staff are unable to adopt and implement the NIPCM • audit data and information, including risks, are fed back to staff, leadership teams, the executive team and registered services, as appropriate • when an audit programme is not undertaken within the agreed timescales the risks are discussed, agreed and recorded through internal governance structures • an improvement plan with clearly defined responsibilities and evidence of review is developed in response to audit data • data and themes emerging from audit(s) are used to inform staff education and training and drive improvement in IPC practice • there is access to appropriate specialist clinical advice for IPC and the diagnosis, treatment and management of infections, and • learning from instances where staff are unable to adopt and implement the NIPCM is shared.	Updates via StaffLink and NIPCM Risk assessment would sit with clinical teams IPCT supports wards, departments, care homes Audits undertaken by IPCT, and feedback as per escalation plan. Safe and clean care audit programme for clinical teams to undertake and escalate - ?not in place in all areas despite launching 2019 Action/improvement plans for audits Key themes are utilised to support IPC education programme IPC advice 7 days per week	-

Practical examples of evidence of achievement (NOTE: this list is not exhaustive)			
	• IPC education programme and training records. • Environmental and equipment cleaning schedules. • Membership, terms of reference and minutes of internal governance groups. • NIPCM compliance audits and improvement plans. • Audits with improvement plans. • Completed improvement plans following an outbreak or adverse event. • Risk assessments. • Accessible up-to-date policy information displayed to staff. • Lessons learned document themes are shared with appropriate improvement plan. • Completed care plans for people with an alert organism. • Completed rapid event investigations into HAIs, for example Staphylococcus aureus bacteraemia.	Kept at ward/department level Cleaning schedules insitu ToR available for relevant committees and groups Audit programme Action/improvement plans completed Not currently a standing agenda item for PAGs/IMTS Risk assessments as appropriate Policies available online and via StaffLink Lessons learned shared at ICC Advice documented on ICNET and patients notes Investigation into triggers/outbreaks and data exceedance including SAC, CDI and ECB surveillance.	

STANDARD 7: CLEAN AND SAFE CARE EQUIPMENT			
Standard Statement: The organisation ensures that care equipment is cleaned, maintained and safe for use.			
	CRITERIA	**NHS FIFE COMPLIANCE**	
7.1	The organisation has and implements, cleaning and decontamination policies and procedures in line with current statutory legislation and national guidance	cleaning and decontamination policies and procedures available	✓
7.2	The organisation has effective cleaning and decontamination systems and processes in place to ensure that: • all care equipment is clean, maintained and safe to minimise risk of cross infection. • all care equipment is stored, installed, serviced maintained, repaired, decommissioned and appropriately disposed of in line with the manufacturer's instructions. • cleaning and decontamination of care equipment is carried out in line with manufacturer and national guidance. • reporting and escalation of cleanliness and maintenance issues are routinely undertaken, including evidence that issues have been addressed. • specialist guidance and input where cleaning and decontamination issues are identified • safety notices for care equipment are responded to • there is accurate record keeping and documentation, where relevant, and • feedback from people receiving care, staff and visitors is sought on the cleanliness and maintenance of care equipment and acted upon, where appropriate.	Process in place with support of domestic services and clinical teams as appropriate	✓
7.3	The organisation carries out regular audit to inform risk assessment, with mitigating actions where any part of cleaning or decontamination process cannot or has not been followed.	In place – clinical teams, IPCT and Quality Assurance Team (Domestic and Estates audits)	✓
7.4	Where there is an adverse event associated with the cleaning or decontamination of care equipment, the organisation : • Investigates the reason for the adverse event and reports this using HIIAT tool • Reviews processes during and following the adverse event or near miss in line with the national adverse framework • Reports through national reporting mechanisms	In place	✓

Practical examples of evidence of achievement (NOTE: this list is not exhaustive)			
	• Compliance with legislation and national guidance. • Records of the adverse event with improvement plans and evidence of learning. • Completed and signed cleaning schedules and records. • Minutes of local governance meetings. • Circulation of safety action notices to appropriate teams. • Maintenance records. • Risk assessments. • Education and training records. • Audits of care equipment with improvement plans. • Records/minutes showing how risk assessments for care equipment are regularly reviewed. • Audit reports of decontamination processes with improvement plans. • Completion of HIIAT tool, where relevant. • Facilities monitoring tool feedback being used to inform service improvements. • National reporting to Incident Reporting and Investigation Centre (IRIC).	In place	✓

STANDARD 8: THE BUILT ENVIRONMENT			
Standard Statement: The organisation ensures that infection risks associated with the health and care built environment are minimised.			
	CRITERIA	**NHS FIFE COMPLIANCE**	
8.1	The organisation has, and implements, decontamination policies, records and procedures in line with: • statutory legislation and regulations, and • national guidance and processes.	Policies in place	✓
8.2	There are clear and agreed channels of communication and prompt information exchange across all relevant organisations, teams and settings to enable early assessment of potential and existing IPC risks associated with the environment.	Communication strategy and escalation plan	✓
8.3	The organisation ensures that IPC risks associated with construction, renovation, maintenance and repair of the environment are minimised by demonstrating that • Building, refurbishment and maintenance work follow agreed processes and are planned, appropriately risk assessed, authorised, documented and carried out in ways that minimise infection risk and disruption to staff, people receiving care and visitors. • Risks and issues are identified and communicated through appropriate mechanisms at planning stage, refurbishment and maintenance. A formal risk assessment with mitigation is put in place and acted on appropriately with key staff and teams involved in the relevant stages. • Regular monitoring and audit of maintenance and repair services to ensure that this is carried out in line with an agreed schedule • Robust reporting with follow up action, including associated documented decision making and derogations where the environment cannot be accessed for maintenance and repairs. –Estates colleges • Robust reporting, escalation, follow up action, sign off and documentation of any IPC-related issues associated with the environment and • records and reports relating to maintenance, repair and refurbishment of the environment are accessible and regularly updated and reviewed	RAMS, HAI-SCRIBE and NHS Assure Key Stage Assurance Review KSAR process in place HAI-SCRIBE process in place, need to agree escalation process and authorisation and recording of derogations (Estates may have a system of recording) In place HAI-SCRIBE in place, need to agree escalation process and authorisation and recording of derogations (Estate) Incidents & data exceedance reported to ICT, ICC (Escalated to HAI Executive or Director of Property and Asset Management as appropriate) Clinical contingency group. Is there a Capital planning group?	✓

8.4	The organisation ensures that the environment is safe and clean by demonstrating that • Environmental cleanliness is in line with national guidance • Robust monitoring and audit cleaning, including an escalation plan • Robust decision making and reporting with appropriate follow up action and escalation where the environment cannot be accessed for cleaning • Records and reports relating to cleanliness of the environment are accessible and regularly updated and reviewed • Active engagement with people receiving care, staff and visitors to obtain feedback on the cleanliness of the environment. This includes development of an improvement plan.	In place	✓
8.5	Staff have access to information, specialist guidance and support to minimise infection risks associated with the environment. This ensures that staff are clear on their roles and responsibilities when: • IPC risks and issues are identified in the environment • additional cleaning activity is identified as necessary • there is planned refurbishment or maintenance work in the environment • there is emergency building or repair work to be undertaken • known or suspected outbreaks and incidents relating to the environment are identified • there is an alteration in the function or purpose of an area • there is a change of use to an area, and • the area cannot be accessed.	In place	✓
8.6	Learning from incidents, outbreaks and building maintenance projects is shared throughout the organisation and across sectors to support continuous quality improvement in IPC	Area for further consideration	**x**

Practical examples of evidence of achievement (NOTE: this list is not exhaustive)			
	• Compliance with legislation and national guidance, including the NIPCM • Evidence that learning has been shared within and across organisations • Assurance mechanisms and accreditation checks when working with external partners • Water safety policy • Water outlet monitoring records • Infection-related risk assessment, for example Legionella risk assessment • Inspection reports and improvement plans. • IPC audits with improvement plans, for example audits in line with the Safe Management of the Care Environment. • Feedback from people receiving care and their representatives, and evidence of learning from complaints or feedback • National facilities monitoring tool • Annual validation and verification of ventilation systems. • IPC audits with improvement plans, for example Scottish Ambulance Service vehicle and station audits. • Patient feedback, for example, Care Opinion reviews • Incident and outbreak data and reports • HAI-SCRIBE documentation • IPC committee, water safety group, and ventilation and pressure systems management group minutes • Ventilation systems management records • Compliance with Scottish Capital Investment Manual including completion of NHS Scotland Design Assessment Process, where required • Completion of key stage assurance reviews, where required, and improvement plans • NIPCM compliance data	NIPCM and SHTMs etc Area for further consideration RAMS & HAI-SCRIBE address WS policy available Records available As per WSG Inspection reports and improvement plans actioned as required Programme of audit in place Feedback encouraged NF Monitoring tools adopted by Quality Assurance Team Ventilation Group SAS – no as covered by their own IPCT Care opinion Incident and outbreak reports – ICT, ICC and ARHAI Scotland as appropriate HAI-SCRIBE completed ICC, WSG and Ventilation Group all minuted meetings Via Ventilation group Estates colleagues to provide assurance NHS Assure and KSAR process in place Audit programme in place	

STANDARD 9: ACQUISITION AND PROVISION OF EQUIPMENT			
Standard Statement: The organisation demonstrates the acquisition and provision of equipment that is safe for use in health and social care settings.			
	CRITERIA	**NHS FIFE COMPLIANCE**	
9.1	The organisation has, and implements, policies and procedures for acquiring equipment in line with current: • statutory legislation and regulations, and • national guidance	IPC involvement in CEMG and Clinical Contingency Group	✓
9.2	There is IPC consideration and multidisciplinary involvement in the acquisition process prior to procurement. This includes the acquisition of new equipment.	CAP panels and CEMG In place	✓
9.3	Organisation has systems and processes in place to ensure that: • all acquired equipment is compatible with national guidance • all acquired equipment that cannot be effectively cleaned or decontaminated is removed from use and • feedback is provided to relevant teams on equipment that cannot be effectively cleaned or decontaminated to support continuous quality improvement	CAP panels and CEMG In place	✓
9.4	All adverse events associated with equipment are: • reported through organisations local adverse event system • reported through national reporting mechanisms and • managed in line with the organisations adverse event policy and the national adverse events framework	Datix reporting system is in place. National Reporting system for equipment issues in place through NSS Incident Reporting and Investigation Centre (IRIC) Adverse Events Policy	✓

Practical examples of evidence of achievement (NOTE: this list is not exhaustive)			
	• compliance with statutory legislation, regulations and guidance • assessment of compatibility of all equipment, which impacts on IPC, with existing cleaning or decontamination processes • adverse event reporting, where indicated • the implementation of a loan policy • the implementation of a procurement policy • multidisciplinary involvement in decision making on the acquisition of equipment, where required. • procurement policy, procedures and records related to the acquisition of care equipment that impacts IPC	As per NIPCM Datix/riddor Loan policy development being considered Procurement Strategy available CAP panels CEMG	

Key	
Areas coloured gray	Require further information/review or action

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**2 September 2022**
Title:	**Information Governance and Security Steering Group Update**
Responsible Executive:	**Margo McGurk – Director of Finance and Strategy - SIRO**
Report Author:	**Alistair Graham – Associate Director of Digital & Information**

1 Purpose

This is presented to the Clinical Governance Committee for:

- Assurance

This report relates to a:

- Government policy/directive
- Legal requirement
- Local policy

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

- Safe
- Effective

2 Report summary

2.1 Situation

The Information Governance & Security (IG&S) Steering Group, through this report, provides oversight of its work and assurance for the key priorities for the 2022-23 period.

The Steering Group continue to support the tasks, activities and projects that are key to the continuous improvement, mitigation of risk and evidence of improved controls for the areas of IG&S. The Steering Group has an agreed workplan and revised measures necessary to evidence assurance. The workplan assurance and risk reporting continues to develop following critical review. Issues of key importance are carefully considered between the IG&S Operational Group and IG&S Steering Group.

The reporting to the Steering Group covers the following areas: -

- Data Protection & GDPR
- Freedom of Information Requests
- Public Records
- Network and Information Systems Directive (NISD)

The prioritisation of activities is based on the current risk profile within IG&S, through direct instruction by competent or audit authority or via the guidance of the IG&S Steering Group.

2.2 Background

Risk Management

The risk reporting to the IG&S Steering Group includes summary information of risk performance and a detailed review of root cause and committed mitigating actions for the highest ranked risk items.

This work ensures that IG&S Steering Group can support the risk mitigation activities specific to the IG&S domains.

The summary risk position for IG&S compared to March 2022 is currently: -

Categorisation	Total Risks March 2022	March 2022 Risk Level Breakdown	Total Risks August 2022	August 2022 Risk Level Breakdown
DPA and GDPR Risk that data maybe lost, used inappropriately, or retained for longer than necessary	13	High Risk – 6 Moderate Risk – 6 Low Risk – 1	**13**	**High Risk – 6** **Moderate Risk – 6** **Low Risk - 1**
Freedom of Information Risk that inhibits the organisation's ability to comply with the statutory requirements and proactive publication of information	0	High Risk – 0 Moderate Risk – 0 Low Risk – 0	**0**	**High Risk – 0** **Moderate Risk – 0** **Low Risk - 0**
Public Records Risks that inhibit the organisation's ability to create, maintain and comply with a Records Management Policy	4	High Risk – 3 Moderate Risk – 1 Low Risk – 0	**3**	**High Risk – 2** **Moderate Risk – 1** **Low Risk - 0**
NISD Risks that inhibit the organisation's ability to comply with the necessary security controls protecting access to data and digital assets including user behaviour	9	High Risk – 3 Moderate Risk – 5 Low Risk – 1	**10**	**High Risk – 4** **Moderate Risk – 5** **Low Risk – 1**

Key Priorities

The presentation of the Activity Tracker and Assurance measures continues to be a focus for the Steering group. At their most recent meeting, of 22 July 2022, additional views were shared on the improvement of the tracker given a baseline position had been achieved during 2021-22. A summary of the available measures is provided in Appendix 1.

The key areas of action for the year have been identified as:-

- Continue with the implementation of the improvement plan for Subject Access Requests (SARs)
- Develop a Governance Gate assurance framework to support adoption of new technologies

- Planned improvement to Information Asset Recording and associated Service Catalogue
- Development of project plan and highlight report in support of the implementation of Records Management Action Plan
- Policy review
- NISD Action Plan design and implementation following NISD Audit April 2022
- Preparation for ICO Audit – Commencing 9 August 2022, with interviews held between 6 October and 11 October 2022.
- Additional assurance mapping across the Information Commissioner's Office (ICO) Accountability Framework, NISD and Scottish Public Sector Cyber Resilience Framework

Assurance Measures

Measurement and performance information are presented to provide assurance and evidence the impact of the improvement plans, controls and performance. The measures are developed into a summary set of indicators and aligned and cross-referenced with the activity tracker across the IG&S areas.

Preferred measures are yet to be established across all areas due to data not being available or able to be reported on consistently.

The IG&S Operational and Steering groups continue to use these measures to adapt their approach within priority areas to ensure improved performance.

Of key importance to the work of the IG&S team and their ability to sustain improvement, was the ability to recruit to a substantive, skilled and permanent workforce. Following a review of the Digital and Information financial plans, representations made to EDG in February 2022 and through the Strategic Planning and Resource Allocation (SPRA) the process of recruitment commenced at the start of the Financial Year 2022-23 and concluded in June 2022.

2.3 Assessment

Through the establishment of control and reporting mechanisms in 2021-22, we have established a baseline of consistent and reliable assurance. The improvement plans summarised in this paper will further enhance performance as we embedded these improvements into practice.

Look at each of the priority areas the following can be reported.

Review the management and implement an improvement plan for Subject Access Requests (SAR)

At the most recent Steering Group meeting, the group reviewed a revised SAR procedure and agreed the recommendation that a single point of contact be established to coordinate and monitor responses to requests. This single point would support services in meeting the required one-month standard and include the visibility of assurance measures in a timely manner. This approach mirrors the work carried out for FOI requests and a suitable

system of record keeping will be adopted across all areas. This work is now being progressed by the SAR Short Life Working Group (SLWG). Performance across areas remains variable as highlighted in Appendix 1.

The improvement work is planned to conclude by November 2022.

Develop a Governance Gate assurance framework to support adoption of new technologies

Actions completed in this area includes the establishment of an Architecture Review Board. This Board provides a single group of multidisciplinary teams able to review request for new technologies and ensure compliance with a range of standards to ensure we are introducing required, safe and secure systems.

The range of assessments made by the Architecture Group include: -

- Technical Review – including Cyber Standards
- Information Governance and Security Review
- Record and Data Management Considerations
- Financial Review
- Exit Plan – data retention

The governance gates have also been extended as part of a readiness checklist to ensure that all appropriate IG&S documentation and risk assessments are complete much earlier in the deliver process and prior to any system commissioning. System commissioning will not progress unless governance has been complied with.

Ongoing actions relate to the digital procurement policy, which is being updated to reflect changes to the Financial Operating Procedures and Business Case Templates for Digital items agreed at Finance, Performance and Resources Committee in January 2022.

The improvement work is planned to conclude by October 2022.

Planned improvement to Information Asset Register and associated Service Catalogue

Work continues to catalogue all information assets in use within NHS Fife, including those that have been mandated nationally. While rapid risk assessment was allowed during the initial period of the pandemic, the appropriate identification of Information Asset owners will be sought within the services in support of this work. The resources now aligned to IG&S allows this work to progress in a more consistent manner.

The establishment of an Information Asset Register is complete. Where information assets are managed within Digital and Information the items are added to the register.
Plans for its population across all NHS Fife Information Assets will progress for the remainder of 2022-23. The data will also ensure cataloguing of existing contractual arrangements.

Development of project in support of the implementation of Records Management Action Plan

The initiation of the records management project continues and is informed by feedback received from the Keeper of the Records of Scotland, the Records Management Policy (GP/R4) and the baseline assessment for some services where Records Management review and practices have been adopted. The records management plan is required for both paper and digital information assets and represent a significant undertaking for NHS Fife, however, focus on this area matches the risk profile associated with DPA and Public Records – with 17 risks in this area, 8 of which are rated as High Risk.

Increased demand for physical space across NHS Fife provides an additional challenge when considering the safe storage, retrieval and retention of our paper records.

The project plan is estimated to take 2 years to complete.

Policy review
All IG&S Policy documents have been reviewed within the year and are now submitted for publication. A significant rewrite of the Data Protection and Confidentiality Policy (GP/D3) has concluded with work now focussing on the associated procedures that underpin this.

NISD Action Plan Implementation
The NISD Audit Report (May 2022), was reviewed by the Steering Group at their July 2022 meeting. The report, the 3rd in the series of audits reported a compliance level of 76% and increase from the previous year of 69%.

The Key Messages identified in the report are:-

- The progress made in controls and recommendations implementation are clear evidence of a commitment by the board to information and cyber security. This is reflected by the uplift in the Overall Compliance status from 69% to 76%.
- Moreover 16 of 17 categories have now achieved ≥60% compliance with 9 at ≥80% compliance and only 2 subcategories are <30% compliant resulting in a low risk profile of 3%.
- This significant improvement has been driven by the appointment of new staff and regular reporting on NIS compliance progress to the Resilience Group.
- Areas of Good Practice developed and enhanced since 2021 are: Governance and Staff Training & Awareness. This latter area is a real strength of the board with several initiatives in place that may be of interest to other boards including scenario-based tailored training to Clinical Service staff.

The development of the associated action plan is complete and will focus on the following areas identified within the report. These areas include:-

- Actions to address the remaining 9 urgent recommendations
- Supplier Management
- Asset Management (associated with Information Asset Recording)
- Privileged Access Controls and Network Segregation
- Resilience and Disaster Recovery Testing

These plans will be delivered during the remainder of 2022-23 with further audit expected towards the end of that period.

Preparation for ICO Audit

The ICO has confirmed their intention to conduct an audit of NHS Fife in relation to their responsibility for enforcing and promoting compliance with data protection legislation and their entitlement to conduct audit. This audit is consistent with many other areas of NHS Scotland.

The ICO has stated in their engagement letter that: -

- The primary purpose of the audit is to provide the ICO and NHS Fife with an independent opinion of the extent to which we (within the scope of this agreed audit) are complying with data protection legislation and highlight any areas of risk to their compliance.
- The audit will also review the extent to which NHS Fife (within the scope of the audit) demonstrates good practice in their data protection governance and management of personal data.
- Good data protection practice is promoted by the ICO through its website and the 'Guide to the UK General Data Protection Regulation (UK GDPR)' guidance, the issue of good practice notes, codes of practice and technical guidance notes. The ICO will use such guidance when delivering an audit opinion on 'good data protection practice'. In addition, the ICO will use the experience gained from other data protection audits, appropriate sector standards and enforcement activity.

The audit will consist of NHS Fife submitting a list of documents as evidence, the interviewing of key stakeholders and will result in the submission of a report and action plan that NHS Fife will be able to respond to. The audit is expected to conclude by the end of October 2022.

Work has already commenced in the cataloguing and preparation of evidence.

Additional Assurance Mapping

As requested by the Steering Group activities are ongoing to develop the reporting and analytics associated with the IG&S domains. Specific consideration is being given the measures and controls associated with the ICO Accountability Framework, NISD and Cyber Resilience Framework along with additional requirement for Records Management.

Summary Frameworks

Framework	Categories	Controls
ICO Accountability Framework	10	338
NISD	17	436

The assurance mapping worked is planned to conclude by October 2022.

2.3.1 Quality/ Patient Care

A culture that is supported in understanding its collective and individual responsibilities for Information Governance and Security is necessary to ensure services can consistently provide high levels of care and services and are not impacted by disruption, financial loss or reputational damage.

2.3.2 Workforce

The previously reported resource limitations within the IG&S team have been resolved, however full mitigation will take some months to achieve as the necessary induction and training of new staff takes place.

Many of the activities identify will require NHS Fife to embrace the work and projects associated with improvements. The modelling of approach, consultation and impact to services will be consider via the IG&S Operational and Steering Groups, with appropriate escalation to EDG.

2.3.3 Financial

Some of the activities to mitigate risk and support compliance may incur additional costs.

2.3.4 Risk Assessment/Management

The risk management approach and review has concluded, and the ongoing reporting and mitigation actions forms a standard component of the IG&S Steering Group activities. The IG&S Operational, Steering groups and D&I teams continue to monitor existing and emerging risks.

2.3.5 Equality and Diversity, including health inequalities

An impact assessment has not been considered in the creation of this report.

2.3.6 Other impact

No other impact considered.

2.3.7 Communication, involvement, engagement and consultation

- Report creation reflects the work undertaken by the IG&S Team, view of the Information Governance Steering Group and associated stakeholders.

2.3.8 Route to the Meeting

- This paper was presented to EDG on 18 August 2022

2.4 Recommendation

- **Assurance** – CGC are asked to note the progress being made across the IG&S domains and take assurance from the governance, controls and measures in place.

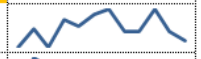
3 List of appendices

Appendix 1 – IG&S Operational Performance

Report Contact

Alistair Graham
Associate Director of Digital & Information
Email alistair.graham1@nhs.scot

Appendix 1 – IG&S Operational Performance

	Information Governance & Security Performance Summary	Target	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Trend
Operational Performance	Cyber Security - Exposure Score*	25%	56	25	30	29	37	38	26	24	25	23	20	26	
	FOI's - Responses within target	85%	83.3%	74.5%	78.0%	84.1%	85.4%	80.8%	90.8%	90.3%	97.6%	96.0%	90.5%	83.0%	
	SARs Received (% responded to timeously)	100%	96.7%	94.0%	99.5%	100.0%	97.0%	96.0%	100.0%	97.0%	67.0%	87.0%			
	Information Governance Incidents	Avg 102	75	101	75	114	105	120	129	98	97	128	98	85	
	Incidents Reported to ICO		0	4	3	0	1	1	1	0	0	2	1	1	
	Incidents Reported within 72 Hours		0	3	3	0	1	1	0	0	0	2	1	1	
	Follow up required by ICO		0	0	0	0	0	0	0	0	0	0	TBC	TBC	
	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

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**2 September 2022**
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 to the Clinical Governance Committee for:

- Assurance
- Discussion

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%)

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

On reviewing the stage 2 complaints, an improving position is evident. There is now a level of detail which clarifies where each complaint is in the process. There are currently 192 stage 2 complaints in the system, with 25 in total ready to draft or being drafted (13%).

A Test of Change is taking place, which will release time for the Patient Experience Officers to draft more complex complaints responses.

STAGE 2 COMPLAINTS

	08/08/2022	
Total	**192**	%
Awaiting Statements	71	37
Drafting in Progress	11	6
FR out for approval	53	28
FR out for comment	20	10
FR sent to CEO	4	2
FR with Director H&SCP	13	7
FR with GM for sign off	2	1
FR with Head of Service for sign off	1	1
Ready to draft	14	7
Blank	3	2

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 Relations Team will be rebranded to the Patient Experience Team and the launch will take place over the next quarter. The Patient Relations Team will be referred to as the Patient Experience Team within this document.

The Patient Experience Team establishment is under review, 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.

The new Head of Patient Experience (HoPE) commenced in post on the 4th July 2022 and will provide leadership, direction and oversight to the Patient Experience Team.

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. Report was noted at EDG on 18 August 2022.

2.4 Recommendation

Clinical Governance Committee is asked to take assurance from the report.

Report Contact

Author: Siobhan McIlroy
Email: Siobhan.mcilroy@nhs.scot

Patient Experience and Feedback

Recovery and Improvement Plan

July 2022

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	31/5/22	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 09/08/22, 73 (37%) stage 2 complaints are outstanding awaiting statement returns Reviewing statement memo with aim to reduce duplication, streamlining process and improving quality	In progress

1.8	Analyse data from process mapping exercises and agree improvement trajectory with services	PR Lead / HoPE	30/6/22	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.	In progress
1.9	Establish focus groups to discuss complaints management with services	PR Lead / HoPE	30/6/22	Initial induction meetings have taken place with HoPE and several HoN and ADoN's.	In progress

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	1/8/22	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	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	1/5/22	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.	In progress
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	8/6/22	Data systems are currently in place to gather this data. Further work to be done to enhance quality of data	In progress
2.5	Develop criteria against which quality of statements are assessed	PR Lead	22/4/22		Not started

2.6	Develop criteria against which quality of draft responses are assessed	PR Lead	22/4/22		Not started
2.7	Develop criteria against which complaints are assessed as being upheld, not upheld or partially upheld	PR Lead	22/4/22		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	22/3/22	Process mapping to be arranged	In progress
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	1/5/22	Outcomes being reviewed and recommendations considered	In progress
3.4	Benchmark complaints management teams / processes across other Boards and public sector agencies	PR Lead	1/5/22	Ongoing contact to be made with all Boards to review establishments, documentation and processes	In progress
3.5	Process mapping analysis to elicit gaps, duplication, more efficient way of working	PR Lead	22/4/22	Process mapping underway with Quality Improvement project manager	In progress
3.6	Proactively seek feedback from complainants re the complaints handling process (as per KPI) (will also support QI)	PR Lead	22/4/22	Questionnaire sent with all final response letter as of 1/4/2022	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 IT solutions (text, apps etc.)	In progress

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	1/6/22	OLG in early stages of development. ADoN co-Chair. Systems and processes being worked through	In progress
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	1/5/22	Identify ToCs following review of outcomes and recommendations from process mapping	Not started
4.4	Ensure feedback loop with services	PR Lead	1/5/22	Processes to ensure effective feedback to be indentified	Not started
4.5	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	Not started

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	22/4/22	First ‘Spaces for listening’ session took place with Chaplain Service in July. Enquire about additional ‘Spaces for listening’ sessions	In progress
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	1/5/22	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	1/5/22	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	1/5/22	Ongoing literature search for coding and categorization of complaints	In progress
5.7	Measure workload to support workforce planning	PR Lead	1/5/22	HoPE to confirm progress with PR Lead Ongoing review of caseloads, roles and responsibilities	In progress
5.8	Review of PR team roles and responsibilities	HoPE / PR Lead	30/11/22	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	In progress
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 with in establishment and will soon advertise an interim Band 4 PR Support Officers post	In progress
5.10	Rebranding of Team	HoPE / PR Lead	30/11/22	Launch rebranding of Patient Relations Team to Patient Experience Team	Not started

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**2 September 2022**
Title:	**Nursing, Midwifery, Allied Health Professionals – Professional Assurance Framework**
Responsible Executive:	**Janette Owens, Director of Nursing**
Report Authors:	**Nicola Robertson, Associate Director of Nursing** **Aileen Lawrie, Associate Director of Midwifery** **Amanda Wong, Director of AHPs**

1 Purpose

This is presented to the Clinical Governance Committee for:

- Assurance

This report relates to a:

- Government policy / directive
- Legal requirement
- Local policy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The Professional Assurance Framework (PAF), which was developed in 2018 and based on the Nursing and Midwifery Professional Assurance Framework for Scotland (2014), sets out how the Director of Nursing provides assurance to NHS Fife Board on the quality and professionalism of nursing, midwifery and allied health professions care. It was updated and submitted to EDG and the Clinical Governance Committee in 2020. This iteration of the Framework has been reviewed and incorporates references to new strategies and an update on Excellence in Care.

The framework provides evidence that structures and processes are in place to provide the right level of scrutiny and assurance across all nursing, midwifery and AHP services.

2.2 Background

Accountability for the quality of nursing, midwifery and AHP care is devolved to the Board Director of Nursing to ensure there is clarity of professional responsibility and robust accountability structures for professional nurses, midwives and AHPs.

The Framework applies to all nurse, midwife and allied health professional registrants, irrespective of their grade or seniority. It is closely aligned with the statutory regulatory frameworks and professional guidance that underpin nursing, midwifery and allied health professional practice. Crucially, it enables nurses, midwives and AHPs to carry out their clinical responsibilities confident in their knowledge of accountability both for their actions and those actions which they have delegated to others.

2.3 Assessment

The Assurance Framework, which has been set out in the format of a Driver Diagram (logic model), aims to ensure that there are:

'*Explicit and effective lines of accountability from the care setting to the NHS Board and through to the Chief Nursing Officer which provide assurance on standards of care and professionalism'.*

The building blocks to meeting the aim are provided as a series of Primary Drivers. Core specific actions, systems and processes needed to meet each Primary Driver are set out in separate sections.

PRIMARY DRIVER NO 1:
'Practitioners are equipped, supervised and supported according to regulatory requirements'

PRIMARY DRIVER NO 2:
'Dispersed professional leadership focuses on outcomes and promotes a culture of parity and respect'

PRIMARY DRIVER NO 3:
'There is clear accountability for standards and professionalism at each level to the NHS Fife Board and Scottish Government'

PRIMARY DRIVER NO 4:
'NHS Fife Board has a clear understanding about the quality of the nursing, midwifery and AHP services'

The PAF can be used in the following ways:

- To confirm there is a system of assurance in place for which the Chief Executive is ultimately accountable
- Review and strengthen what is already in place in relation to nursing, midwifery and allied health professional roles and practice, leadership, governance and reporting arrangements and highlight where improvements are required
- Clarify what is expected of nurses, midwives and AHP professional leaders and operational managers
- Provide guidance on what should be in place in organisational structures
- Reinforce the importance of professional conduct and competence during appraisal, personal development and review processes
- Assist managers and practitioners in ensuring that appropriate professional attitudes and behaviours are identified and in taking supportive and remedial action where required.

2.3.1 Quality / Patient Care

The Framework applies to all nurse, midwife and allied health professional registrants. It enables nurses, midwives and AHPs to carry out their clinical responsibilities confident in their knowledge of accountability, supporting excellence in person-centred care.

2.3.2 Workforce

The Framework encompasses Health and Care (Staffing) (Scotland) Act, leadership development, performance appraisal and delegation of duties.

2.3.3 Financial

Robust management of workforce planning and review, will support financial governance

2.3.4 Risk Assessment/Management

The Framework confirms that there is a system of assurance in place.

2.3.5 Equality and Diversity, including health inequalities

The Framework ensures that processes are in place to provide assurance across all services, promoting equality and diversity agenda.

2.3.6 Other impact

The Framework assists managers and practitioners in ensuring that appropriate professional attitudes and behaviours are identified and in taking supportive and remedial action where required, to ensure that the people of Fife can expect the highest standard of person-centred care

2.3.7 Communication, involvement, engagement and consultation

The Professional Assurance Framework was launched at a NMAHP event in 2018. It is anticipated that a relaunch will take place when system pressures allow.

2.3.8 Route to the Meeting

- Associate Directors of NMAHPs meeting. Report was also considered at EDG on 18 August 2022.

2.4 Recommendation

- **Assurance**

Report Contact
Janette Owens, Director of Nursing
janette.owens@nhs.scot

NHS Fife

NURSING, MIDWIFERY

ALLIED HEALTH PROFESSIONS

PROFESSIONAL ASSURANCE FRAMEWORK

2022 - 2023

CONTENTS

- **'NHS Fife Board'** is used throughout this document , referring to Acute Services, Corporate Services and the Health and Social Care Partnership
- **'NHS Fife Executive Director of Nursing'** is used throughout this document , denoting 'NHS Fife Board Director of Nursing, Midwifery and Allied Health Professions'

Version Control: 23.06.22 Review V 2.0

1. INTRODUCTION

Nurses, Midwives and Allied Health Professionals[1](AHPs) working in NHS Scotland perform their roles in a diverse range of settings. Many of these staff are hospital based while a significant number work in community settings or in people's own homes. The organisational context in which nurses, midwives and AHPs fulfil their roles is complex. Lines of accountability can be convoluted and often span organisational boundaries. Fostering team working is equally important as developing the roles of any one professional group[2].

NHS Boards have corporate accountability for maintaining and improving the quality of services in the form of clinical governance[3]. The question is, how can they be assured of the quality of the nursing, midwifery and AHP services?

Accountability for the quality of nursing, midwifery and AHP services is devolved to Executive Nurse Directors to ensure there is clarity of professional responsibility and robust accountability structures for nurses, midwives and AHPs. This is likely to be most needed in times of significant organisational and structural change and in the commissioning of nursing, midwifery and AHP services, when patients, families and service users may be more at risk if responsibilities for tasks and care are unclear. It is particularly pertinent because of the impact of the COVID-19 pandemic on healthcare delivery.

Individually, nurses and midwives are professionally accountable to the Nursing and Midwifery Council (NMC) and AHPs to the Health and Care Professionals Council (HCPC) but they also have a contractual accountability to their employer and are accountable in law for their actions[4]. This is the position irrespective of the setting and context within which these staff perform their roles.

This Framework, based on the Nursing and Midwifery Professional Assurance Framework for Scotland (2014), sets out how NHS Fife Executive Director of Nursing provides assurance to the NHS Fife Board on the quality and professionalism of nursing, midwifery and AHPs. The framework provides evidence that structures and processes are in place to provide the right level of scrutiny and assurance across all nursing, midwifery and AHP services. The Professional Assurance Framework and the systems in place to demonstrate assurance in Fife is shown in Appendix 2.

1.1 THE PROFESSIONAL ASSURANCE FRAMEWORK IN CONTEXT

Taking a wider perspective, nurses, midwives and AHPs are fundamental to Scottish Government's ambitions for NHS Scotland to be a world leader in healthcare quality. As of March 2022, the NHS in Scotland employs 70,971 nurses, 3,845 midwives and 15,023 AHPs[5]. (The NHS in Fife employs 4,349nurses, 290 midwives and 828 AHPs as of March 22. They work across fourteen regional NHS Boards, seven special health boards[6] and one public health body[7].

[1] The term Allied Health Professionals (AHPs) has been used throughout this document and is reflective of a broad range of professions which are described in Appendix 1

[2] Kings Fund (2013), Making Integrated Care Happen at Scale and Pace, The Kings Fund London

[3] RCN (2013) Clinical Governance, Available online http://www.rcn.org.uk/development/practice/clinical_governance

[4] NMC (2018) Regulation in Practice, Available Online https://www.nmc-uk.org/Nurses-and-midwives/Regulation-in-practice/

[5] ISD Nursing and Midwifery AHP Workforce Statistic June 2017 Available online http://www.isdscotland.org/Health-Topics/Workforce/Nursing-and-Midwifery/ http://www.isdscotland.org/Health-Topics/Workforce/Allied-Health-Professionals/

[6] NHS in Scotland Available online http://www.scotland.gov.uk/Topics/Health/NHS-Workforce/NHS-Boards

The NHS in Fife employs 4,349nurses, 290 midwives and 828 AHPs as of March 22. Each NHS Board is accountable to Scottish Ministers, supported by the Scottish Government Health and Social Care Directorates.

The Scottish Government Health and Social Care Directorates oversees NHS Scotland on behalf of Scottish ministers. The Chief Nursing Officer (CNO) for Scotland is the Board member with overall responsibility for nursing, midwifery and allied health professionals. The CNO and a team of professional advisors including the Chief Midwifery Advisor and Chief Allied Health Professions Officer work in partnership with Executive Nurse Directors to ensure the highest standards of nursing, midwifery and allied health professional care in Scotland. The Healthcare Quality Strategy (2010) has inspired NHS Scotland to work towards a shared vision of world-leading, safe, effective and person-centred healthcare.

Since the launch of the Quality Strategy, the Scottish Government set out the 2020 Vision and Strategic Narrative for achieving sustainable quality in the delivery of health and social care [8]across Scotland.

This Framework, as well as assuring NHS Fife Board, demonstrates to Scottish Government how NHS Fife's nurses, midwives and allied health professionals are meeting the ambitions to provide highly integrated, person-centred care as set out in the Public Bodies, (Joint Working) (Scotland) Act 2014[9].

2. WHY IS THIS PROFESSIONAL ASSURANCE FRAMEWORK NECESSARY?

A number of demographic and environmental changes have influenced a shift in the delivery of health and social care. These are well articulated in other documents and it is not the intention to repeat them here. However, in setting the context for this Assurance Framework, three of these have specific relevance and should be regarded as underpinning documents. These are the Joint Declaration on Nursing Midwifery and AHP Leadership[10], the Chief Nursing Officer's paper on Professionalism in the NMAHP professions in Scotland[11] and the Clinical and Care Governance Framework (2015)[12]. The Transforming Nursing Roles Programme, which commenced in 2016, provides an education framework for the development of the nursing, midwifery and health professions (NMaHP) and their contribution to the wider transformational change agenda in health and social care in Scotland.

2.1 THE INTEGRATION OF HEALTH AND SOCIAL CARE

The Public Bodies (Joint Working) (Scotland) Act 2014 introduced a significant programme of reform affecting most health and care services. The integration of health and social care has been a Scottish Government imperative for over 20 years.

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[7] Healthcare Improvement Scotland Available online http://www.healthcareimprovementscotland.org/welcome_to_healthcare_improvem.aspx

[8] Scottish Government 2020 Vision available online http://www.scotland.gov.uk/Topics/Health/Policy/2020-Vision

[9] the Public Bodies, (Joint Working) (Scotland) Act 2014 (revised) https://www.legislation.gov.uk/asp/2014/9/contents

[10] NHS Scotland Joint Declaration on NMAHP Leadership 2010 http://www.knowledge.scot.nhs.uk/media/CLT/ResourceUploads/1005857/Joint_Declaration_-_final.pdf

[11] Scottish Government (2012) Professionalism in nursing, midwifery and the allied health professions in Scotland http://www.scotland.gov.uk/Publications/2012/07/7338

[12] Scottish Government (2015), Clinical and Care Governance Framework http://www.gov.scot/Resource/0049/00491266.pdf

In light of the significant organisational and structural change, the need for rigorous governance with unquestionable clarity around accountability and responsibility is imperative.

2.2 THE VALE OF LEVEN HOSPITAL INQUIRY REPORT

The Vale of Leven Hospital Inquiry Report 2014[13] was a landmark publication for NHS Scotland with widespread implications for all NHS Boards. Of the 75 recommendations (65 for NHS Boards), many of which implicated nursing care, the report specifically recommended that Health Boards should ensure that there is a clear and effective line of professional responsibility between the ward and Board. One of the key recommendations was to create an assurance system (Excellence in Care (EiC)) that demonstrates the implementation of the 65 recommendations. The aim is that all NHS Boards and Integrated Joint Boards will have consistent and robust processes and systems for measuring, assuring and reporting on the quality of nursing and midwifery care and practice. The EiC programme was not progressed as quickly as originally intended because of COVID-19 but has been relaunched in 2022. The EiC framework signals a move away from retrospective evaluation of the quality and care experiences of patients and moves towards interactive, real-time engagement with patients to understand care needs and how well we are meeting those needs.

The Francis Report [14] was a landmark publication for NHS England with implications for the rest of the UK. Among the many recommendations the Report called for a stronger nursing voice in safeguarding acceptable standards of care. It called for fundamental standards, clearer accountability, simplified regulation and more effective external scrutiny. Executive Nurse Directors must balance empowering facilitative leadership with absolute clarity in roles, accountabilities and expectations.

3. WHO IS THE PROFESSIONAL ASSURANCE FRAMEWORK FOR?

This Framework applies to all nurse, midwife and allied health professional registrants, irrespective of their grade or seniority. It is closely aligned with the statutory regulatory frameworks[15],[16] and professional guidance that underpin nursing, midwifery and allied health professional practice. Crucially, it will enable nurses, midwives and AHPs to carry out their clinical responsibilities confident in their knowledge of accountability both for their actions and those actions which they have delegated to others.

The Framework also has wider applicability to those responsible for clinical services and the quality of care delivered to patients/clients. This may be within the NHS but also in settings where staff from different organisations work together with a manager who may be from a different professional group or a non-clinical background. As a member of the Integrated Joint Board, the NHS Fife Executive Director of Nursing must ensure that all agencies in the Health and Social Care Partnership fulfil the responsibilities set out in the Assurance Framework. In fulfilling their role in multi-agency settings, the NHS Fife Executive Director of Nursing must have access to people and information from across the NHS and the local authority, partner services and agencies where nurses, midwives and allied health professionals perform their roles.

[13] The Vale of Leven Hospital Inquiry Report 2014 http://www.valeoflevenhospitalinquiry.org/Report/j156505.pdf
[14] The Francis Report http://www.midstaffspublicinquiry.com/
[15] NMC Code https://www.nmc.org.uk/standards/code/ https://www.nmc.org.uk/standards/professionalism/
[16] Midwives Rules & Standards

4. COMPONENTS OF THE PROFESSIONAL ASSURANCE FRAMEWORK

The Assurance Framework, which has been set out in the format of a Driver Diagram (logic model), aims to ensure that there are:

'*Explicit and effective lines of accountability from the care setting to the NHS Board and through to the Chief Nursing Officer which provide assurance on standards of care and professionalism'.*

The building blocks to meeting the aim are provided as a series of Primary Drivers. Core specific actions, systems and processes needed to meet each Primary Driver are set out in separate sections. The Primary Drivers and the rationale behind them are summarised below. **The local application of the driver diagram is shown in Appendix 3.**

4.1 PRACTITIONERS ARE EQUIPPED, SUPERVISED AND SUPPORTED ACCORDING TO REGULATORY REQUIREMENTS

The building blocks to effective systems of assurance starts where caring takes place - at the interface between practitioners and the people they serve. As such practitioners must be fully equipped, supported and supervised. The Framework sets out what is needed in this respect and explains how to provide assurance that systems are in place and working effectively.

4.2 THERE IS DISPERSED LEADERSHIP WHICH FOCUSES ON OUTCOMES AND PROMOTES A CULTURE OF MULTI-PROFESSIONAL PARITY AND RESPECT

Executive Nurse Directors are professionally accountable for the quality of the nursing, midwifery and AHP services provided in Fife. Given the size and complexity of the organisation, they must extend their span of clinical governance and professional influence through a dispersed and devolved professional leadership structure. Hierarchies can be constraining but equally there must be easy access to professional leadership, advice and support for operational managers at the different levels throughout the organisation.

The professional leaders selected for these roles must be able to foster and demonstrate effective team working through a mutual respect for the contribution of other professional groups and agencies. The focus must be on achieving health and social care outcomes as well as the ones that matter to the people served. An effective nursing, midwifery and AHP leadership structure can be likened to the weave of a fabric that can be tightened or loosened depending upon the circumstances and the capability of the leaders that occupy professional leadership roles. It must set clear parameters but also empower.

4.3 THERE IS CLEAR ACCOUNTABILITY FOR STANDARDS AND PROFESSIONALISM AT EACH LEVEL AND UPWARDS TO NHS FIFE BOARD

As well as structures there must be clearly defined roles and accountabilities in terms of the uniqueness of registered nurse, midwife or AHP roles particularly where they overlap.

Practitioners and professional leaders must understand what is expected of them, how to fulfil these expectations and how to provide assurance on their effectiveness. Non-clinical managers must also be clear about what is expected when nurses, midwives and AHPs report to them in a line management capacity. Similarly, nurses, midwives and AHPs should be clear on the supervision requirements of non-nursing, midwifery or AHP staff for whom they may be accountable for.

4.4 NHS FIFE BOARD HAS A CLEAR UNDERSTANDING ABOUT THE QUALITY OF THE NURSING, MIDWIFERY AND AHP SERVICE

The final building block in this Framework is that, for NHS Fife Board to be fully accountable, it must have a clear understanding about the quality of the nursing, midwifery and allied health professional service provided in its area. Crucially there must be transparency. A combination of retrospective and real time data should be used to provide assurance that systems and processes are in place and working effectively.

Both the NMC and HCPC have robust processes in place for ensuring nurses, midwives (NMC) and AHPs (HCPC) are fit to practice.

5. WHAT THE PROFESSIONAL ASSURANCE FRAMEWORK WILL DO

The Assurance Framework will be used in the following ways:

- To confirm there is a system of safeguarding in place for which the Chief Executive is ultimately accountable
- Review and strengthen what is already in place in relation to nursing, midwifery and AHP roles and practice, leadership, governance and reporting arrangements (see appendices 4 and 5)
- Highlight where improvements are required
- Clarify what is expected of nurses, midwives and AHP professional leaders and operational managers
- Provide guidance on what should be in place when setting up new organisational structures
- Reinforce the importance of professional conduct and competence during appraisal, personal development and review processes
- Assist managers and practitioners in ensuring that appropriate professional attitudes and behaviours are identified and in taking supportive and remedial action where required.

6. PROFESSIONAL REQUIREMENTS

As an aid to using the Professional Assurance Framework some of the underlying concepts are clarified below.

6.1 ACCOUNTABILITY AND RESPONSIBILITY

The terms 'responsibility' and 'accountability' should not be used interchangeably. The Scottish Government Health Directorates' paper on Professionalism defines these terms as follows:

- **Responsibility** can be defined as a set of tasks or functions that an employer, professional body, court of law or some other recognised body can legitimately demand.

- **Accountability** can be defined as demonstrating an ethos of being answerable for all actions and omissions, whether to service users, peers, employers, standard-setting/regulatory bodies or oneself.

6.2 SCOPE OF PRACTICE

Nurses, midwives and AHPs must work within the parameters of their designated role, their education/training and capability.
For nurses and midwives, guidance on this is in the 'NMC Code'.
For AHPs both the HCPC and the individual professional bodies have guidance on scope of practice: 'Standards of conduct, performance and ethics' [17]

6.3 DELEGATION

If a registered practitioner delegates a task, then that practitioner must be sure that the delegation is appropriate. This means that the task must be necessary; and the person performing the delegated task, for example a Support Worker or student, must understand the task and how it is performed, have the skills and abilities to perform the task competently and accept responsibility for carrying it out.

Apart from a number of specific circumstances, the law does not prescribe which tasks are suitable for particular healthcare personnel. However, it does provide a crucial regulatory framework that applies to every individual practitioner, irrespective of their rank or role. The law imposes a duty of care on practitioners, whether healthcare support workers, registered nurses, midwives or allied health professionals, in circumstances where it is 'reasonably foreseeable' that they might cause harm to patients through their actions or their failure to act. If these conditions have been met and an aspect of care is delegated, the delegatee becomes accountable for their actions and decisions. However, the nurse, midwife or AHP remains accountable for the overall management of the person in their care, and cannot delegate this function or responsibility.

Where another, such as an employer, has the authority to delegate an aspect of care, the employer becomes accountable for that delegation. In accordance with the NMC Code, HCPC Standards of conduct, performance and ethics, the nurse, midwife or AHP must act without delay if they believe a colleague or anyone else may be putting someone at risk.

7. CONCLUSIONS

The requirement for nursing and midwifery and AHP professional accountability remains the same no matter where they work or who they work with. In times of organisational change and upheaval it is possible to lose sight of this. Previously accepted norms deconstruct and professional identity is challenged. Sometimes such challenge is appropriate to enable progress to be made, but the four primary drivers set out in this Framework are fundamental to assuring professional nursing, midwifery and AHP practice in Scotland. They must not be eroded or compromised.

There is undoubtedly rugged terrain to navigate as NHS Fife works more formally with other NHS Boards in the East Region and agencies to build new relationships and working practices in pursuit of integrated care. Nurses, midwives and AHPs need to feel confident that their organisation understands what is required of them to meet their codes of professional conduct, indeed to work within the law. Aa human level, it is often only when there are clear parameters and a concordance in approach that people feel confident enough to innovate and flourish.

[17] HCPC Standards of conduct, performance and ethics http://www.hcpc-uk.org/aboutregistration/standards/standardsofconductperformanceandethics/

APPENDIX 1

THE ALLIED HEALTH PROFESSIONS COMPRISE OF THE FOLLOWING DISCIPLINES; EACH HAS ITS OWN PROFESSIONAL BODY WHICH PROVIDES A WIDE RANGE OF SERVICES TO ITS MEMBERS AND FOR THE PROFESSION	
PROFESSION	**PROFESSIONAL BODY**
Arts Therapists use art, dance, drama and music as a therapeutic intervention to assist people with physical, mental, social and emotional difficulties. There are 4 distinct therapies with the preferred name of art therapy/art psychotherapy; dance-movement psychotherapy; dramatherapy; music therapy.	*The British Association of Art Therapists* *Association of Dance Movement Psychotherapy* *The British Association of Drama Therapists* *The British Association of Music Therapists*
Diagnostic radiographer employ a range of imaging techniques to produce high quality images of injury or disease, often interpreting them so that correct treatment can be provided	*The Society and College of Radiographers*
Dietitians translate the science of nutrition to assess, diagnose and treat diet and nutrition problems at an individual and wider public health level. They work with people to promote nutritional wellbeing, prevent food-related problems and treat disease.	*British Dietetic Association*
Occupational therapists enable services users to participate in activities of daily living by modifying the occupation or environment to better support their occupational engagement.	*Royal College of Occupational Therapists*
Orthoptists assess and manage a range of eye movement disorders and defects of binocular vision.	*The British and Irish Orthoptic Society*
Orthotists design, manufacture and apply devices such as braces, splints and specialist footwear to help people with movement difficulties and to relieve discomfort	*The British Association of Prosthetists and Orthotists*
Physiotherapists help people affected by injury, illness or disability through movement and exercise, manual therapy, education and advice.	*The Chartered Society of Physiotherapists*
Podiatrists assess the vascular, neurological and orthopaedic status of the patient's lower limbs to diagnose and treat diseases and conditions of the feet	*The Society of Chiropodists and Podiatrists*
Speech and language therapists work with children and adults who have problems with speech, language, communication and swallowing difficulties	*The Royal College of Speech and Language Therapists*
Therapeutic radiographers plan and deliver radiotherapy in the treatment of cancer, providing care and support for service users throughout their treatment.	*The Society and College of Radiographers*

NURSING, MIDWIFERY AND ALLIED HEALTH PROFESSIONALS
PROFESSIONAL ASSURANCE FRAMEWORK: FROM CARE SETTING TO NHS FIFE BOARD

Aim	Primary Drivers	Secondary Drivers
Explicit and effective lines of accountability from the care setting to the NHS Fife Board and through to the CNO which provide assurance on standards of care and professionalism	**1. Practitioners are equipped, supervised and supported according to regulatory requirements**	Each registered practitioner meets professional regulatory (NMC/HCPC) requirements Staff with the right skills and values are recruited in line with NMC/HR requirements Staff undertake mandatory training and continuing professional development activities Staff are managerially supervised and formally appraised Staffing levels are informed by local & National Workforce and Workload Planning tools There is an underpinning agreement with relevant Further and Higher Education Institution to govern student placements Continuing 'fitness to practice' requirements are fully met
	2. Dispersed professional leadership focuses on outcomes and promotes a culture of interagency parity and respect	A team culture of collaboration is the norm through cross-professional/agency formal education and development Staff have the interpersonal skills and leadership ability to engage constructively in multi-agency partnership to achieve outcomes The unique contribution and accountability of professional roles in integrated care settings is clear Staff understand and have easy access to guidance on their professional accountability in multi-agency teams where role blurring is expected Staff have access to formal supervision to discuss professional practice
	3. There is clear accountability for standards and professionalism at each level to the NHS Fife Board and Scottish Government	Senior professional leaders are engaged in all decisions affecting Nurses, Midwives and AHPs An escalation process is in place to raise issues of concern Vacancy levels, reasons for absence and temporary staffing-use are monitored A process measurement is used to demonstrate/improve caring behaviors A summary of learning and improvement from quality measures such as indicators, complaints and critical incident investigations are made available There is a system in place for operational and professional managers to jointly review data
	4. NHS Fife Board has a clear understanding about the quality of the nursing, midwifery and AHP services	There is a direct reporting link from each level through to the NHS Fife Executive Director of Nursing The NHS Fife Executive Director of Nursing is aware of areas of concern and seeks further assurance and improvement The Executive NMAHP Council (ENMAC) supports the NHS Fife Executive Director of Nursing and models effective professional leadership Retrospective and 'real time' performance data is reviewed at NHS Board level There is a reporting and escalation mechanism in place for professional assurance to the CNO acting on behalf of the named government minister

HOW WE PROVIDE ASSURANCE TO NHS FIFE BOARD

PRIMARY DRIVER 1: Practitioners are equipped, supervised and supported according to regulatory requirements

Steps to Meeting Secondary Drivers	Assurances in place
➢ Practitioners work to NMC Code / HCPC Standards of conduct, performance and ethics ➢ An up-to-date record is held of each practitioner's registration details ➢ A senior nurse /midwife/AHP is involved in the recruitment of all nurses, midwives or AHPs ➢ Professional values and attitudes are explicitly assessed as part of the interview process (values based interviews). ➢ Each practitioner holds their own training record and understands their responsibility along with their manager for meeting mandatory training requirements ➢ Performance appraisal is undertaken by operational line managers. A senior NMAHP must be involved in the appraisal meeting if the line manager is not employed as a Registered NMAHP. ➢ Practitioners have access to a professional supervisor (mandatory in professionally isolated multi-agency settings) ➢ Inter-agency / cross-professional formal education and development is monitored through governance arrangements ➢ Implementation of NES and NMC quality standards ➢ Nursing and midwifery staffing levels are informed by HSP workforce and workload planning tools ➢ Compliance with the Health and Care (Staffing) (Scotland) Act 2019 implementation timetable	✓ All Fitness to Practice referrals are made online and advised to the NHS Fife Executive Director of Nursing's office to ensure they are fully aware of all referrals ✓ NMC and HCPC Registration data (websites) ✓ Revalidation process ✓ Recruitment monitoring data ✓ Performance appraisal records ✓ Personal Development Planning and Review (PDR) statistics (including extent to which actions identified and agreed upon during PDP/PDR processes have been progressed and completed) ✓ Individual learning and development records ✓ Method and capacity to provide and monitor uptake of professional supervision ✓ Practice Education Facilitator (PEF) reporting; NES performance management reports: NMC validation and monitoring reports ✓ Mandatory training records ✓ HSP tools are run on, at least, an annual basis with workforce reports prepared for Staff Governance Committee, Executive Directors Group (EDG), Integrated Joint Board (IJB) and NHS Fife Board ✓ HSP tools are used in redesign projects ✓ Escalation processes in place to manage staffing levels

PRIMARY DRIVER 2: Dispersed professional leadership focuses on outcomes and promotes a culture of inter-agency parity and respect

Steps to meeting Secondary Drivers	Assurances in place
➢ Senior practitioners have access to leadership development in partnership working and leading across organisational boundaries ➢ Protocols are in place to support and advise practitioners on delegation of clinical and non-clinical activities within the NHS and in multi-agency settings ➢ A senior nurse/midwife/AHP agrees staffing levels/skill mix with operational managers informed by local and national tools ➢ An explicit decision-making process underpins which professional is most appropriate to provide specific aspects of care based on assessed need and person-centred outcomes. ➢ An independent and objective senior nurse /midwife/AHP sits on disciplinary panels when professional conduct /competence is an issue ➢ An independent and objective senior nurse /midwife/AHP sits on capability panels when professional competence / capability is an issue ➢ A system is in place to enable all staff to raise a concern if they are asked to undertake a task for which they do not feel competent ➢ Senior practitioners have professional support and training in order to be able to engage constructively in multi-agency partnership supervision of nurses, midwives & AHPs	✓ Nursing and Midwifery and AHP profession specific leadership and professional reporting structure (see Appendix 4) ✓ % staff undertaking multi-agency leadership development programmes ✓ Compliance with protocols on: • role clarity • delegation principles in multiagency settings • professional accountability and reporting processes ✓ Use of NMWWPP tools ✓ Implementation of Health Care Staffing legislation ✓ Patient record audits (outcome data) ✓ Patient feedback data ✓ Staff feedback data ✓ Staff absence data ✓ Staffing establishments and vacancy levels ✓ Staff Experience data ✓ Launch of Leading Excellence - focus on Band 6 and Band 7 ✓ Nursing Midwifery Leadership Group (NMLG)monthly meetings with Executive Director of Nursing ✓ Nursing Leadership Team: focus on Associate Directors, Head of PPD: monthly meetings ✓ ADoNs have a structure for professional engagement with nursing at all levels (e.g. HoN meeting, Lead Nurse/CNM/CMM meetings, SCN/M meetings) ✓ DoAHPs has a structure for professional engagement across AHP services

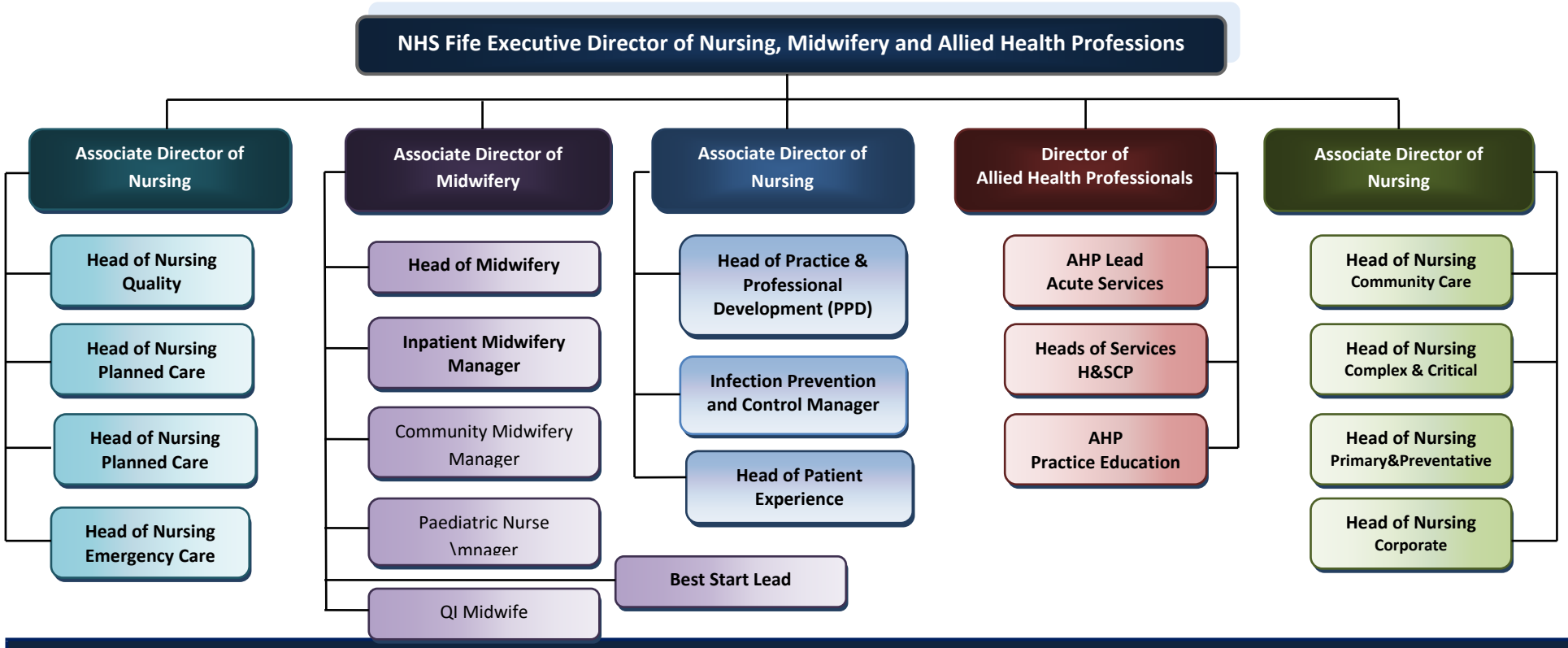
PRIMARY DRIVER 3: There is clear accountability for standards and professionalism at each level to NHS Fife Board

Steps to Meeting Secondary Drivers	Assurances in place
➢ There is a formal system for involving the senior nurse / midwife/AHP in professional issues involving nurses, midwives and AHPs e.g. HR issues, the workforce and clinical governance implications of service design/redesign ➢ The senior nurse/midwife/AHP reviews workforce data with operational managers e.g. actual against proposed skill mix, vacancies, absence rates ➢ A measure is used to demonstrate / improve professional caring behaviors ➢ Summaries of learning and improvement from quality measures (such as quality indicators, complaints and critical incident investigations) are used for organisational learning and are embedded within governance structures ➢ A recognised and well-publicised escalation process is in place to ensure nurses, midwives and AHPs are able to bring concerns to the attention of professional NMAHP leads / senior managers and that they receive feedback ➢ PIN Guidelines and Policies underpin practice	✓ Workforce data e.g. skill mix reviews, staff vacancies, temporary staffing use (agency and bank) ✓ Core mandatory quarterly attendance statistics, capability, disciplinary and grievance data ✓ Risk management reports ✓ Critical incident review reports (SAER/LAER) ✓ Care Assurance Audit ✓ Nursing and Midwifery Balanced Scorecard ✓ CAIR (Excellence in Care Dashboard) ✓ Escalation reports and outcomes ✓ Learning summaries from SAERs/LAERs

PRIMARY DRIVER 4: NHS Fife Board has a clear understanding about the quality of the nursing, midwifery and AHP services

Steps to Meeting Secondary Drivers	Assurances in place
➢ There is a formal system for reporting to the NHS Fife Executive Director of Nursing on professional issues involving nurses, midwives and AHPs ➢ A quality report is made to the NHS Fife Board via relevant governance structures which triangulates indicators of workforce and professionalism with relevant aspects of scrutiny and review reports and demonstrates evidence of the learning and continuous improvement arising from these. ➢ There is a reporting and escalation mechanism in place for professional assurance to the CNO acting on behalf of the named government minister	✓ NHS Fife Integrated Performance and Quality Report ✓ Independent scrutiny reports, action plans and progress reports ✓ Ombudsman reports ✓ Complaints, compliments and critical incident statistics and reports (including reports of near misses) ✓ Nursing, Midwifery & AHP Workforce reports ✓ Records of referrals to NMC and HCPC and outcome of investigations and hearings. ✓ Pre and Post Registration Education Placement Audit reports ✓ Patient feedback data ✓ Staff feedback data ✓ Nursing and Midwifery Balanced Scorecard ✓ CAIR (Excellence in Care Dashboard ✓ Risk management data (e.g. DATIX reports) ✓ Specific Scottish Patient Safety Programme indicators ✓ Healthcare Improvement Scotland inspection reports and audits

NURSING, MIDWIFERY AND ALLIED HEALTH PROFESSIONALS PROFESSIONAL ACCOUNTABILITY STRUCTURE



Professional Lead for NMAHPs employed in the following services / teams				
• Emergency Department • Critical Care • Theatres • Renal • Medical • Surgical • Medicine of Elderly	• Inpatient Midwifery • Community Midwifery • Children's (Acute) • Neonates	• PPD • IPC • Patient Relations • Equality & Human Rights • Occupational Health • Research • Digital • Public Health	• Nutrition and Dietetics • Occupational Therapy • Orthoptists • Orthotics • Physiotherapy • Podiatry • Radiography • Speech and Language Therapy • Art Therapies	All nursing staff working within both inpatient and community services in the Health and Social Care Partnership e.g. : • Adult • Children's (Community) • Health visiting • Schools • Child protection • Mental health • Learning Disability • Specialist Services

NURSING, MIDWIFERY AND ALLIED HEALTH PROFESSIONALS: ROLES AND RESPONSIBILITIES

All Registrants	All NMC registrants must commit to uphold the standards outlined in the NMC Code which are a series of statements under the four headings of Prioritise People, Practice Effectively, Preserve Safety and Promote Professionalism and Trust. All HCPC registrants must commit to uphold the standards outlined in the HCPC Standards of conduct, performance and ethics (SCPE) which is the ethical framework within which HCPC registrants must work.
NHS Fife Executive Director of Nursing	The NHS Fife Executive Director of Nursing has a responsibility to the Board to provide robust evidence regarding professional nursing, midwifery and allied health workforce issues as well as intelligence on the quality of nursing, midwifery and AHP care so that the Board may make informed and sound decisions regarding quality assurance and patient safety. The evidence should also include issues regarding escalation so that the Board is sighted on the risks and challenges the organisation faces. In order to do this effectively, the NHS Fife Executive Director of Nursing is responsible for ensuring that there are robust and effective Ward to Board assurance processes in place that drives improvement in the quality of care delivered to patients and which addresses any identified suboptimal standards of care. The NHS Fife Executive Director of Nursing is responsible for ensuring that care provided to patients is of a high standard meeting national standards and statutory requirements.
Associate Directors of Nursing Associate Director of Midwifery Director of AHPs	The Associates/Directors are responsible for ensuring that the NHS Fife Executive Director of Nursing is able to fulfil her role at the Board. This includes ensuring that robust assurance processes are implemented and their effectiveness monitored. They hold delegated responsibilities from the NHS Fife Executive Director of Nursing They are responsible for ensuring that the NHS Fife Executive Director of Nursing is briefed about each clinical area and that items are escalated accordingly. The Associates/Directors are responsible for ensuring that care provided to patients is of a high standard meeting national standards and statutory requirements. Where significant quality issues are identified, the Associates/Directors will initiate processes, where appropriate, to enable a deep dive into the clinical area/ service and subsequent formulation of an improvement plan. The Associates/Directors will ensure that the NHS Fife Executive Director of Nursing is well briefed regarding any need to initiate quality review processes.
Heads of Nursing /Midwifery Midwifery Managers AHP Heads of Services Therapy Services Manager	The Heads of Nursing /Midwifery /Midwifery Managers / AHP Heads of Services/Therapy Services Manager are responsible for ensuring that care provided to patients is of a high standard meeting national standards and statutory requirements within their area. They are responsible for ensuring that the Associate Directors are briefed about each clinical area and that items are escalated accordingly.
Clinical Nurse Managers Lead Nurses Lead AHPs	The Clinical Nurse Managers / Lead Nurses / Lead AHPs are responsible for ensuring that care provided to patients is of a high standard meeting national standards and statutory requirements within their area. Where quality falls short of key performance indicators, the Clinical Nurse Managers / Lead Nurses / Lead AHPs should present improvement plans that address this variance and report progress, aligned to identified milestones, to their Head of Nursing / Midwifery Coordinators / AHP Heads of Services/Therapy Services Manager. The Clinical Nurse Managers / Lead Nurses / Lead AHPs should ensure that any lessons learnt from SAERs etc, are communicated to all staff in their area.
Senior Charge Nurses / Midwives Team Leaders	Senior Charge Nurses / Midwives / Team Leaders are responsible for ensuring that nursing, midwifery and AHP care and interventions provided to patients is of a high standard, meeting national standards and statutory requirements within their area. They are responsible for ensuring that the expected standards are effectively communicated to their teams and where deficits are identified, they are addressed through quality improvement mechanisms or relevant HR processes.

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting Date:	**Friday 2 September 2022**
Title:	**Occupational Health & Wellbeing Service Annual Report 2021/22**
Responsible Executive:	**Linda Douglas, Director of Workforce**
Report Author:	**Sue Ponton, Occupational Health and Staff Wellbeing Team Leader**

1. Purpose

This is presented to Clinical Governance Committee for:

- Assurance

This report relates to a:

- Local policy

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

- Safe, Effective and Person Centred

2. Report Summary

2.1 Situation

The report attached at **Appendix 1** provides an overview of the Occupational Health & Wellbeing Service's clinical and related activity for the period 1 April 2021 to 31 March 2022, including data compliance with Key Performance Indicators.

2.2 Background

The NHS Fife Occupational Health (OH) and Wellbeing Service (the Service) includes a comprehensive OH Service provision including Occupational Therapy expertise, Physiotherapy access, as well as access to a Mental Health Nurse Practitioner and Self Referral to Counselling for staff.

2.3 Assessment

This report provides the annual overview of the OH Service, describing the activity and functions, to satisfy the Clinical Governance Committee of the performance of the

Service and which will be used to demonstrate compliance with statutory requirements and to inform future governance activity, including formal accreditation plans.

Performance Monitoring

The Service's performance against Key Performance Indicators (KPIs) is reported on a rolling three-monthly basis and the current agreed KPI compliance rate is 95%. Performance is measured in terms of compliance with achieving 95% of management referral appointments offered within the agreed timeframes (10 days) and 95% reports dispatched following appointments (within 5 days). Comparative data with the previous year's activity has been included within the Appendices of the Annual Report.

The structure of the Annual Report is as follows:

- **Appendix 1** describes the functions of the Occupational Health and Wellbeing Service
- **Appendices 2a, 2b, 3a, 3b and 3c** relate to the data on Service delivered to / for NHS Fife and its employees.
- **Appendix 4** details the data in relation to the Services delivered to external organisations.

2.3.1 Quality / Patient Care

The Service contributes to promoting staff health and wellbeing creating a positive impact on employee wellness and attendance and therefore contributes to patient care.

2.3.2 Workforce

While the Occupational Health and Staff Wellbeing Service contributes to effective recruitment, to managing staff health at work, to health and safety in the workplace and through the additional OH Services available for staff support the ambition of NHS Fife being an exemplar employer, it is another area where supply and demand of staff is a resourcing challenge, with qualified OH practitioners for both nursing and medical posts being in short supply. Our succession planning in this area is key.

2.3.3 Financial

Effective OH input can support prevention of and a reduction in staff sickness absence, which in turn can have a positive impact on the direct and indirect costs of sickness absence.

2.3.4 Risk Assessment / Management

N/A

2.3.5 Equality and Diversity, including health inequalities

N/A

2.3.6 Other Impact

N/A

2.3.7 Communication, Involvement, Engagement and Consultation

This paper has been previously considered by the OH Management Team as part of its development and their feedback has informed the development of the content presented in this report.

2.3.8 Route to the Meeting

This paper has been previously considered by the Senior Workforce Leadership Team, and Executive Directors Group, as part of its development and their feedback has informed the development of the content presented in this report. The report will also be considered at the Staff Governance Committee meeting on 1 September 2022.

2.4 Recommendation

This paper is provided to Clinical Governance Committee members for:

- **Assurance** – Clinical Governance Committee members are invited to **note** the content of this report and the Occupational Health and Wellbeing Service Annual Report for 2021 / 2022.

3. List of Appendices

The following Appendix is included with this report:

- Appendix 1: Occupational Health and Wellbeing Service Annual Report for 2021/22

Report Contact:

Rhona Waugh
Head of Workforce Planning and Staff Wellbeing
Email: rhona.waugh2@nhs.scot

NHS Fife

Occupational Health and Wellbeing Service

Annual Report

2021 / 2022

Edition 02: 28 July 2022

Table of Contents

Foreword

This is the second annual report where the COVID-19 pandemic has brought the importance of staff health and wellbeing across the whole of the NHS into critical focus.

The demands on our Occupational Health and Wellbeing Service (the Service) in Fife have increased significantly since the outset of the COVID-19 pandemic and we wish to acknowledge and celebrate that the Service has continued to deliver a safe and effective Service to employees and managers during this period.

In addition to the efforts relating to the pandemic and recovery, the Service has continued to provide a responsive and resilient Service and has supported NHS Fife in meeting the legal responsibilities under the Health and Safety at Work etc. Act 1974, the COSHH Regulations (2002), communicable diseases screening and health surveillance.

Our Service continues to demonstrate innovation and commitment in meeting the occupational health needs of staff and managers and the requirements of NHS Fife. I am delighted that this report highlights the commencement of two new Services; the Occupational Health Mental Health Nurse Support Service and the Occupational Therapy Fatigue Management Service, both available to support staff to be well and get well.

I look forward to the Service continuing to support our staff as we adapt to the legacy of the pandemic and the potential impacts of Long COVID.

LINDA DOUGLAS
Director of Workforce
July 2022

Introduction

The report describes the comprehensive Occupational Health (OH) Service provided to NHS Fife and its employees.

The Service also delivers a comprehensive OH service to Fife General Practitioners and their staff in Fife (GPOH Service) and all Dental Practitioners and their staff and local Fife based Independent Pharmacies under other contractual agreements. A wide ranging defined Service is provided to Scottish Ambulance Service employees referred under an NHS Scotland Procurement 'Consortium' agreement; and by external contractual agreements with St Andrews University for their medical students, with Fife College for nursing students and for NHS Fife based employees of Equans (Estates Service contract).

Appendix 1 provides further details of the full range of Services provided by the OH Service.

Service Developments

Mental Health Support to Staff Service

The Mental Health Support to Staff Service (MHSS) within OH commenced in August 2020, to help staff who were experiencing deterioration within their mental wellbeing during the COVID-19 pandemic. However, as the pandemic progressed, there was a reduction in "COVID-19" being the reason for new referrals and the Service has since evolved, widening the scope for new staff referrals.

Staff supported by this Service are predominantly front line and usually require 3 sessions; occasionally only 2 sessions are required and for more complex conditions, these clients may require 4 sessions. There has been a steady turnover of caseload every 4-8 weeks, due to the light touch interventions Service and there have been no conflicts should the staff be engaging with counselling.

Occupational Therapy Fatigue Management Service

Occupational Therapy Fatigue Management Service (OTFM) commenced in June 2021 and aims to assist people who have experienced COVID-19 and as a consequence are experiencing fatigue impacting on their return to, or functioning at, work. To date this Service is continually evolving to meet the demands. The majority of individuals referred to the new Service require between 6-8 sessions of intervention and this is delivered via telephone, Near Me or Face to Face, as required.

Occupational Therapy (OT) Service

OT evaluations and interventions support an employee in performing their work duties safely with a reduced risk for aggravating their existing condition.

Key Activities

COVID-19 Pandemic Activity

2021-2022 remained an extremely busy time in the Service with models of Service delivery under regular reassessment in order to respond at pace to the needs of the organisation. Review of the Service identifies the impact COVID-19 work has on every aspect of occupational health activity: COVID-19 risk and assessment has to be considered routinely now as part of all usual management referrals, pre-placement assessments and all health-related queries. This often brought an extra level of complexity to the work undertaken which influenced the amount of time spent on each case by the OH clinician, which in turn has an influence on KPI achievement. Consequently the number of cases that are escalated to more senior/experienced OH staff increased.

Support to NHS Fife Committees and Groups

The Occupational Health and Wellbeing Service provides input to the Infection Prevention and Control Committee; Bacillus Calmette-Guerin (BCG) Implementation Group and Tuberculosis Multi-disciplinary Group both of which are recently re-established post pandemic.

Other Groups include: Skin Strategy Group; Occupational Health / HR Operational Group; Promoting Attendance Group; Wellbeing group; Nursing & Midwifery Workforce planning and Recruitment & retentions groups.

In addition, support is given via information, informal training and guidance to Departments, Directorates and Divisions on an 'ad hoc' basis.

Clinical Governance Activity

Agreed light touch clinical governance monitoring was implemented due to diverted efforts during the pandemic, with these were kept under review and internal measures have been reintroduced during the last quarter of 2021.

The Occupational Health & Wellbeing Service's clinical governance structure has recently been aligned to the Faculty of Occupational Medicine's quality standards: Safe aAnd Effective, Quality Occupational Health Services (SEQOHS) standards (2015). SEQOHS is a professionally-led accreditation scheme based on a quality management system format. This provides a framework designed specifically to accommodate all professional aspects of Service provision of a quality Occupational Health Service. At this stage the Occupational Health & Wellbeing Service is not seeking to achieve accreditation, but to align all its work with the standards in preparation for this.

Occupational Health Workforce – Resourcing, Planning and Development

Successful recruitment to the Occupational Health Nurse Team Lead role added to the staffing complement in June 2021. Work commenced in January 2022 to recruit to the Head of Service post which becomes vacant in 2022/23. In addition, there have been challenges to recruit to the qualified Occupational Health Advisor role, and it has taken several advertising campaigns to secure a successful candidate, demonstrating the difficulties being experienced across Scotland to recruit appropriately trained practitioners. The deficit has affected the skill mix of the team and impacted on Service delivery.

Learning and training remain an important part as OH recognises our staff are integral to everything we do. Induction and training programmes for new team members and ongoing development and supervision sessions for existing staff are in place. This is delivered via regular team huddles and case management meetings and during 2021 in-house training sessions have been re-introduced, providing staff with information and training on a variety of topics.

Performance Monitoring

The Service's performance against Key Performance Indicators (KPIs) is reported on a rolling three-monthly basis and the current, agreed historical KPI compliance rate is 95%. Performance is measured in terms of compliance with achieving 95% of management referral appointments offered within the agreed timeframes (10 days) and 95% reports dispatched following appointments (within 5 days). Comparative data with the previous year's activity has been included within the appendices below, for ease of reference.

The data presented within **Appendices 2a, 2b, 3a, 3b and 3c** relates only to the Service delivered to NHS Fife employees, excluding the work / activity done for the other organisations outlined above.

Appendix 4 details the activity data of all other organisations the Service delivers OH support to under agreed external contractual arrangements.

Compliance with Key Performance Indicators

KPI compliance has been affected by staff long term absence as well as the ongoing Service's need to respond to the pandemic timeously. This was seen with reduced capacity in January 2021 following the surge in calls and pandemic related activity associated with the emergence of COVID-19 variants. Despite this the Service prioritised and redirected activity that directly supported organisational need whilst maintaining Services such as recruitment of new staff at pace and management referrals, contamination injury assessments and delivery of occupational vaccination schedules.

The overall level of appointment activity (appointments that were carried out) for 2021/2022 has increased from that of the previous year (6,878 as compared to 6,501 in 2020/2021). This is an increase of 6% in activity (see Graph 1: green)

To fully support employees, line management and the organisation, COVID-19 related activities continue with provision of advice regarding employee's health risks in relation to possible workplace exposures. Telephone or email remains the key methods of contact to the Service. COVID-19 contact tracing and test calls / emails totalled 4439 were timeously responded to. This has demonstrated a 30% reduction in this level of activity; however, much of the COVID-19 work was reactive and so not possible to capture in the usual way, skewing the true level of activity.

As per previous reports, analysis of pre-placement figures has confirmed a rise in numbers of pre-placement appointments with an increase this year of 26% in face to face and telephone consultations (596 compared to 473 in 2020/21), with an increase by almost 300% of OH clinicians passing prospective employees 'fit' on paper screen (1330 compared to 340 in 2020/2021). This change may be explained by three factors:

- A noticeable change in behaviour of prospective employees during pandemic ensuring they attached all evidence required at time of submission of their pre-placement questionnaire (PPQ) perhaps in response to new information to do so.

- The development of a revised, risk-assessed, more general pre-placement screening questionnaire which focused on function in the workplace rather than health diagnoses.

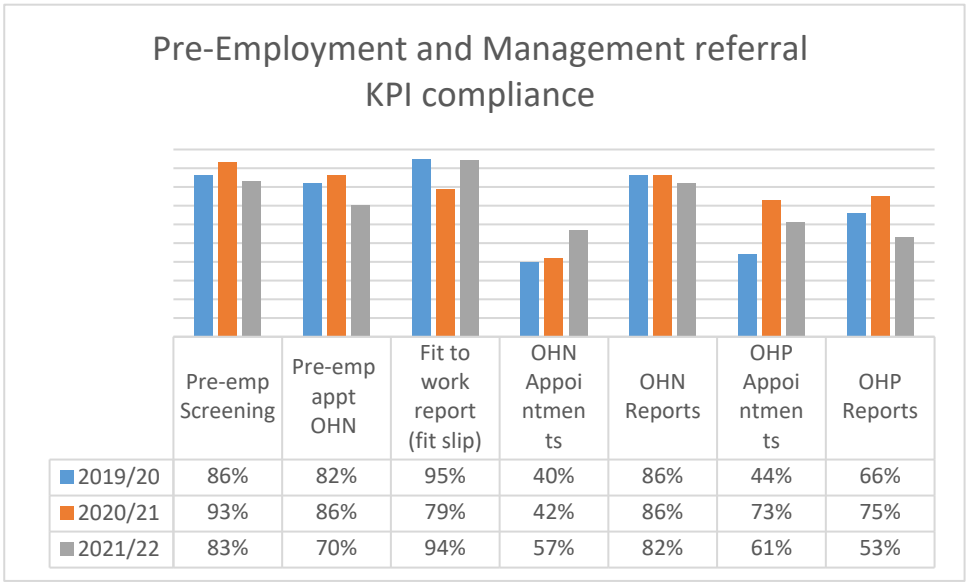
- Changed processes within OH with regards to contacting prospective employees by telephone if there were omissions in the information submitted rather than arranging an appointment.

It is also notable that the "Did Not Attend" (DNA) rate for face to face or telephone appointment for pre-placement assessment has increased by 21% (76 compared to 63 in 2020/2021). The reasons for this are not clear but may be a function of aspects of the pandemic and its impact on other industry sectors.

Analysis of the activity report highlights that DNA rates have remained elevated. Overall 10,149 total appointments were offered with 1,607 DNA'd (16%) and 941 (9%) cancelled which results in additional resource to follow these up. From this is noted that a portion of these are related to communicable disease activities. These form approx 60% of appointments offered with DNA rates at 17% and cancellations 11%. Vaccination remains an effective tool against communicable diseases; lack of protection poses risk to HCW and patients.

The average total KPI for Management Referrals (referrals appointed within 10 days of receipt) across Nurse and Physician has increased this year to 56% (for 2020-2021 was 41%). The impact of the Service's need to focus on the response to the pandemic work as detailed above, has had an effect on this area of activity

Graph 1: Pre-Placement and Management Referral KPI Compliance



	Pre-emp Screening	Pre-emp appt OHN	Fit to work report (fit slip)	OHN Appointments	OHN Reports	OHP Appointments	OHP Reports
2019/20	86%	82%	95%	40%	86%	44%	66%
2020/21	93%	86%	79%	42%	86%	73%	75%
2021/22	83%	70%	94%	57%	82%	61%	53%

Further details of the 2021/22 KPI and activity information, per operational unit, are attached at **Appendices 2a and 2b**.

Appendix 1: Occupational Health and Wellbeing – Occupational Health Functions

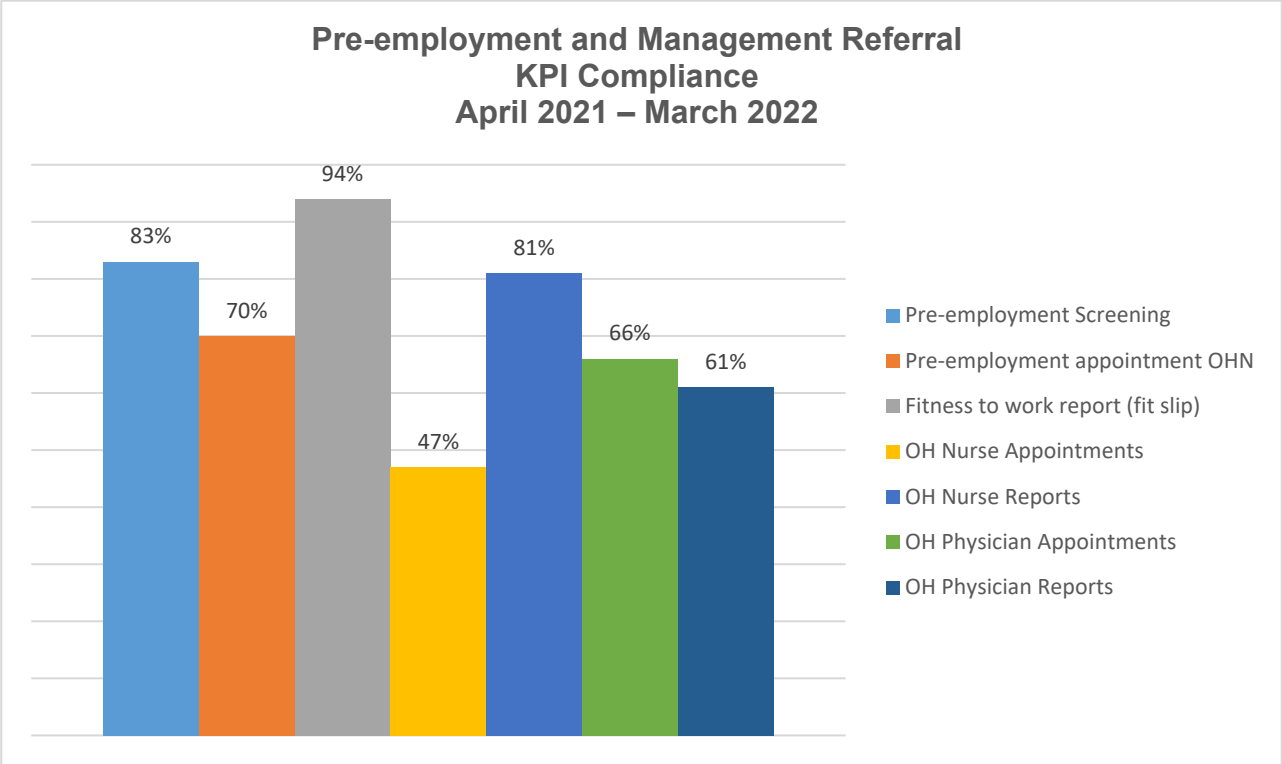
The functions provided by Occupational Health include a comprehensive Service for all NHS Fife employees. The OH team also delivers the same comprehensive Service to Fife General Practitioners and their staff, General Dental Practitioners and their staff, and local Fife-based independent Pharmacies under other contractual agreements.

A defined Service is provided to Scottish Ambulance Service employees referred under an NHS Scotland Procurement 'Consortium' agreement and under agreed external contractual agreements with St Andrews University for their medical students, with Fife College for their nursing students and for NHS Fife based employees of Equans (Phase 3 Estates Service contract).

The activities covered are

- Pre-placement screening to national standards and complying with Equality Act 2010 and Health and Safety at Work etc. Act 1974.
- Communicable diseases screening complying with the 'Green Book', and HPS guidance.
- Contamination incident risk assessment and follow up complying with national guidance.
- Problem Assessment Groups and Incident Management Teams for infectious diseases outbreak scenario. Risk assessment of staff and related follow up.
- Health Surveillance and Health Assessments complying with Control of Substances Hazardous to Health Regulations 2002 (COSHH) and 'fitness to work' (such as for occupational drivers, Exposure Prone Procedure Workers [EPP] and those entering confined spaces).
- Management referral appointments complying with GMC recommendations on transparency, confidentiality and consent, Faculty of Occupational Medicine 'Good Occupational Medicine Practice' and Ethics guidance.
- Expert OH Occupational Therapy assessments to support an employee in performing their work duties with a reduced risk for aggravating their existing medical condition. I.e. DSE; Workability or Job Evaluation assessments.
- Occupational Physiotherapy assessment and treatment.
- Workplace based assessments / visits.
- Support from Mental Health practitioner to support employees in managing their mental health.
- Staff Counselling Service provided by BACP accredited counsellors.

Appendix 2a: Occupational Health and Wellbeing Service – Pre-Employment and Management Referral KPI Compliance (April 2021 to March 2022)



KPI Compliance

Description	KPI Target	Ave days	Processed/ attended	Nos within KPI	KPI Compliance
Pre-Employments:	**Within:**				
Pre-employment Screening	3 working days	2	1300	1073	83%
Pre-employment appointment OHN	13 working days	8	1279	894	70%
Fitness to work report (fit slip)	21 working days of appt	5	677	633	94%
Management Referrals:	**Within:**				
OH Nurse Appointments	10 working days of receipt	10	648	303	47%
OH Nurse Reports	5 working days of appt	6	783	633	81%
OH Physician Appointments	10 working days of receipt	10	646	424	66%
OH Physician Reports	5 working days of appt	9	538	330	61%
Combined Dr/Nurse MRs:	**Within:**				
OH Nurse & Doctor Appointments	10 working days of receipt	10	1294	727	56%
OH Nurse & Doctor Reports	5 working days of appt	7	1321	963	73%

Appendix 2b: Occupational Health and Wellbeing – NHS Fife Activity Report (April 2021 to March 2022)

Pre-employment Questionnaires Received - **2,348 (1,966 in 2020 to 2021)**
Management Referrals Received - **1,496 (1,299 in 2020 to 2021)**

Appointment Reason	Attended	Cancelled	Cancelled within 3 w/days	Cancelled within 24 hrs	DNA	Postponed by OH	TOTAL
Pre-Employment Screening	596	92	6	11	76	42	823
Management Referrals	1463	94	8	16	151	101	1833
Self Referrals	131	3	0	0	20	4	158
Health Surveillance	544	51	1	5	187	41	830
Other Services	**211**	**14**	**8**	**10**	**19**	**21**	**283**
Communicable Diseases Screening	**3748**	**649**	**76**	**241**	**1032**	**97**	**5843**
Contamination Injury Assessments	**185**	**38**	**5**	**25**	**122**	**5**	**380**
TOTAL	**6878**	**941**	**104**	**308**	**1607**	**311**	**10149**

Divisional Activity Aligned to Above – 2021 to 2022:

Division	Attended	Cancelled	Cancelled within 3 w/days	Cancelled within 24 hrs	DNA	Postponed by OH	TOTAL
Acute Services Division	3812	542	53	182	1030	165	5784
Corporate Services	1315	183	28	60	298	67	1951
HSCP	1751	216	23	66	279	79	2414
TOTAL	6878	941	104	308	1607	311	10149

Divisional Activity (for Comparison) – 2020 to 2021:

	Attended	Cancelled	Cancelled within 3 w/days	Cancelled within 24 hrs	DNA	Postponed by OH	TOTAL
Acute Services Division	2949	228	42	76	622	70	3988
Corporate Services	690	55	7	20	140	15	927
HSCP	1254	84	9	21	176	42	1586
TOTAL	**4892**	**367**	**58**	**118**	**939**	**127**	**6501**

PHYSIO / COUNSELLING SELF REFERRAL

Appointment Reason	Attended	
Physio Referral Sessions Via Discharge	999	Including DNA/ cancelled
Caps Referral Sessions Via Discharge	1044	Including DNA/ cancelled

COVID-19

Appointment Reason	Total
COVID-19 testing & Contract Tracing calls/emails	4023
COVID-19 managerial queries	416
TOTAL	4439

OCCUPATIONAL THERAPY

OH Occupational Therapist

Number of clients referred – 137
Number of Jobsite Evaluations (completed) – 43
Number of Computer Workstation Assessments (completed) – 47
Number of Work Ability Evaluations (completed) – 12
Number of Career Search Evaluations (completed) – 7
Number of cancelled appointments – 14

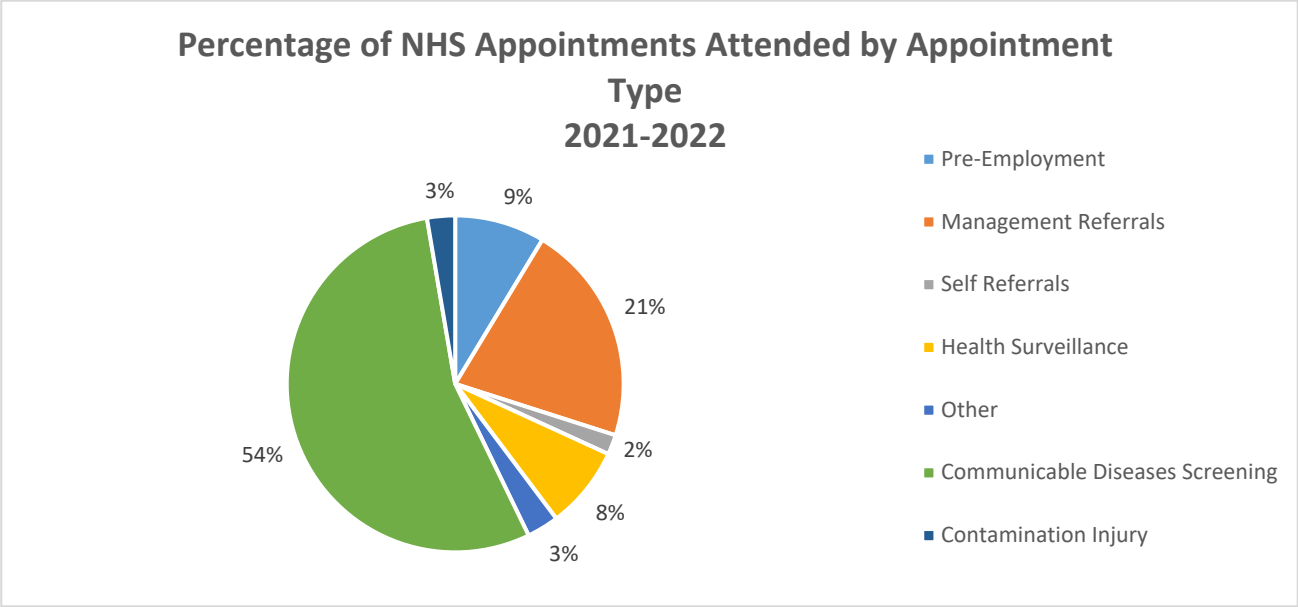
	Referred	Jobsite Evaluations	Computer Workstation Assessments	Work Ability Evaluations	Career Search Evaluations	Cancelled Appointments
OH Occupational Therapist	137	43	47	12	7	14

OT Fatigue Management Service

Referred – 38
Discharged – 8
In progress – 23

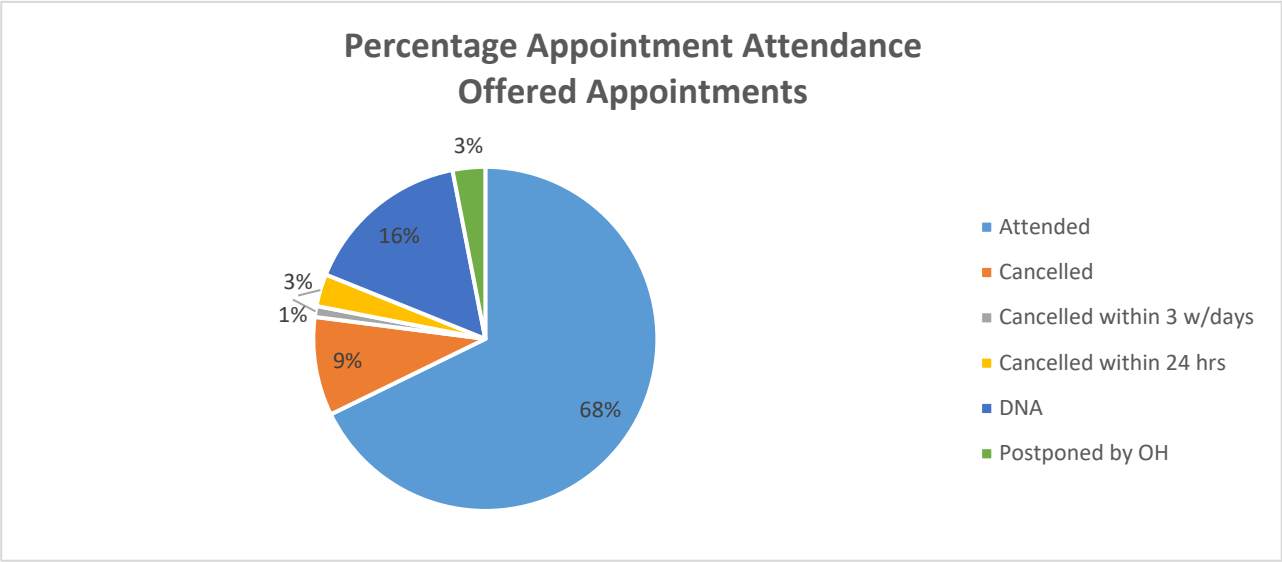
	Referred	Discharged	In Progress
OT Fatigue Management	38	8	23

Appendix 3a: Occupational Health and Wellbeing Service – Percentage of NHS Fife Appointments Attended by Appointment Type (April 2021 to March 2022)



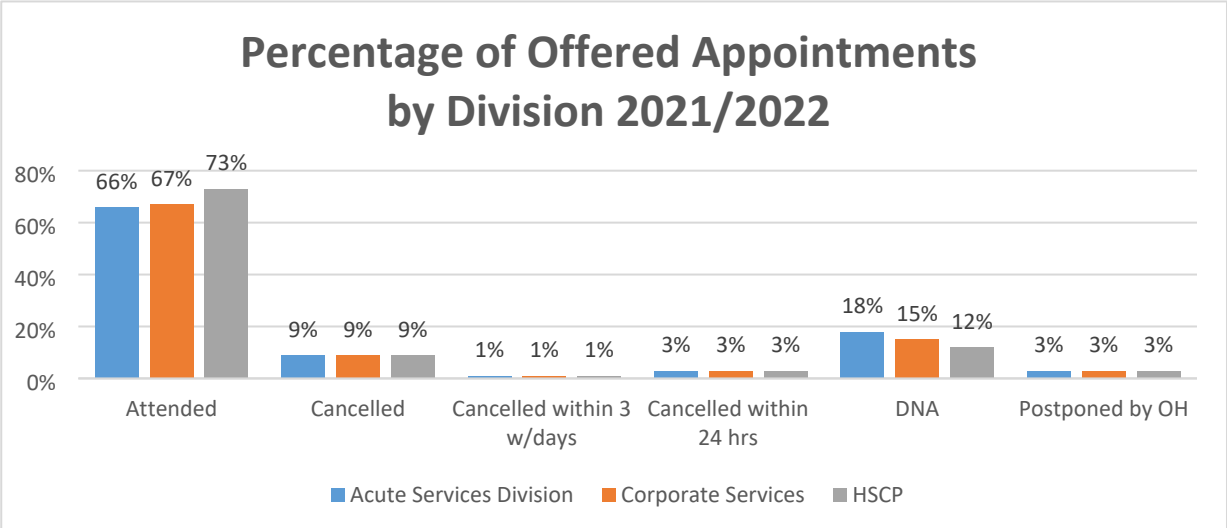
	Pre-Employment	Management Referrals	Self Referrals	Health Surveillance	Other	Communicable Diseases Screening	Contamination Injury	Total
Activity of those attending OH	596	1463	131	544	211	3748	185	6878
% of total number attended	9%	21%	2%	8%	3%	54%	3%	

Appendix 3b: Occupational Health and Wellbeing Service – NHS Fife Appointment Attendance – Percentage of Offered Appointments (April 2021 to March 2022)



	Attended	Cancelled	Cancelled within 3 w/days	Cancelled within 24 hrs	DNA	Postponed by OH
Total	6878	941	104	308	1607	311
Percentage	68%	9%	1%	3%	16%	3%

Appendix 3c: Occupational Health and Wellbeing Service – NHS Fife Appointment Attendance – Percentage of Offered Appointments by Division (April 2021 to March 2022)



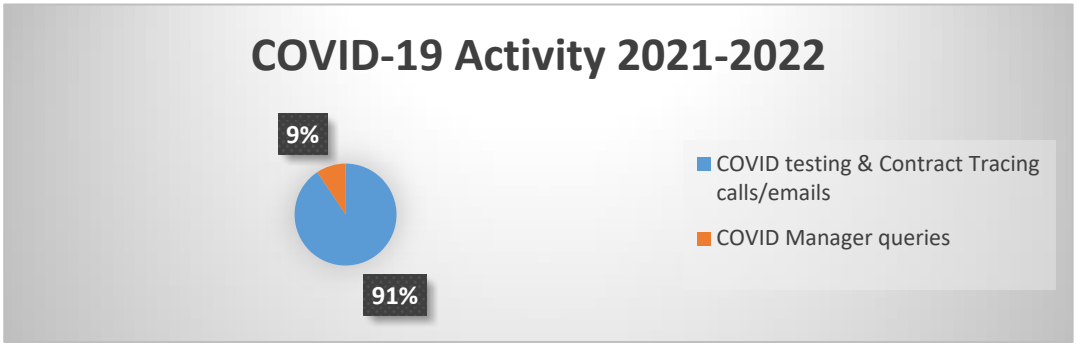
Total Activity By Division:

Division	Attended	Cancelled	Cancelled within 3 w/days	Cancelled within 24 hrs	DNA	Postponed by OH	TOTAL
Acute Services Division	3812	542	53	182	1030	165	5784
Corporate Services	1315	183	28	60	298	67	1951
HSCP	1751	216	23	66	279	79	2414
TOTAL	6878	941	104	308	1607	311	10149

Percentage of Activity By Division:

Division	Attended	Cancelled	Cancelled within 3 w/days	Cancelled within 24 hrs	DNA	Postponed by OH
Acute Services Division	66%	9%	1%	3%	18%	3%
Corporate Services	67%	9%	1%	3%	15%	3%
HSCP	73%	9%	1%	3%	12%	3%
TOTAL	6878	941	104	308	1607	311

Percentage of COVID-19 Activity



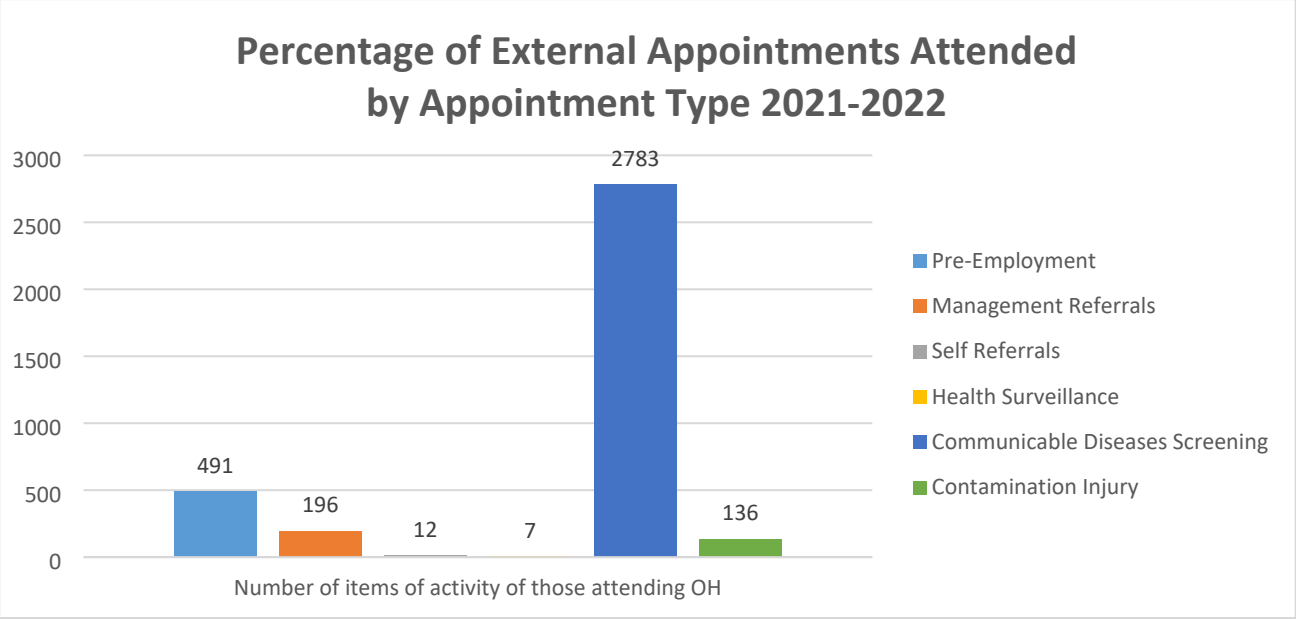
Appointment Reason	Total
COVID-19 Testing & Contract Tracing calls/emails	4023
COVID-19 Managerial queries	416
TOTAL	4439

Appendix 4: Occupational Health and Wellbeing Service – External Activity Report (April 2021 to March 2022)

Pre-employment Questionnaires Received: **364**
Management Referrals Received: **146**

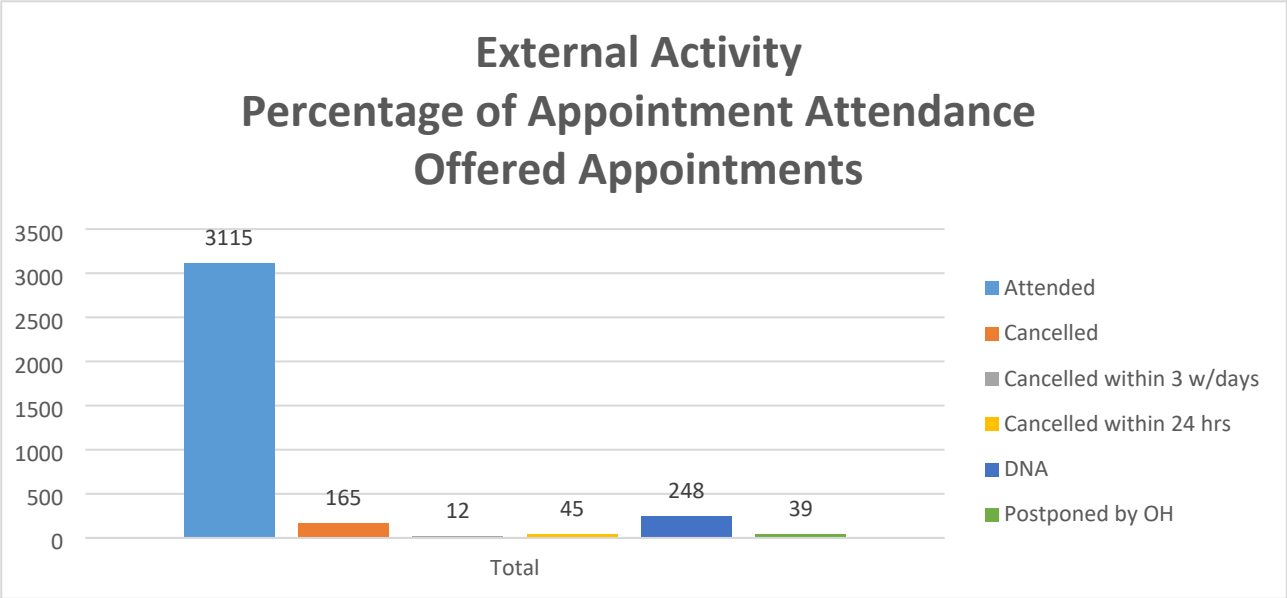
Appointment Reason	Attended	Cancelled	Cancelled within 3 w/days	Cancelled within 24 hrs	DNA	Postponed by OH	TOTAL
Pre-Employment Screening	383	30	2	14	55	7	491
Management Referrals	150	15	0	3	15	13	196
Self Referrals	10	0	0	0	2	0	12
Health Surveillance	5	0	0	0	1	0	7
Communicable Diseases Screening	2490	104	9	21	140	19	2783
Contamination Injury Assessments	77	16	1	7	35	0	136
TOTAL	3115	165	12	45	248	39	3624

External Activity includes the following organisations: Doctors & Dentists in training; Scottish Ambulance Service, Community Sharps, Dental Practices, GP Practices, Fife College, St Andrews University, University of Dundee & University of Edinburgh



Percentage of External Appointments Attended by Appointment Type 2021-2022

	Pre-Employment	Management Referrals	Self Referrals	Health Surveillance	Communicable Diseases Screening	Contamination Injury	Total
Activity of those attending OH	491	196	12	7	2783	136	3624
% of total number attended	13%	5%	0%	0%	77%	4%	



External Activity - Percentage of Appointment Attendance Offered Appointments

	Attended	Cancelled	Cancelled within 3 w/days	Cancelled within 24 hrs	DNA	Postponed by OH	TOTAL
Total	3115	165	12	45	248	39	3624
Percentage	85%	4%	0%	1%	7%	1%	

NHS Fife
Hayfield House
Hayfield Road
Kirkcaldy, KY2 5AH

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CLINICAL GOVERNANCE COMMITTEE
ANNUAL WORKPLAN 2022 / 2023

Governance - General							
	Lead	**29/04/22**	**01/07/22**	**02/09/22**	**04/11/22**	**13/01/23**	**03/03/23**
Minutes of Previous Meeting	**Chair**	✓	✓	✓	✓	✓	✓
Action list	**Chair**	✓	✓	✓	✓	✓	✓
Escalation of Issues to Fife NHS Board	**Chair**	✓	✓	✓	✓	✓	✓
Covid-19 Update							
	Lead	**29/04/22**	**01/07/22**	**02/09/22**	**04/11/22**	**13/01/23**	**03/03/23**
General Covid-19 Update	**Director of Public Health**	✓	✓	✓	✓	✓	✓
Governance Matters							
	Lead	**29/04/22**	**01/07/22**	**02/09/22**	**04/11/22**	**13/01/23**	**03/03/23**
Committee Self-Assessment Report	**Board Secretary**						✓
Corporate Calendar / Committee Dates	**Board Secretary**			✓			
Review of Annual Workplan	**Associate Director of Quality & Clinical Governance**	✓	✓	✓	✓	✓	✓ Approval
Review of Terms of Reference	**Board Secretary**						✓ Approval
Annual Committee Assurance Statement (inc. best value report)	**Board Secretary**	✓					
Annual Assurance Statements from sub-committees	**Board Secretary**	✓					
Annual Statement of Assurance for Clinical Governance Oversight Group	**Medical Director / Associate Director of Quality & Clinical Governance**	**Deferred to next mtg – CGOG not met yet**	**Deferred to next mtg**	✓			✓
Annual Internal Audit Report	**Director of Finance & Strategy**		✓				
Board Assurance Framework - Quality and Safety	**Medical Director / Director of Nursing**	✓	✓	✓	✓	✓	✓
Board Assurance Framework - Strategic Planning	**Director of Finance & Strategy / Associate Director of Planning & Performance**	✓	✓	✓	✓	✓	✓

Governance Matters (cont.)							
	Lead	**29/04/22**	**01/07/22**	**02/09/22**	**04/11/22**	**13/01/23**	**03/03/23**
Board Assurance Framework - Digital and Information	**Medical Director**	✓	✓	✓	✓	✓	✓
Strategy / Planning							
	Lead	**29/04/22**	**01/07/22**	**02/09/22**	**04/11/22**	**13/01/23**	**03/03/23**
Clinical Governance Framework	**Medical Director / Associate Director of Quality & Clinical Governance**	**Deferred to next mtg**	**Deferred to Nov '22**		✓		✓
Clinical Governance Framework Delivery Plan	**Medical Director / Associate Director of Quality & Clinical Governance**				✓		
Corporate Objectives	**Director of Finance & Strategy / Associate Director of Planning & Performance**	✓			✓		
Cancer Strategy	**Medical Director**					**TBC**	
Data Loch	**Medical Director / Associate Director for Research, Development & Innovation**	**Deferred to next mtg**	✓				
Emergency / Resilience Planning	**Director of Public Health**	✓	✓				
Governance of Advanced Practitioners	**Director of Nursing**	✓					
Integrated Unscheduled Care	**Medical Director**				✓		
Redesign of Urgent Care	**Medical Director**				✓		✓
Annual Delivery Plan 2022/23	**Director of Finance & Strategy / Associate Director of Planning & Performance**	**Postponed (awaiting national guidance)**		✓ Private Session			
Quality / Performance							
	Lead	**29/04/22**	**01/07/22**	**02/09/22**	**04/11/22**	**13/01/23**	**03/03/23**
Integrated Performance and Quality Report	**Medical Director / Director of Nursing**	✓	✓	✓	✓	✓	✓
Winter Plan / Winter Performance Report	**Associate Director of Planning & Performance**	✓	**Annual Delivery Plan has replaced this item**				

Quality / Performance (cont.)							
	Lead	**29/04/22**	**01/07/22**	**02/09/22**	**04/11/22**	**13/01/23**	**03/03/23**
Healthcare Associated Infection Report (HAIRT)	**Director of Nursing**	✓	✓	✓	✓	✓	✓
Safer Management of Controlled Drugs	**Director of Pharmacy & Medicines**				✓		
Digital / Information							
	Lead	**29/04/22**	**01/07/22**	**02/09/22**	**04/11/22**	**13/01/23**	**03/03/23**
Digital and Information Strategy Update	**Medical Director / Associate Director of Digital & Information**		✓			✓	
Hospital Electronic Prescribing and Medicines Administration (HEPMA) Programme	**Medical Director**		✓ **(Revised FBC) Private Session**	✓ **verbal**			✓
Information Governance and Security Steering Group Update	**Associate Director of Digital & Information**			✓			✓
Person Centred Care / Participation / Engagement							
	Lead	**29/04/22**	**01/07/22**	**02/09/22**	**04/11/22**	**13/01/23**	**03/03/23**
Equalities Outcome Report *(also goes to PHWC)*	**Director of Nursing**						✓
Patient Experience & Feedback	**Director of Nursing**	✓	✓	✓	✓	✓	✓
Volunteering Report	**Director of Nursing**				✓		
Annual Reports							
	Lead	**29/04/22**	**01/07/22**	**02/09/22**	**04/11/22**	**13/01/23**	**03/03/23**
Adult Support & Protection Annual Report *(also goes to PHWC)*	**Director of Nursing**		**Presented in Jan '22**			✓	
Annual Resilience Report	**Medical Director**	**TBC**					
Clinical Advisory Panel Annual Report	**Medical Director**		✓				
Digital and Information Annual Report	**Associate Director of Digital & Information**					✓	
Director of Public Health Annual Report (also goes to PHWC)	**Director of Public Health**	**Deferred to next mtg (due to timings)**	✓				✓

Annual Reports (cont.)							
	Lead	**29/04/22**	**01/07/22**	**02/09/22**	**04/11/22**	**13/01/23**	**03/03/23**
NHS Fife Equality Outcomes Progress Report	**Director of Nursing**	✓					
Fife Child Protection Annual Report	**Director of Nursing**					✓	
Integrated Screening Annual Report *(also goes to PHWC)*	**Director of Public Health**			**Deferred to next mtg**	✓		
Medical Education Report	**Medical Director**	**Deferred to next mtg**	**Deferred to next mtg**	**Deferred to next mtg**	✓		
Medical Appraisal and Revalidation Annual Report	**Medical Director**				✓		
Nursing, Midwifery, Allied Health Professionals – Professional Assurance Framework	**Director of Nursing**		**Deferred to next mtg**	✓			✓
Organisational Duty of Candour Annual Report	**Medical Director**				✓		
Participation & Engagement Report *(also goes to PHWC)*	**Director of Nursing**		**Presented in Jan '22**		✓		
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/Associate Director of Quality and Clinical Governance**						✓ **Annual Review**
Quality Framework for Participation & Engagement Self-Evaluation	**Director of Nursing**			**Deferred to next mtg**	✓		
Linked Committee Minutes							
	Lead	**29/04/22**	**01/07/22**	**02/09/22**	**04/11/22**	**13/01/23**	**03/03/23**
Acute Services Division Clinical Governance Committee	**Acute Services Director**	23/03 **mtg cancelled**	18/05 **mtg cancelled**	✓ 15/06	✓ 20/07	✓ 16/11	✓ 18/01

Linked Committee Minutes (cont.)							
	Lead	**29/04/22**	**01/07/22**	**02/09/22**	**04/11/22**	**13/01/23**	**03/03/23**
Area Clinical Forum	**Chair of Forum**	✓ 03/02 & 07/04	09/06 **Mtg cancelled**	✓ 04/08	✓ 06/10	✓ 01/12	✓ 02/02
Area Medical Committee	**Medical Director**	✓ 08/02	12/04 **Mtg cancelled**	✓ 14/06	✓ 09/08	✓ 11/10	✓ 13/12
Area Radiation Protection Committee	**Medical Director**	✓ 02/03			✓ 31/08		
Cancer Governance & Strategy Group	**Medical Director**	01/04 **Mtg cancelled**		✓ 02/06	✓ 19/08	✓ 04/11	
NHS Fife Clinical Governance Oversight Group	**Medical Director**	✓ 15/02	✓ 19/04	✓ 14/06	✓ 16/08	✓ 18/10 & 06/12	
Digital & Information Board	**Medical Director**		✓ 19/04	✓ 28/07	✓ 18/10		
Fife Drugs & Therapeutic Committee	**Medical Director**	✓ 09/02	✓ 27/04	✓ 22/06	✓ 24/08 & 12/10	✓ 07/12	
Fife IJB Clinical & Care Governance Committee (Changed to Fife IJB Quality & Communities Committee from July 2022)	**Associate Medical Director**	✓ 04/03	✓ 20/04	✓ 05/07	✓ 09/09	✓ 08/11	
Health & Safety Subcommittee	**Chair of Sub-Committee**	✓ 11/03		✓ 10/06	✓ 09/09	✓ 09/12	
Infection Control Committee	**Director of Nursing**	✓ 02/02 06/04 **mtg cancelled**		✓ 08/06 & 03/08	✓ 05/10	✓ 05/12	
Ionising Radiation Medical Examination Regulations Board (IRMER)	**Medical Director**			✓ 24/05			
Information Governance & Security Steering Group	**Director of Finance & Strategy**	✓ 04/03	08/04 **Mtg cancelled**	✓ 06/07	✓ 04/11		✓ 10/01

Linked Committee Minutes (cont.)							
	Lead	**29/04/22**	**01/07/22**	**02/09/22**	**04/11/22**	**13/01/23**	**03/03/23**
NHS Fife Medical Devices Group *(New group formed in June 2022)*	**Medical Director**				✓ 16/08	✓ 08/12	
Research, Innovation & Knowledge Oversight Group	**Medical Director**	✓ 31/03	✓ ~~24/05~~ 20/06		✓ 31/08	✓ 24/11	
Ad Hoc Items							
	Lead	**29/04/22**	**01/07/22**	**02/09/22**	**04/11/22**	**13/01/23**	**03/03/23**
Neonatal Adverse Events Update	**Medical Director**	✓	✓				
Early Cancer Diagnostic Centre (ECDC)	**Medical Director**	✓	✓ **(Lothian NHS joined mtg)**				
RMP4 Update	**Associate Director of Planning & Performance**	✓					
Edinburgh Cancer Centre Reprovision-Regional Service Model	**Associate Director of Quality & Clinical Governance**	Private Session					
No Cervix Incident – Lessons Learned	**Director of Public Health**		✓				
Occupational Health & Wellbeing Service Annual Report 2021/22	**Director of Workforce**			✓			
Unscheduled Care Performance	**Director of Acute Services**			**Removed from agenda**			
Review of Deaths of Children & Young People	**Associate Director of Quality & Clinical Governance**				✓		
Controlled Drug Accountable Officer Annual Report	**Director of Pharmacy & Medicines**				✓		
Development of Assistant Practitioner Role	**Director of Nursing**			✓			
Development Sessions							
	Lead						
Development Session	**Medical Director**			**Oct – date tbc**			

CLINICAL GOVERNANCE COMMITTEE

DATES FOR FUTURE MEETINGS

Date
Friday 5 May 2023
Friday 7 July 2023
Friday 8 September 2023
Friday 3 November 2023
Friday 12 January 2024
Friday 1 March 2024

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

A pre-meeting of Non-Executive Members is routinely held, beginning at **9.30am**

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ACUTE SERVICES DIVISION CLINICAL GOVERNANCE COMMITTEE **Meeting on 15 June 2022**
No issues were raised for escalation to the Clinical Governance Committee.

ASD Clinical Governance Committee

A NOTE OF THE ACUTE SERVICES DIVISION CLINICAL GOVERNANCE COMMITTEE HELD ON WEDNESDAY 15th JUNE 2022 AT 2.00PM VIA MS TEAMS

Present	**Designation**
Mrs Norma Beveridge	Head of Nursing – Emergency Care Directorate
Mrs Claire Dobson	Director of Acute Services
Mrs Donna Galloway	General Manager – Women, Children & Clinical Services
Dr John Morrice	Associate Medical Director – Women & Children
Mrs Elizabeth Muir	Clinical Effectiveness Co-ordinator
Dr Sally McCormack	Clinical Director – Emergency Care Directorate & Clinical Services (from 14:08 until 15.20)
Mrs Gill Ogden	Head of Nursing – Planned Care Directorate
Mrs Kerrie Perry	Senior Nurse – Quality & Risk – Emergency Care Directorate
Mrs Miriam Watts	General Manager – Emergency Care Directorate (from 14.25)
Professor Morwenna Wood	Associate Medical Director (Interim) - CHAIR

Apologies	**Designation**
Mrs Jane Anderson	Radiology Services Manager
Mrs Lynn Campbell	Associate Director of Nursing - Acute
Ms Fiona Forrest	Deputy Director of Pharmacy & Medicines
Mrs Pamela Galloway	Head of Midwifery
Mrs Aileen Lawrie	Associate Director of Midwifery
Ms Marie Paterson	Head of Nursing – Acute
Mr Satheesh Yalamarthi	Clinical Director – Planned Care Directorate

In Attendance:

Miss Lynn Godsell	PA to the Associate Medical Director & Associate Director of Nursing (minutes)
Dr Marcia McDougall	Consultant in ICU (for Item 5 – until 14.25)
Ms Geraldine Smith	Lead Pharmacist – Medicines & Governance (for Item 5 – until 1500)
Mrs Andrea Wilson	General Manager – Waiting Times (for Item 5 – until 1455)

ACTION

1 Welcome and Introductions

Professor Wood welcomed everyone to the meeting and advised that the March meeting had been cancelled at short notice due to clinical pressures. Professor Wood extended the welcome to Mrs Wilson, Ms Smith and Dr McDougall who were in attendance to present particular updates. Professor Wood asked members and speakers to provide a brief update on papers they were attending to speak to.

2 Apologies for Absence

Apologies for absence were noted from the above named members.

3 Unconfirmed Minute of ASDCGC Meeting held on 26th January 2022

Professor Wood asked for any comments or inaccuracies with the January minutes. There were no issues raised hence the minutes were approved as an accurate record.

4 Matters Arising

4.1 Action List

Professor Wood noted that there were some long term uncompleted actions and proposed that she and Lynn Godsell write a letter to the people concerned rather than going through them one by one at this meeting.

Action 334 – Penicillin Business Case – no update. Write to Dr Alfonzo. **MW**

Action 382 – SAER Learn Summaries – No update.

Action 385 – Patientrak & eHealth Connectivity issues – Mrs Beveridge reported this was complete.

Action 388 – W&C Risk Register – Funding agreed from Capital contingency to proceed with this work. Regard as complete.

Action 389 – W&C Risk Register – BBraun infusion pumps now in use in both the Neonatal and the Children's ward. Regard as complete.

Action 392 – PCD – Robotics Assisted Surgery – Circulate the up to date information re reporting to the Procurator Fiscal via the usual routes. Regard as complete.

Action 394 – Divisional Risk Register – Professor Wood said this was about moving the Cancer Waiting Times risk. Regard as complete.

Action 395 – Divisional Risk Register – Ensure the structure regarding cancer is aligned correctly within the Directorates. Mrs Dobson confirmed this was now compete and it is all dealt with through the Cancer Operational Delivery Group.

Action 402 – ECD CG Report – Harms – This will be dealt with via the ECD reporting structure. Regard as complete.

Action 404 – Specialty/ departmental audit (Synaptik) – Regard as complete.

5 Hospital/Board or Population Level Reports:

Scheduled Governance Items:

- **Private Provider Report**

Mrs Wilson presented the Private Provider report (Synaptik).

Mrs Wilson advised that NHS Fife has contracted with external providers for several years in order to meet gaps in new outpatient and daycase capacity and enable patients to be seen within the national standard of 12 weeks from referral. The report covers activity during the period December 2019 – November 2021. It was noted that the quarterly reports were stopped during COVID and now the data collected will be reported on an annual basis instead.

Mrs Wilson said the report denotes patients on the specialties that were delivered

by Synaptic during the reporting period and there was one incident to highlight within Neurology which has been thoroughly investigated and as far as Mrs Wilson was aware, has been resolved and the Clinical Director is content with the outcome. The outcome report is being shared with this Committee. Mrs Wilson said that we have clear processes and good systems in place which have been developed over the past few years and normally there are very few issues or complaints raised. Mrs Wilson added that we will continue to use Synaptik for Neurology on an ad hoc basis although it was unlikely that they will do much this year as there is no additional monies to do so. Mrs Wilson advised members that there were two appendices included for information which detail the figures on the activity.

The update was noted.

- **Waiting Times Report**

Mrs Wilson spoke to the Waiting Times report and advised that this is the regular annual report which shows the current waiting times in comparison to previous years. The main highlights from the report show that waiting times have deteriorated for both outpatients and inpatient daycases – the waiting times have stabilised for the time being so they are not deteriorating further but equally are not improving either. Mrs Wilson noted that the waiting list size is increasing, this is due to the fact that our capacity is still less than it was pre COVID. Mrs Wilson added that there are a number of other reasons for the capacity and she is currently preparing a paper on this subject. It was noted that demand has also been increasing, after seeing a fairly restricted demand over the past two years some, not all specialities are seeing an increase for outpatient appointments.

Mrs Wilson noted that the percentage of patients who are unavailable for appointments and the number of cancellations has decreased slightly and this is particularly for inpatients and day cases, likely because people who are listed really need and want their surgery and have made every effort to attend the hospital for it. Mrs Wilson said that the audits that are reported are NHS Fife's way of checking that we manage our Waiting Time appropriately – noting that we are only required to do this for inpatients and day cases but have expanded it to outpatients and was reassured that any issues are picked up and dealt with accordingly. Mrs Wilson said that the issues are not affecting the waiting times of a patient but they are affecting our communications on the whole and how we communicate to patients which is equally important and this is being addressed. Mrs Wilson said there were appendices with the report which was done historically for Scottish Government but is now used for internal audit purposes only now as they no longer have a requirement for it.

The update was noted.

Professor Wood thanked Mrs Wilson for the comprehensive report and advised that she took comfort from the fact that the compliance with the auditing activity was very good.

Professor Wood queried the figures on page 3 about the unavailability of patients being significantly less. Mrs Wilson confirmed that Professor Wood was correct as Mrs Wilson was referring to outpatients and because the patients, unless unlisted patients were not available and they weren't on holiday then it has begun to rise again because patients are now saying they are unavailable again for a significant amount of time. Mrs Wilson said that patients are reminded that there is supposed

to be a maximum unavailability period of 12 weeks applied.

- **Medicines Incident Report**

Professor Wood thanked Ms Smith for attending both to present the Medicines Incident report and for deputising for Fiona Forrest.

Ms Smith advised members that this was the inaugural report produced for submission to this Governance Committee and it shows the medication incidents that were analysed from April 2021 – March 2022 for the Acute Services Division. The report notes that:

- There were 669 medication incidents
- 77% of these resulted in no harm
- There were 9 major medication incidents -
  3 related to missing stock (2 from the same area) and are still under investigation.
  3 related to medicine fridge audits – an LAER is still to be completed.
- Three of the incidents still under review are from 2021. The Safer Use of Medicines Group currently reviews all major medication incidents to share any learning and themes from incidents.
- Most common reasons for medication errors is human error and workload which reflects the pressures on the system and the staff.
- Medicine Safety Huddle sessions have resulted in some improvements with medication incidents.

Ms Smith added that this report has been presented to the Pharmacy Senior Leadership Team and the Safer Use of Medicines Group who made the following recommendations:

- Send report to organisational learning group to review and consider if any system wide objective can be added to their work plan.
- Each Division to further analyse Datix to drill down any themes and trends for their specific service
- Review training and education and ensure medicine management competency tool is implemented across all ward/dept
- Review test of change in relation to missed doses in ward 54 and any learning shared across all wards and departments.
- Lead antimicrobial pharmacist to review NHS Greater Glasgow and Clyde key messages and learning following gentamicin incident review for potential implementation within NHS Fife.

Professor Wood asked about SMART objectives in terms of Ms Smith's recommendations and how we could do measurable systems change as Professor Wood said that recording that someone has attended a learning session does not necessarily change behaviour.

Mrs Beveridge commented that the system report reflects the Emergency Care Directorate report in terms of the themes. Mrs Beveridge agreed that we should be taking the learning from other boards that has been done particularly as the Directorate has a fair number of issues with Gentamicin and the complexities of the administration with it. Mrs Beveridge added that for assurance the Directorate do endeavour to drill down on the Datix themes and missed doses for their areas.
Professor Wood thanked Ms Smith for a helpful, detailed report.

Fluid Standards Report

Professor Wood invited Dr McDougall to speak to the Fluids paper.

Dr McDougall advised that the fluid work in Fife has resulted in a well-established guideline, fluid charts and a pharmacy department which is actively engaged in managing fluid stocks. Dr McDougall noted that there are still many wards in which fluid practice could be improved, particularly with regard to the documentation of fluid balance. The COVID19 pandemic has resulted in fluid education being curtailed for junior doctors and nurses which has had a detrimental effect.

Dr McDougall said that there are issues currently with the replacement of all the pumps in Victoria Hospital and Queen Margaret Hospital. Emily Ridley, Fluid Nurse has been working hard with BBraun, Medical Physics and Alan Timmins to find a solution as BBraun are not producing the pumps when NHS Fife needs them. The aforementioned are putting in place another innovation imminently where a patient's AKI will be added to Patientrak and there will be an alert to Practitioners.

Dr McDougall spoke about fluid related activities this year and noted that it would be beneficial to do more education for nurses but is proving difficult with staffing on the wards. Dr McDougall added that the induction day fluid video for junior doctors was not being accessed and therefore the aim is to revert back to face to face induction sessions. Dr McDougall highlighted that it would be useful if we could make the modules for fluid compulsory for nurses and doctors as there is no formal teaching apart from the induction.

Dr McDougall informed the Committee about achievements during 2021 which included:

- Following a few years of work, a paper was published in the BMJ Open which shows that the changes in fluids are safe for electrolytes and we have saved money.
- Overseas Doctor from Germany visited VHK to see the fluid work done in NHS Fife
- Dr McDougall doing 4 presentations overseas this year

Dr McDougall noted that the Midline service is taking up a considerable amount of Emily Ridley's time on the ward with line problems which is detrimental to the education aspect of the service.

Professor Wood acknowledged the recommendations but advised that this Committee were not in a position to approve them.

Professor Wood said that she would liaise with Dr McDougall outwith the meeting regarding the modules in her role of Director of Medical Education. **MMcD/MW**

Professor Wood commended Dr McDougall and the team on the publications and the international recognition and noted the enormous efforts that have go into the Fluid work.

The update was noted.

- **Mortality Report**

Professor Wood advised that there was no Mortality report at this meeting and

planned to reduce the frequency of the report from bimonthly to bi-annually.

- **IPQR Report**

The IPQR report was not discussed in detail and noted by the Committee**.**

- **Cardiac Arrest/Peri-Arrest Reports Q4**

Professor Wood commented that the reports were very detailed and self-explanatory and asked Mrs Muir if there were issues or highlights from the Cardiac Arrest or Peri-Arrest reports? Mrs Muir advised that an in depth discussion around the themes and improvement work takes place at the Deteriorating Patient Group hence the reports are submitted for information/noting.

- **FOR INFO - Cardiac Arrest/Peri-Arrest Reports Q1 & Q2**

The reports were noted.

- **FOR INFO - Adults with Incapacity Audit Report**

The Adults with Incapacity Audit Report was noted.

- **FOR INFO - SBAR Governance of Advanced Practitioners**

The SBAR was noted.

- **End of Life Report/Audit – N/A – c/f to September 2022**

The End of Life report was not available.

- **Consent Report – N/A – c/f to September 2022**

The Consent report was not available.

6 Planned Care Directorate

6.1 Directorate Governance – Specialty National Reports

There were no Specialty National reports.

6.2 Directorate Level Outcomes Data:

- **Clinical Audit**
  QI Poster – Redesign of Orthopaedic & Musculoskeletal Pathways

Mrs Ogden advised this poster related to a Quality Improvement project which was done by a Senior Physiotherapist and the Orthopaedic team.

- **SAER LEARN Summaries**

Mrs Ogden referred to the LEARN summaries and highlighted to members that there is a theme which has been identified around Senior Orthopaedic cover and availability particularly in the out of hours periods. Mrs Ogden reassured the Committee that work is ongoing with Mr Ballantyne about this issue.

6.3 Directorate Report

Mrs Ogden referred to the Directorate report.

Incidents
There were 394 incidents reported during the period with 4 of these being graded as major. The major incidents relate to Cardiac Arrests, Endoscopy and Tissue Viability incidents.

There was 1 incident with a patient fall which resulted in the patient sustaining a fracture. This was downgraded from major to moderate and the Medical Director did not feel this incident warranted further investigation. The reporting period saw a 4% decrease in the number of falls reported.

There were 47 medication incidents reported across the Directorate – 94% of these had an outcome of no harm.

Mrs Ogden noted that there has been a marked increase of Tissue Viability incidents within Ward 44 and added that one of the ward staff is now a member of the Pressure Ulcer Collaborative, the Senior Charge Nurse is doing Tissue Viability as part of her QI project for a Leadership course and has also developed a small group within the ward to look at the Tissue Viability incidents. Mrs Ogden was hopeful that with these measures in place that the ward will see improvements in the next few months.

Complaints
Mrs Ogden advised that the Directorate remained poor compliance with the 20 day target. Mrs Ogden added that the Directorate would previously try and support the Patient Relations department with drafting and completing complaint responses but the team are unable to give that support at the moment, although Mrs Ogden hoped that this could happen again in the future.

There was 1 SPSO decision outcome which resulted in the Directorate having actions – this case related to a delay in recognising an Anastomotic leak.

There was also 1 legal claim for Clinical negligence – this related to a delay in referring a patient to Gastroenterologists and surgical intervention.

Patient Opinion remains very positive within Planned Care areas. The teams are quite good at encouraging patients to use Patient Care opinion to provide their feedback.

Dr Caroline Styles, Consultant Ophthalmologist has been appointed Ophthalmology Advisor to the Scottish Government. This is regarded as the highest lead role in Scottish Ophthalmology. This is a huge accolade for both Dr Styles and the department.

Dr John Donnelly has been appointed as President of the Scottish Society of Anaesthetists. This is a huge honour with Dr Donnelly being the first NHS Fife Consultant to be President of the world's oldest national Anaesthetic society.

Professor Wood thanked Mrs Ogden for a clear and self-explanatory report and conveyed her thanks to the Directorate.

Professor Wood asked Mrs Ogden if Ward 44, a GI and Medicine ward came under Planned Care's remit? Mrs Ogden advised that it did and highlighted that the Datix system needs to be clearer as there are four entries for Ward 44.

Professor Wood then congratulated the Directorate for the positive feedback on Care Opinion and for the two successes of the Consultants mentioned.

The Directorate update was noted.

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

- **Clinical Quality Indicators**
- **ENT/Thyroid function**

The papers were noted.

- **Positive Feedback via SG**

The feedback was noted.

- **The Lancet Oncology Surveillance Jan 2022**

The Oncology surveillance was noted.

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

Professor Wood advised Mrs Ogden that Mr Yalamarthi had submitted an older version of the presentation slides at a previous meeting and Mrs Campbell had requested that Mr Yalamarthi produce a report for the Committee in the correct format. Professor Wood asked Mrs Ogden to feed that information back to the team and request an update for the September meeting. Mrs Ogden agreed. **GO/PCD**

Mrs Ogden informed members that Mr Yalamarthi and provided a brief update and is planning an Education day in September and the Executive team will be invited. The event will consist of presentations amongst other information on the Robotic programme.

Mrs Ogden said there was a third surgeon coming on board to carry out Robotic surgery and a new Urologist would be doing Robotic prostatectomies from August.

- **Update re Interventional Procedures Register**

There was no update provided on the Procedures register.

6.5 New Interventional Procedures

- **Parathyroid Surgery**

Professor Wood referred to the Parathyroid surgery procedure and advised that she had previously seen this report and did not want to dominate the discussion but would endorse the recommendation for this new service in Fife as it would be beneficial for the patients of Fife to have a Parathyroidectomy locally as Professor Wood said it was much safer as some patients get post operative hypoglycaemic episodes and that's not good when you have had surgery and are further away from home.

Professor Wood asked others for their thoughts on this procedure?
Mrs Dobson said she was supportive from the point that this is better for the patients and it is positive for Fife as an NHS Board, albeit she was not a doctor or an ENT surgeon. Professor Wood explained that the procedure is mainly for primary hyperparathyroidism referred by the endocrine team, but renal patients could come on board in due course if that was deemed to be appropriate. The Committee approved the procedure. Mrs Ogden to feedback to Mr Walker and the relevant team. **GO**

6.6 SPSO Recommendations

This was covered under Item 6.3.

7 Emergency Care Directorate

7.1 Directorate Governance – Specialty National Reports

7.2 Directorate Level outcomes data:

- **Clinical Audit**
- **FOR INFO - Cancer Reports – Lung**

Mrs Beveridge advised that the Lung cancer reports were included for noting/information.

- **FOR INFO - Cancer Reports – Oesophago-Gastric**

Mrs Beveridge advised that the Oesophago-Gastric cancer reports were include for noting/information.

- **SAER LEARN Summaries**

The SAER summary related to a misdiagnosis of a new lung cancer which was a result of it being entered on a system that relies on paper copies being generated. Mrs Beveridge added that reassurance has been given that the electronic rate reconciliation has been included as part of the digital and information strategic planning process.

7.3 Directorate Report

Mrs Beveridge introduced Kerry Perrie who was now in post replacing Margaret Dodds as Lead Nurse for Governance & Risk.

Mrs Beveridge presented the Directorate report. The following points were noted:

Incidents
There were 588 incidents during this reporting period. The Directorate reported a 50% reduction in major harm during March & April. The major/extreme incidents reported related to cardiac arrests, pressure ulcers, patient falls. PVC SAB and medication incidents.

SAERs/LAERs
There are 48 LAERs outstanding and 14 ongoing SAERs at present.
18 LAERs relate to on ward developed pressure damage.
10 of the SEARs have had oversight meetings and are progressing.
Mrs Beveridge anticipated that discussions would take place soon regarding the outstanding LAERs as many have been delayed due to clinical commitment and COVID.

Falls
There has been 157 patient falls of which 16% of falls have sustained harm. This reporting period saw a reduction in the number of falls but an increase of falls with harm. Ward 32 remains a high reporter of falls although the severity of harm is low, it does remain an area with cause for concern.

Tissue Viability Incidents
There have been 23 incidents with hospital acquired pressure damage. The report notes that there has been a deduction with onward developed including Grade 3.
Mrs Beveridge highlighted a significant improvement in Ward 32 and no Grade 3 have be reported since January which is very encouraging.

Medication Incidents
There have been 59 reported medication incidents over the 2 month period with administration of medication and prescribing being the top 2 categories. Mrs Beveridge reported that the Directorate are looking at the critical review process that will aid managing the fridge audits.

Infrastructure
The Directorate has seen a significant increase in incidents relating to infrastructure. There have been 40 incidents reported during this period. These relate to overcapacity and staffing including staffing levels/skill mix and ratio. Mrs Beveridge said the concern could be significantly higher if staff have not reported shortfalls.

SAB
There were 5 SAB incidents – 1 major within Ward 22 which resulted in a SAER Mrs Beveridge is re-assured by the improvement work that continues within the inpatient and outpatient areas.

MCCD
Mrs Beveridge advised there has been an increase in the delay of completion of death certificates and this is being closely monitored across the nursing and medical workforces.

Complaints
The Directorate are struggling to keep within the deadline for complaint responses with 66 Stage 2 complaints, the majority being over the 20 day target. It was noted that there are a large number with the Patient Relations department for drafting and this is now becoming quite overwhelming.

Risk Register
The Directorate added 2 new risks to the risk register, these relate to:
Ward 23 - ongoing concerns around dual trained cardiology cover
Ward 53 – concerns around high levels of nursing staff vacancies (currently 9.76 WTE)
Professor Wood asked about the delays in treatment related to pressures at the

front door referred to in item 1.6 in the Directorate report and if this was a significant concern? Mrs Beveridge said that it was a capacity related issue getting patients into the correct ward.

Professor Wood then asked about the pressure sores and said that the incidents in AU1 could be ward developed pressure ulcers rather than on arrival? Mrs Beveridge agreed and said that this required further investigation and will form part of the improvement work that is required in AU1. Mrs Beveridge said it could be due to mis-recording of the data and would ask Mrs Perrie to look into this. **NB/KP**

Professor Wood asked Dr McCormack to submit the Royal College of Physicians external review report to the Committee – either at the September or November meeting. **SMcC**

Professor Wood also noted that the COVID outbreak within the Dialysis unit was not reported in this submission and asked that it was included in the next Directorate report at the September meeting. **ECD**

Professor Wood thanked the ECD team for a clear report which was easy to digest.

Ms Smith also thanked Mrs Beveridge for all the work which has been done around the medicine fridge audit. Ms Smith noted for the Committee's information that the audits are now finished for the Acute Division with the reports being presented to the Safer Use of Medicines group in July and subsequently back to this Committee thereafter. Ms Smith to link in with Mrs Beveridge. Lastly, Ms Smith advised that the Controlled Drug ward audits will be taking place soon and will continue until the end of December. **GS/NB**

Dr McCormack continued for Emergency Care and would be presenting the medical specialty highlights.

MOE
Dr McCormack advised that the stroke bundles/targets were not met in February or March due to a COVID outbreak closing off part of the stroke unit. The unit has had a re-audit of TIME bundle completion for admitted patients with delirium shows improvement of 25%, further improvement is desired and so further intervention and reaudit is planned. Audit of Frailty round patient identification and outcome showed that process is working well.

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

- **Clinical Quality Indicators**
- **Endocrinology Service Update (action 354)**

This item was not discussed. Follow up via outstanding actions. **ECD**

- **Synaptik – Neurology May 2022**

Dr McCormack informed the Committee that Synaptik have been providing an insourced service for Neurology outpatients since 2016 and have seen over 5000 new patients during this time. A number of issues were flagged by members of the wider local Neurology team whereby one particular doctor had omitted to request follow up investigations or make onward referrals to other specialities despite having referenced these in clinic letters. Dr McCormack said that she had not had

been able to speak with the Caldicott Guardian about this issue and whether this raised Duty of Candour issues. The report details that a 20% sample of 430 new patients seen during the period in question was undertaken for investigation and 4 errors were found, this resulted in all new patient clinic letters being looked into and 14 errors were found. Dr McCormack noted that any missed diagnostic tests have now been ordered or completed by the local team. There have been no new issues. Dr McCormack was hopeful to meet with Dr McKenna this week to finalise and sign off the report and actions taken. **SMcC**

There were no questions from the Committee. Professor Wood said it had been well audited and was nearly at the point of completion.

The update was noted.

- **SBAR & SOP – Rapid Assessment & Discharge (RAD) Unit**

Dr McCormack provided an update on the Rapid Assessment & Discharge Unit (RAD). Dr McCormack advised that the RAD was agreed by the Executive Directors Group (EDG) in 2020 and has been up and running since then in terms of the inpatient element. The RAD unit was developed to schedule the unscheduled, urgent car of frail people via an ambulatory model alongside the development of a criteria led assessment and discharge focussed in-patient MOE ward.

Dr McCormack said that the unit had experienced issues as members will be aware of the capacity issues and this has affected the surge area which in turn increases the numbers in the RAD unit which makes it harder to deliver the principles of the RAD unit. The report notes one of the recommendations is to try and launch the ambulatory part of the RAD unit, Dr McCormack said that a partial launch has been done and TIA patients are being seen but further work regarding a Geriatrician of the Day making more ambulatory decisions is required.

Mrs Dobson asked for more information on the graph shown for Length of Stay as the title of Rapid and a patient staying 15 days do not really match so the statistics for the unit are not accurate. Dr McCormack said that an ongoing issue has been ensuring that patient placement is appropriate and sometimes the placement of patients has not been following the Standard Operating Procedure (SOP) where it is a pool model and patients have been placed out of hours into the RAD unit. Dr McCormack added that there is a plan to relaunch and rebrand the unit and ensure that the multi-disciplinary and capacity teams are fully aware of the criteria for the RAD unit. Mrs Dobson commented that even with that mix it still feels quite long and it needs to be those who are RAD suitable versus those that aren't as 15 days is a long time in an Acute hospital under that model of care is too long. Dr McCormack hoped that with education this would change but the unit has been branded along with Ward 6 during the winter period and it seems that the areas have been seen as the same although they are very different. Professor Wood asked Dr McCormack to make a more in-depth analysis but still present all the RAD patients in the audit but somehow keep them separate as to correct RAD patients or not in order to see where the length of stay on the RAD side is going too slowly or otherwise. **SMcC/ECD**

Professor Wood commented that she would be supportive of the development of the RAD unit doing more Ambulatory work. Professor Wood asked the Committee for comments – they agreed to support this in principle. Dr McCormack said that the unit may struggle to deliver this in the shot term but it was good to have the

backing of the Committee.

The update was noted.

- **SBAR Toxin Injection Service for Injection Service for Sialorrhoea**

Dr McCormack referred to the SBAR and noted that this is from Neurology initiation of a toxin service to treat chronic Sialorrhoea, which for those who are unaware, is drooling and this aids drooling by receiving Botox injections. Dr McCormack highlighted that the process and procedure is very similar to the Botox headache paper that has been to the Committee previously. The injection will be carried out by a nurse who will be trained to give these injections and in the meantime, a Consultant Neurologist is able to give these injections. Dr McCormack said this is proposed to be a Consultant LED service and at the moment there is only 1 patient per year who may benefit. The patient will require 4 injections per year although the patient does get an accumulation benefit. Dr McCormack advised that the paper did not contain any information on audit or feedback as with the very low numbers this would be difficult to obtain but suggested that an update be submitted to the Committee in a year's time, provided the Committee were content to give the service the go ahead.

Professor Wood asked members if they were agreeable for this to proceed within the service? Dr Morrice advised that this initiative is used by the Paediatrics ENT team in Edinburgh and added that it did not appear to be too expensive. Dr Morrice said he was supportive from a governance aspect. Dr McCormack said there would be the cost of the Neurologists but it would be good to obtain approval from a governance aspect.

The Committee were agreeable for the service to implement the Sialorrhea treatment.

- **ED Syncope Audit**

The audit was noted.

- **FOR INFO - Chest Pain Service**

The chest pain service paper was noted.

7.5 New Interventional Procedures

There were no new Interventional Procedures.

7.6 SPSO Recommendations

There were no issues from SPSO.

8 Women Children & Clinical Services Directorate

8.1 Directorate Governance – Speciality National Reports

There were no specialty national reports submitted.

8.2 Directorate Level Outcomes Data

- **Clinical Audit**

- **SAER Learn Summaries**

There were no LEAR summaries submitted.

8.3 Departmental Reports

- **Clinical Services Report**

Mrs Galloway spoke to Clinical Services Report. The following points were highlighted:

There were no radiation incidents and the biggest number of incidents for Laboratories were incorrectly labelled specimens of wrong blood in tube. The Laboratory spends a significant amount of time recording these errors on the DATIX and the Lab Quality Management systems. Mrs Galloway noted that these errors do not appear on the Planned or Emergency Care Directorate reports although there is a significant number and said that these are Emergency Care and Planned Care patients, hence Mrs Galloway asked if there was a mechanism than could be used in order that these incidents are captured in the respective Directorate reports. Mrs Galloway said that the incidents are being logged and closed with no real learning outcomes and asked if colleagues would be interesting in discussing? **ECD/PCD**

Professor Wood asked if there were any common themes with the incidents?...was it a particular group of staff or any staff that take blood?

Mrs Galloway mentioned that an area of very good practice is Accident & Emergency as Dr Roy looked at why it was happening and how they could make it easier for it not to happen. Other areas of good practice were noted as Paediatrics and Obstetrics & Gynaecology but the poor practice areas outnumbered the good. Mrs Beveridge agreed that Dr Roy had done a lot of good work and thought that this practice had been filtered into other areas. Ms Galloway agreed that a lot of the Front door areas were but the numbers have dropped significantly. Mrs Beveridge said that the Directorate do need to take responsibility. Mrs Beveridge & Mrs Galloway to discuss. Mrs Ogden also agreed and asked if the learning and work that Dr Roy had done could be shared with the Planned Care team? **NB/DG** **NB/GO**

Mrs Galloway escalated a significant risk for the Directorate which related to the Laboratory Information Management system (LIMS) which generates the results that go onto TrakCare and SCI Store and advised that there was a consortium approach across 11 Health Boards in Scotland and the company who were awarded the contract are not the current contractor, hence the current contractor will cease supporting the system we have from 1st April 2023. Mrs Galloway added that there is considerable work going on at the moment in terms of the mitigation, the legal position and business continuity and the Directorate have taken papers through Digital & Information as well as Senior Leadership Team and wanted to make the Committee aware of the position.

Mrs Galloway informed the Committee for awareness that the Radiology CT mobile scanner will be on site for around 24 weeks while we replace scanners. Mrs Galloway was aware there had been discussion around the processes and said that although these had been worked on and resolved she was always happy to further

discuss if necessary for any of the Directorates.

Professor Wood asked Mrs Galloway to bring back an update on the LIMS situation to subsequent meetings for assurance. **DG**

Professor Wood then asked about cancelling tests on Trak to stop this being an issue? Mrs Galloway said that it was not an easy fix as it transfers from one system to another and the systems seem to be dis-jointed so it is a real issue. Mrs Galloway said several conversations have taken place about this but was happy to re-visit it again. Mrs Galloway asked Dr McCormack if she could speak with Digital & Information regarding a resolution. **DG/SMcC**

Professor Wood asked Mrs Galloway to provide some comms around the issues for the beginning of August which is when the junior doctors changeover because they request the majority of tests. Mrs Galloway to send the comms to Medical Education for distribution and this will also be circulated to trained medical staff if needed. **DG/MW**

The Clinical Services update was noted.

- **Women & Children**

Dr Morrice presented the Women & Children report highlights.

Cluster Review
Dr Morrice informed the Committee about the Perinatal cluster review which has now been completed. Dr Morrice added that this review relates to Therapeutic cooling cases where there were a number of neonatal deaths over the past 18 month which triggered the need for the cluster review. Dr Morrice said the review did not find any common themes in the 12 Obstetrics Neonates cases that were scrutinised although it did raise a few learning points including neonatal intubation. Dr Morrice said that we are incubating fewer Neonates generally and Neonatology are using more non-invasive ventilation. The Best Start initiative means that any extreme premature babies in Fife are transferred to Glasgow and Edinburgh and this is recognised as an issue and has been picked up by the Peri-natal network. The network has recently issued a survey to all Neonatal units in Scotland which has revealed that more SIM training is required. Dr Morrice also raised issues with communications between different departments which is also being addressed.
Dr Morrice advised that as the review did not find any common themes it was felt appropriate to commission an external review, hence a letter has been sent to Greater Glasgow Health Board asking for assistance – no response has been received yet.

The final report has now been submitted to the Medical Director and then onto Executive Director's Group (EDG). Dr Morrice said the final report would be included in the submission for the next meeting. Professor Wood asked that an update on the external review also comes back to the Committee.

SAERs & LAERs
There were SAERs in Paediatrics, Neonatal, Obstetrics & Gynaecology.

The major incidents related to sudden infant death, birth at home and cardiac arrest in theatre.

Dr Morrice noted that Dr Laura Stewart has begun producing a Powerpoint slide for

lessons learnt and positive feedback and this is circulated on a weekly basis to the Directorate teams to read over which has been well received.

Complaints
There were 10 Stage 1 complaints and 5 Stage 2 complaints reported during the period

Risk Register
Risk 2087 – Anti-ligature risk in the children's ward – has been on the register for considerable time but there may be movement with it now.
Risk 2199 – Delay to refurbishment in Ward 24 (Gynae) – Dr Morrice said the ward requires work done but more significantly highlighted there is a risk with the length of the delays. It has been out to tender but seems to be delay after delay with this work progressing making a clinical risk with patients not where they should be.

Child Death Review
Dr Morrice advised that a commissioning group meets regularly to commission reviews relating to all child deaths. The first meeting of the Governance group has taken place and there has also been a visit from Healthcare Improvement Scotland (HIS) which was warmly received. Dr Morrice added that we have time allocated in one of the Consultants job plans to contribute to this and are awaiting recruitment of a Nurse to the service so there is progress being made.

Dr Morrice thought there may be a difference in how adverse events are described within Maternity and Neonates as there has been a national steer on this so was flagging up a potential change in language which may filter through.

Specialty Reports
Dr Morrice informed members that the Directorate has altered how they carry out their Clinical Governance and each department feeds into the bi-monthly Directorate Clinical Governance meetings and from that the specialty reports will come to this Committee although there may be a month delay in reports reaching this Committee depending on the submission dates.

Quality Improvement and Audit
Dr Morrice said that with regard to Quality & Improvement the Directorate have the Ockendon reports which were in the national media in recent months and the Directorate are looking very carefully at benchmarking their practice against the recommendations in that report. Dr Morrice will update in due course at future meetings. **JM**

Professor Wood thanked Dr Morrice for a detailed report and noted it was helpful to have advance warning about the language around SAERs etc.

Professor Wood asked Dr Morrice to send an example of the weekly learning to Miss Godsell who could then circulate to the group. **JM/LG**

FOR INFO:

- **Paediatrics Report**

The Paediatrics report was noted.

- **Neonatal Report**

The Neonatal report was noted.

- **Maternity Report**

The Maternity report was noted.

- **Gynaecology Report**

The Gynaecology report was noted.

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

PAPERS FOR INFORMATION

- NNU Dietetics Paper
- Parliament Motion re NHS Fife Nursery Nurses
- Vulnerable in Pregnancy (VIP) Report
- Complex Care Review Template – Obstetrics
- Paeds CF 2020 Data Network Report
- SSI Review Summary 2021
- Perinatal Cluster Review Meetings

The above papers for information were noted. These were not discussed.

8.5 New Interventional Procedures

There were no new Interventional procedures.

8.6 SPSO recommendations

There were no SPSO recommendations.

9 Divisional Risk Register – Active Risks

Professor Wood referred to the Divisional Risk Register and asked if this requires discussion at every meeting? Mrs Beveridge responded that each Directorate has their own Risk Register which is regularly reviewed and discussed but the Divisional one warranted discussion every so often. Professor Wood suggested that we discuss the Divisional Risk Register twice per year.

Mrs Muir said she thought that Dr Cargill and Mrs Campbell looked at the Risk Register offline and brought updates back to the Committee for consideration.
Professor Wood said that she would look at the Risk Register with Mrs Campbell. **MW/LC**

Mrs Dobson advised that the organisational approach towards risk is changing so agreed it was not imperative to review the risks today. Professor Wood suggested that herself and the co-chair familiarise themselves with what the organisational changes to risk will entail. **MW/LC**

The risk Register was noted.

10 Review of ToR (2021 version attached)

Professor Wood referred to the Terms of Reference and advised she thought it was fit for purpose. Professor Wood asked for comments about the Terms of

Reference and suggested that this be updated and reviewed if everyone was content with them. Mrs Dobson requested that she be added onto the membership. Miss Godsell to update and will thereafter be approved. **LG**

Professor Wood thanked those attending for participating in good useful discussions today.

11 Items for information only:

11.1 NHS Fife Activity Tracker

The Activity Tracker was noted.

11.2 SIGN Guidance

The SIGN Guidance was noted.

11.3 Attendance Matrix for 2021 - 2022

The completed attendance matrix was noted.

11.4 ASD CGC Workplan 2022/2023

The workplan was noted.

11.5 Infection Control Committee Minutes of 2nd March 2022 (incorporating AMT)

The Infection Control Committee minutes were noted.

11.6 HAIRT Report – April 2022

The HAIRT report was noted.

11.7 NHS Fife CP&PAG Minute of 28th March 2022

The NHSF CP&PAG minutes were noted.

11.8 Resuscitation Minutes of 10th May 2022

The Resuscitation Committee meeting was cancelled.

11.9 HTC Minutes of 6th May 2022 (& associated papers)

The Hospital Transfusion Committee minutes and papers were noted.

12 AOCB

There were no matters raised for discussion.

13 Date of Next Meeting/s:

Wednesday 7th September 2022 at 2.00pm via MS Teams

Area Clinical Forum

AREA CLINICAL FORUM

(Meeting on Thursday 4 August 2022)

No issues were raised for escalation to the Clinical Governance Committee.

Fife NHS Board

Unconfirmed

MINUTES OF THE NHS FIFE AREA CLINICAL FORUM HELD ON THURSDAY 4 AUGUST 2022 AT 2PM VIA MS TEAMS

Present:
A Lawrie, Chair
A Mackay, Speech and Language Therapy SLT Operational Lead
J Fearn, Consultant Clinical Psychologist
D Galloway, Women Children & Clinical Services General Manager
E O'Keefe, Consultant in Dental Public Health *(part)*
C Notman, Practice Pharmacist

In Attendance:
L Holloway, Service Manager *(agenda items 1 - 5 only)*
H Thomson, Board Committee Support Officer (Minutes)

1. Apologies for Absence

The Chair welcomed everyone to the meeting, and extended a welcome to L Holloway who joined the meeting to provide a verbal update on the Scottish Government Women's Plan at agenda item 5.

Apologies were received from P Duthie (General Practitioner), B Hannan (Director of Pharmacy & Medicines), P Madill (Consultant in Public Health Medicine), C McKenna (Medical Director) and J Owens (Director of Nursing).

2. Declarations of Members Interests

There were no declarations of interest from those present.

3. Minutes of the Previous Meeting held on 7 April 2022

The minutes of the previous meeting were **agreed** as an accurate record.

4. Matters Arising and Action List

There were no matters arising or outstanding actions.

5. Scottish Government Women's Plan

L Holloway, Service Manager joined the meeting and provided an update on the Scottish Government Women's Plan as per appendix 1.

C Notman highlighted the governance around medicines for women and noted it would be beneficial to review material and guidance documents within Pharmacies in line with the Scottish Government's material, particularly as we move to an East Region Formulary for medicines; NHS Fife would still have some control over guidance documents. It was agreed it would be beneficial to have Pharmacy representation on the relevant groups. C Notman agreed to take forward.

Action: C Notman

A Mackay highlighted the accessibility of women's services, and questioned if there are barriers to access, and if there are, how those barriers are being managed. L Holloway noted that the demand for services is increasing on a yearly basis, which is challenging. It was advised that there are materials available for those who have been referred. It was also advised that support elements of the services will be considered to ensure we are inclusive with accessibility, and that services are available to everyone.

J Fearn asked if there were psychological interventions for those going through the menopause. L Holloway reported that there is no Psychologist on the subgroup and J Fearn agreed to discuss psychology in relation to menopause pathways outwith the meeting. It was also noted that if it's identified psychological interventions are required to achieve the recommendations within the plan, this could be taken forward via a business plan case.

Action: J Fearn

It was confirmed that the Menopause Nurse Led Services can prescribe relative medicines.

Following a question from the Chair, L Holloway advised that the Termination of Pregnancy Group do not necessary take a minute, however, information is shared via other channels from meetings.

L Holloway agreed to attend a future meeting to provide a further update. H Thomson to send L Holloway a list of the group members.

Action: L Holloway/H Thomson

The Forum **noted** the update.

6. Winter Systems Review

This item was deferred to the next meeting. H Thomson to add to the agenda.

Action: H Thomson

The Chair agreed to discuss with J Owens outwith the meeting, if there are any actions for the ACF to consider in relation to the Winter Plan.

Action: Chair

7. Area Clinical Forum Chairs Group For Scotland Update

The Chair reported on the recent meeting and advised that there were a few changes to the representation of the ACF Chair's Group, as it had been some time since they had last met, due to Covid.

Discussions at the recent meeting were focussed on the remobilisation of the ACFs.

It was reported that the attendance at ACFs can fluctuate, and that this occurs at a national level, and not specific to NHS Fife. Work will be carried out to raise the profile of the ACF.

The Forum **noted** the update.

8. Area Clinical Forum Organisational Chart

Members of the Forum were asked to identify the new Chairs of the various Groups on the ACF Organisation Chart, and advise H Thomson who will make the updates.

Action: ACF Members

The Chair agreed to identify the Chair of the Area Optical Committee.

Action: Chair

J Owens to agree the Chair of the Nursing & Midwifery Committee.

Action: J Owens

9. Annual Area Clinical Forum Workplan

The Chair advised the Forum an Annual Workplan requires to be developed which will set out the planned work for the financial year. The Chair also advised that consideration should be given to aligning the Area Clinical Forum Chairs' Group for Scotland Workplan 2022.

It was requested to add the following to the workplan:

- Quality and Improvement Facility Updates
- Scottish Government Rehabilitation Plan

Action: H Thomson

It was agreed to add to the agenda at a future development session, a review of the Constitution & Terms of Reference (ToR) for the ACF. It was also agreed the Constitution & ToR for each of the groups that are represented at this Forum be shared, to support the review of the ACF's Constitution & ToR.

Action: ACF Members/H Thomson

10. Subcommittee Minutes

The Forum noted the following subcommittee minutes:

10.1 Allied Health Professionals Clinical Advisory Forum dated 6 April 2022 (confirmed)
10.2 Area Pharmaceutical Committee dated 28 March 2022 (confirmed)
10.3 GP Subcommittee dated 15 March 2022 (confirmed) & 19 April 2022 (confirmed)
10.4 Area Medical Committee dated 14 June 2022 (unconfirmed)

11. Escalation of Items to the Clinical Governance Committee

There were no items to escalate to the Clinical Governance Committee.

12. Any other Business

12.1 Area Dental Committee

E O'Keefe advised that the Area Dental Committee has been postponed due to no secretarial support, noting that the Area Dental Committee is a statutory professional committee. The Chair agreed to take forward identifying secretarial support.

Action: Chair

13. Date of Next Meeting

The next meeting will take place on Thursday 6 October at 2pm via MS Teams.

Appendix 1

Meeting and Date	Area Clinical Forum 4.8.22
Service Update	Obstetrics and Gynaecology
Update Subject Matter	Women's Health Plan (WHP)
Author	Lynne Johnston (Holloway)

Introduction

The WHP is a plan for 2021-24

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

A range of biological factors impact on women's health. Women and girls experience various health needs and risks during their lives which are not the same as those of men. This may relate to starting and managing periods, choosing contraception, accessing abortion services, planning for pregnancy, managing menopause symptoms and the manifestation of chronic conditions such as heart disease.

Women make up 51.5% of Scotland's population with 1:3 women expected to experience a reproductive or women's health problem at some point in their life . In Scotland there are 400,000 women are of menopausal age, plus those who have had an early onset or interventional onset of menopause.

Deprivation impacts women's health, with life expectancy reducing from 81.1 years to 75.6 years. In 2020 the TOP rate was 2.2 x higher in the more deprived areas.

It should also be acknowledged that over 75% of NHS Scotland workforce is women.

The plan covers 8 key areas

- Menopause
- Endometriosis
- Abortion and contraception – we have chosen to split this
- Postnatal contraception
- Women's general health
- Miscarriage
- Breastfeeding and Mental Health and Wellbeing - we have chosen to split this

It should be noted that the plan is not just the responsibility of the acute women's service, but requires involvement from all agencies. Our membership is diverse, but to be effective requires the support and involvement from primary care and secondary care, health and social care, the third sector and public health.

The oversight group meets bi monthly but is still in its infancy and requires updates from all sub groups in order to monitor progress against priorities.

Sub group priorities as identified in the plan

Sub Group	Priority
Menopause	Priority: Ensure women who need it have access to specialist menopause services for advice and support on the diagnosis and management of menopause
Endometriosis	Priority: Improve access for women to appropriate support, speedy diagnosis and best treatment for endometriosis
Women's General Health	Priority: Reduce inequalities in health outcomes for women's general health, including work on cardiac disease.
Miscarriage	Priority: Dignified, compassionate miscarriage service
Breast feeding and mental health and well being	Priority: Review HV and Midwifery pathways for new families and babies, improving access to breastfeeding support, physical therapy advice and increased postpartum and mental wellbeing support
TOP	Priority: Improve access to abortion and contraception services
Post natal contraception	Priority: Ensure rapid and easily accessible postnatal contraception

Sub Group Current Position:

Menopause

- Current capacity identified as being insufficient to meet demand
- Nurse specialist in post who runs a nurse led clinic that has reduced the waiting time to first consultant appointment from over 31 weeks to 16 weeks.
- Training packages for Primary and Secondary Care under development with some already being delivered.
- Co-working across Acute and Sexual health Service with a GP delivering 1 clinic per month in acute.
- DEXA Scan waiting time 1.5-2 years – Radiology aware

Endometriosis

- Specialty clinic was set up in 2018/19
- Patient centred approach to management setting realistic goals and a holistic view
- Review patients may be managed through PIR

- Demand and capacity issues – service has identified a role for a nurse specialist, though currently funding is not available
- Links with urology and colorectal colleagues
- Lead for endometriosis is also the lead for infertility with a strong link between the 2. Patietns referred to ACU where appropriate
- Link with menopause service where patients are considering surgery to remove ovaries.

Women's General health

Work to identify group participants and remit still required. Requires mult agency working.

Miscarriage

- There is a dedicated EPC service
- Nurse led service managing patients who have had 2 not 3 successive losses
- Environmental improvement work to rooms 10 and 11 in CLU has been approved to soundproof rooms used by families suffering loss, providing a more appropriate environment for them
- Consideration to potential EPC/RMC bereavment support service – further work and staffing resource required

Breastfeeding and Mental Health and well being

Multi disciplinary team established comprising the perinatal mental health team, the maternity and neonatal psychology team – along with the infant psychology team. These teams work closely together to improve both antenatal and postnatal mental wellbeing; this is facilitated by regular cross disciplinary MDT meetings.

- **Perinatal Mental Health (PNMH) team includes:**

This team provides specialist assessment and intervention for women with severe of complex mental health problems. We also have access to a Mother and Baby unit in Livingstone. Preconceptual advice is available for women with pre-existing mental health problems – although timely referral for and uptake of this could be improved.

- **Maternity and Neonatal Psychology (MNP) team includes:**

This arm of the team allows for access to specialist psychology services for up to 12 months following delivery. This includes working with women with previous experience of trauma, birth trauma, specific phobias e.g. tokophobia and needlephobia. Our referral criteria are currently being expanded to also include women who have had stillbirths and neonatal deaths. Members of this team are also physically present several days a week on the neonatal unit and provide support for families there. Their remit also includes support for staff members in maternity and neonatology.

- **Birth Trauma Training:**

The MNP team have also been working on raising awareness amongst healthcare professionals who work with the maternity population of the underlying causes and risk factors of birth trauma (both individual trauma and vicarious trauma); the symptomatology and diagnosis; the importance of language choice; and treatment and healing options. Dissemination of these messages will help create a trauma-informed culture in NHS Fife –

where maternity and psychology services work together to ensure that women feel safe and supported.

The team have been awarded funding for Birth Trauma training for staff working with the maternity and neonatal population in NHS Fife. This online training is going to be provided in collaboration with the 'Make Birth Better' charity. This will include: an online webinar – providing up to date evidence on birth trauma and postnatal PTSD. This would be available for all maternity staff and will provide a baseline of knowledge and awareness of Birth Trauma throughout our service. We will then offer five smaller online action based workshops focusing on bespoke topics which are important to NHS Fife. These sessions would take place between April 2022 and December 2022.

The main beneficiaries of this training would be the people who are looked after in pregnancy and who give birth within NHS Fife. This equates to approximately 3500 deliveries in NHS Fife per annum. Given the current evidence which suggests around 30% of all women will find some aspect of their birth traumatic, this would equate to approximately 1050 women/year in Fife. The Fife Maternity & Neonatal Psychology service currently receive on average 8 referrals/week with a significant proportion being related to birth trauma. Further beneficiaries of this project would be the infant, the birth partners and wider families of women who experience a traumatic birth as these crucial relationships can also be significantly impacted with wider implications for the mental wellbeing of the family as a whole.

It will also benefit the maternity staff who look after these people: both in terms of developing their clinical practice, but also in terms of developing our pathways to help them deal with traumatising clinical events.

- Midwifery Mental Health champions
- Service users

TOP

- High demand for service with waits of 4 weeks.
- MTOP well utilised
- Training underway for nursing staff re: telemedicine
- Telemedicine with select scanning protocols being reviewed in relation to NHS Fife
- Shared plans with Sexual and Reproductive Health for LARC post telemedicine
- One stop clinic in place but limited by scan slots
- Surgical TOP list now reinstated weekly to provide women with a choice
- Self referral now available, though insufficient clerical funding will impact upon delivery

Post-natal contraception

- 6 months' supply of contraceptive pill given to post-natal women as they leave hospital.

- Educational videos for staff available, but training and resources required to support staff with LARC

NOTE OF MEETING OF THE AREA MEDICAL COMMITTEE (AMC) HELD ON TUESDAY 14 JUNE 2022 AT 2PM VIA MS TEAMS

Present:

Dr Phil Duthie	Co-Chair
Dr Chris McKenna	Co-Chair & Medical Director
Dr Annette Alfonso	Clinical Director Emergency Care
Dr Helen Hellewell	AMD H&SCP
Dr John Kennedy	Clinical Director H&SCP (East)
Dr Sally McCormack (from 3.15pm)	Clinical Director Emergency Care
Dr Susanne Galae Singer	Clinical Lead, Addictions Service

In Attendance:
Catriona Dziech (Notes)

1 APOLOGIES FOR ABSENCE
Dr Marie Boilson, Dr Fiona Henderson, Dr Claire McIntosh, Dr Sunil Sahu, Professor Morwenna Wood

2 DECLARATIONS OF MEMBERS' INTERESTS
There were no declarations of interest.

3 MINUTES OF PREVIOUS MEETING HELD ON 8 FEBRUARY 2022
The notes of the meeting held on 8 February 2022 were approved.

4 MATTERS ARISING

i) Revised Constitution – Requirements for AMC in Statute
Dr McKenna advised he has not reviewed further but will follow up. Two new members have been invited to join the Committee; Dr Claire McIntosh, Chair of Division of Psychiatry and Dr Susanna Galea Singer, Clinical Lead for Addictions who was present at the meeting today.

5 STANDING ITEMS

i) Financial Position – Including (IPQR considered at Clinical Governance Committee 29 April 2022)
Dr McKenna advised NHS Fife broke even last year but it will be difficult to break even this financial year. A Finance Sustainability plan is being pulled together by Finance and operational colleagues with the support of Directors. This seems to be the most reasonable way to try and manage finances and there will be challenging conversations and being prepared to invest to save. There is a process in place for cash releasing projects going forward.

The extent of the financial challenges is unprecedented with varying demands on services along with the requirement to save money and do things more efficiently. Realistic medicine is going to matter more than before. There also needs to be an understanding around the costs of being in an acute hospital and changing the default position of keeping patients in hospital.

Dr Duthie suggested if the Hospital @ Home service was up and running this would save beds within the acute hospital. Historically spend to save was lacking and needs to be sorted out to move forward. It was also noted there is difficulty recruiting to home care due to the less attractive value for these jobs and staff.

Dr McKenna advised an idea has been proposed to St Andrews University and Research to monitor trends of acute admissions and the impact of Covid on the demographic and multi morbidity. This research would help to understand and inform change.

Dr Alfonso highlighted there is currently more frailty coming through the front door and staying longer in hospital. The difficulty is when patients are waiting on a social care service to allow them to get back home with patients joining the queue daily the list continues to grow. This is a big part of workload on Acute with numbers having increased significantly since the Pandemic. Dr Duthie agreed the patient journey from start to finish needs to be looked along with a frank discussion with Social Work and the Government providing additional funding.

Dr Alfonso highlighted one strategy that may be worth developing to avoid admission to the acute site would be having a Social Worker sitting in the Flow and Navigation Hub who could try and deal with the problem at source to avoid admission. Dr Duthie agreed this was a helpful suggestion and certainly worth exploring.

In closing it was agreed this was a difficult issue to resolve when fighting a losing battle of availability. As a system we work better together now across Health and Social Care and Acute than previously. Pressure rises very quickly in the Acute setting, and it is very easy not to see that in Health & Social Care where the pressure rises slower as it is spread over larger areas. Although a work in progress there are ways of escalating issues with the OPEL structure which gives a common understanding each day across the system.

ii) Medicines

Dr McKenna advised medicines remain a big spend area. Within the financial plan this year it includes £1m for CF drugs. A medicines strand is also included with the financial savings plan to look at prescribing.

iii) Adverse Events

Dr McKenna agreed for future meetings the adverse events summary that is considered at the Clinical Governance Oversight Group would be included on the agenda.

Action: CDz

Dr Hellewell advised some SAERs have been commissioned and once completed would be shared with the Committee.

iv) Medical Staff Committee

Dr McKenna advised he has done all he can on this issue. It remains there is no Medical Staff Committee.

v) Update from GP Sub Committee

Dr Duthie advised issues are covered in the notes from meetings (at Item 7i).

Dr Duthie highlighted there is a recurring issue around Resuscitation Training and a process for getting this up and running again. Dr McKenna advised Jackie Beatson was preparing a paper for EDG consideration. It was noted Jackie Beatson would be leaving NHS Fife.

vi) Realistic Medicine

Nil to report.

vii) Medical Workforce

Dr McKenna advised some areas have done well with Planned Care having fully recruited to all specialties. Other areas such as Emergency Care had been up and down depending on the specialty. Dr Alfonso advised she has started a comprehensive job planning exercise across her six specialties including ED. Deficits have been identified within almost all the specialties with a feeling that almost everyone is doing beyond their contracted hours. The problem is how this can be fixed with limited resources, and this will be a challenge. The biggest concern is ED and Dr Alfonso agreed to update Dr McKenna with a status report before she leaves her post as Clinical Director.

Further work is required on recruitment. On a positive note, three new Consultants have been recruited. One has already started with a further two due to start in the coming month. Interviews are also taking place for a Respiratory Consultant. The recent exercise will help identify gaps.

Dr Kennedy highlighted it should be acknowledged by the Committee there is a worrying deterioration picture across Scotland and Fife. Despite the inevitable expansion of the 2C practice network it is difficult to recruit medical practitioners. The bygone solution of Locums is drifting. It is clear something has gone wrong in the last few years with population challenges not being planned for.

Dr Duthie advised recruitment within General Practice was not without challenges and GP numbers going down. On a positive note, the ScotGem students will be coming through.

viii) Education & Training

Dr McKenna advised a DL has been issued with stricter rules around the number of days long shifts can be undertaken with rotas being 48 hours compliant for a working week.

On a positive note, the Celebrating Success event had been held with trainees presenting all their projects and work. This is the third year this has been held with support from the Royal College of Physicians.

Dr McKenna advised he would be attending the first Scotgem students' graduation at St Andrews University.

ScotCom will hopefully align with the community transformation and the Hubs that are being developed.

Challenges for recruitment from a Clinical Fellow perspective has been a challenge not just in Fife but across the whole region. This is a consequence with the NHS not being perceived as a good place to work.

It was noted it would be interesting to see how the 48-hour week would impact with the current staff shortages. A way forward may be to ramp up the Advanced Nurse Practitioner workforce who are more stable and could provide skills at ward level within every speciality to delivery what we need and support junior doctors. It was agreed this was a difficult situation and we need to find different ways to meet the demands.

It was agreed a long-term recruitment strategy is required to address workforce issues for both Primary and Secondary Care. It was suggested discussion with NES may also be helpful.

6 STRATEGIC ITEMS

i) Update from Health & Well Being Portfolio Board

It was noted Claire Dobson's slides presented to the Portfolio Board on 9 June 2022 on Review of Waiting Times, Demand, Capacity and Activity provide the context for why we need a Clinical Strategy for Fife.

ii) GMS Implementation

Dr Duthie advised the spending of £6.5m of underspend has been sorted out and work is progressing to digitalise all General Practice. Dr Duthie made a note of thanks to Finance for adjusting their governance to a level that allows things to move forward.

Dr Hellewell advised the first meeting of the Phase II of the GMS Contract had taken place with the Government. There is a plan for an early joint exploratory meeting with SGCP colleagues and Primary Care with the Government and Primary Care Leads to jointly look at this. This will be looked at separately and not waiting for the conclusion of the GMS Contract.

iii) COVID & Remobilisation

Dr Duthie advised General Practice is open.

Dr McKenna advised secondary care has been slower to respond with the desire to prevent overcrowding. This will remain a work in progress. Any restrictions on outpatient capacity now are driven by other service demands.

The Orthopaedic Hospital is progressing at pace and should open in October 2022 with first patients being treated in January 2023. There are no significant delays to the project. There will be an uplift to what can be done with National and Regional work also being undertaken.

7 ITEMS FOR INFORMATION

i) Notes of the GP Sub Committee held on 18 January,15 February, 15 March and 19 April 2022

Noted.

ii) Notes of the Clinical Governance Oversight Group 26 August 2021, 15 February 2022 & 19 April 2022

Noted.

8 AOCB

The Committee noted this was Dr Duthie's last meeting as Chair. Dr McKenna will be Chair of the Committee for the next two years.

9 DATE OF NEXT MEETING

Tuesday 9 August 2022
Tuesday 11 October 2022
Tuesday 13 December 2022
(all meetings will commence at 2pm) – Teams invites have be circulated.

NHS FIFE CANCER GOVERNANCE & STRATEGY GROUP (CGSG)

Draft Note of the Meeting Held at 14:30 on Thursday 02nd June 2022 via Microsoft Teams

Present:	**Designation:**
Izzy Corbain (IC)	Patient Representative
Claire Dobson (CD) Acting Chair	Director of Acute Services
Nick Haldane (NH)	Lead Cancer GP
Alistair Graham (AG)	Associate Director Digital and Information
Jennifer Leiper (JL)	Patient Representative
Neil McCormick (NM)	Director of Property and Asset Management
Murdina MacDonald (MM)	Lead Cancer Nurse
Kathy Nicoll (KN)	Cancer Transformation Manager
Nicola Robertson (NR)	Associate Director of Nursing, NHS Fife
Amanda Wong (AW)	Associate Director of Allied Health Professions
Apologies:	**Designation:**
Paul Bishop (PB)	Head of Estates
Joanna Bowden (JB)	Consultant – Palliative Care
Catherine Jeffery Chudleigh (CJC)	Consultant in Public Health
Nicky Connor (NC)	Director Health and Social Care
Gemma Couser (GC)	Head of Quality and Clinical Governance
Susan Fraser (SF)	Associate Director of Planning & Performance
Ben Hannan (BH)	Director of Pharmacy & Medicines
Margo McGurk (MMcG)	Director of Finance and Strategy
Chris McKenna (CM) Chair	Medical Director
Janette Owens (JO)	Director of Nursing
Frances Quirk (FQ)	Assistant Director Research, Development & Innovation
John Robertson (JR)	Lead Cancer Clinician - Surgery
In Attendance:	**Designation**
Fiona Forrest (FF)	Deputy Director of Pharmacy
Rebecca Hands (RH)	Clinical Governance Administrator (minute taker)
Sudha Singh (SS)	Consultant in Obstetrics and Gynaecology

		Action
	Welcome	
	CD welcomed everyone to the meeting and advised she will be acting Chair for this 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 28 January 2022 via Microsoft Teams**	
	The Unconfirmed Note of 28 January 2022 was **accepted** as an accurate record.	

3.	**Matter Arising/Action list**	
	KN advised they have not noticed an increase in ECDC referrals for tumour specific pathways due to GPs trying to fast track referrals. The rejection rate for this reason (61% of rejected referrals) is consistent from launch of ECDC. Action to be closed.	

TOTAL NO. REJECTED REFERRALS TO DATE	214
Meets criteria for site specific pathway	131
Does not meet ECDC criteria	63
Unfit for pathway	8
Meets criteria for benign pathway	7
Serious non-cancer diagnosis is highly likely	4
Previous cancer diagnosis and symptoms likely due to recurrence	0
Patient seen by ECDC within last 3 months with no new symptoms	0

4.	**GOVERNANCE**	
4.1	**Cancer Risks**	
	KN thanked Pauline Cummings for providing the updated cancer risks. KN advised there were 14 risks brought to the October meeting. Since then 7 risks have closed. KN advised 3 risks have had their risk level redefined to high risk. KN advised 4 new risks have been added: • Lack of registered SACT nurses • CWT deterioration • Chemocare letter printing • Diagnosis of polyps from screening KN advised Pauline has requested the group consider inclusion of two public health risks. KN advised one is around the misuse of suspicious malignancy for the screened referrals. It was suggested this may be an error. KN advised the second risk is roundabout no cervix, patients who had been flagged of having no cervix but actually did have a cervix. KN asked the group if these risks should be on the risk register. CD advised the 'no cervix' issue has come forward again this week just in terms of a letter around action for the Board and should remain. The group to let KN their comments in regard to this. KN asked CD if she would be happy for the Acute Cancer Services Delivery Group to take ownership operationally of the risks. CD agreed to this. Presentation of the risk report is under consideration. KN advised any risks associated with delivery of the Effective Cancer Management Framework and any QPI risks will be explored. CD agreed to this.	**ALL** **KN** **KN**

4.2	**Acute Cancer Services Delivery Group Update**	
	CD advised she will ensure the minutes from the Acute Cancer Services Delivery Group are available for this meeting. These will be added to the agenda going forward. CD advised the group have met twice and they have agreed the terms of reference. CD advised they have considered the cancer risks, CEL 30, Cancer Waiting Times performance overview, participation and engagement, ECDC, the delivery of chemotherapy, and the future models of care. CD advised they had a really important paper from BH around the national oncology taskforce that has been brought together between Medical Directors and Chief Executives. CD advised there is no pharmacy representation on that group but BH has done a really helpful piece of work looking at the terms of reference of that group and the position in Fife currently. CD to share this paper with the group.	**RH** **CD**
5.	**STRATEGY/PLANNING**	
5.1	**Cancer Framework & Delivery Plan**	
	KN advised they just completed the second round of engagement. KN advised they sent out the Framework along with a Forms questionnaire. KN advised 39 responses were received and feedback was very positive. KN advised edits are underway and the framework has been formatted by Comms. KN advised some updates are still required and links to other documents to be added. KN advised once the Framework has been ratified and published, the Cancer Leadership Team will oversee the programme of delivery and will provide assurance to this group by way of status updates.	
5.1.1	**Draft Cancer Framework v0.7**	
	This was shared with the group.	
5.2	**ECDC Update**	
	MM advised ECDC is 1 of the 3 pilot sites across Scotland (Ayrshire & Arran, Borders and Fife) that have been successfully rolled out. MM advised it is a pathway for patients with vague but concerning symptoms who do not meet any of the tumour specific Scottish Referral Guidelines. MM advised they aim to see, assess, diagnose and refer/discharge patients within 21 days. MM advised ECDC has been in operation for a year with anniversary on 7th of June. To date 655 referrals have been received, 452 accepted onto the ECDC pathway, and 423 of those patients have completed their pathway. MM advised 51% of patients have been discharged back to the GPs, and 34% of patients have had significant benign pathology identified which has required ongoing referrals to secondary care. MM advised they are currently doing a piece of work to see what the significant benign diagnoses are. MM advised 15% conversion rate to cancer diagnosis. MM	

	advised the most common cancers diagnosed through ECDC are Upper GI and lung. MM advised they receive approximately 19 referrals per week. From June 2021 to December 2021, their monthly referrals have increased from 37 to 68 and in May 2022, monthly referrals rate has risen to 76. MM advised the Scottish Government are keen to highlight the 1 year anniversary. MM advised the Cabinet Minister is interested in having a visit. MM asked CD if NHS Fife would welcome that visit. CD agreed to that visit.	
5.3	**Single Point of Contact Hub Update**	
	KN advised recruitment is underway for 2.5wte Pathway Navigators. KN advised they have agreed one cancer site, urology as it is the most challenged pathway. KN advised they will determine other tumour groups as resources allow. KN advised there is robust training and induction for Pathway Navigators using a local induction and a prospectus developed by Macmillan specifically aimed at the Pathway Navigators and Cancer Trackers. KN advised they are looking at working in collaboration with eHealth with a view to utilising aspects of the Patient Digital Hub. KN advised they are looking at Queuebuster which allows patients to be directed to a specific member of staff or receive a call back should they wish to not queue. KN advised they are also exploring the ability to provide ad hoc patient information through the Hub. KN advised they are working closely with NH to understand the GP narrative to patients at the point of referral. KN advised there is a national leaflet, in which they have had really good comments on from the patient representative on the project group. KN advised they are deciding whether to update that (if permitted) or develop their own. KN advised contacted eHealth to ask them to add an extra field in the SCI gateway cancer referral protocol to ensure secondary care is aware if the GP has advised the patient that they are being referred to exclude cancer. Baseline data and methods to collect and collate data to evaluated the pilot has been agreed Funding of £107,354 is still awaited.	
6.	**QUALITY/PERFORMANCE**	
6.1	**Cancer Waiting Times**	
6.1.1	**Quarter 4 2021**	
	KN advised across Scotland for 62 day there was an increase eligible referrals of 3.3% compared to the Q3 and 18.3% increase from Q4 2020. KN advised 79% of patients started treatment in target and was not met by any boards. KN advised NHS Fife achieved 82.3%, above the Scottish	

	average but below the SCAN average of 84.7%. KN advised the main issues were around delays to oncology, staffing issues in SACT unit for breast and haematology; waits for molecular testing outwith Fife which affected lung cancer performance, increased referral rates across many specialties attributed to waits, particularly 1st OPA. KN advised the prostate pathway is our most challenged and some progress has been made to reduce waits in the pathway. KN advised whilst this may not directly improve performance, patient experience will be improved. KN advised in regard to 31 day there was an increase of 0.9% compared to Q3 and an increase of 11.8% compared to Q4 2020. KN advised 97.1% of patients started treatment in target and was met by all Boards except Grampian and Highland. KN advised NHS Fife achieved 100%	
6.2	**Quality Performance Indicators**	
6.2.1	**Brain/CNS 2020**	
	KN briefed the group. Brain and CNS cancers are relatively rare cancers with approximately 410 adult cases diagnosed in Scotland each year between 2015 and 2019. The 2020 audit identified 355 patients diagnosed with a new primary cancer of the brain or CNS in Scotland. In the SCAN region a total of 113 cases were diagnosed (25 in Fife). The Scottish Adult Neuro-Oncology Network (SANON) is encouraged by the continued support and commitment of Network members to deliver a high quality service to brain/CNS cancer patients across the country. The results presented in this report demonstrate that patients with brain/CNS cancer receive a consistent and improving standard of care across all geographical locations. Case Ascertainment is 86.6% across Scotland. Case Ascertainment for the SCAN region is 87.6% (based on an average of cases from 2015-2019). Scotland met 6 of the 14 QPIs (including sub QPIs) and SCAN met 6 of the 12 QPIs for Brain & CNS. No new actions were identified for SCAN, however, updates to aid the previous actions identified were documented: • QPI 1: Documentation of Performance Status: Edinburgh centre will ensure that performance status is recorded by introducing a nominated person to chair the MDT. The chair will review MDT minutes to ensure that all the correct information has been documented. • QPI 12: Key Worker: Edinburgh has been agreed that the Oncology CNSs will be named key workers and they will try to ensure that key worker is consistently recorded for all eligible patients at the time of MDM discussion.	

6.2.2	**Colorectal 2020-21**	
	This will be brought to the next meeting.	
6.2.3	**Gynaecology 2019-20**	
	Dr Sudha Singh reviewed papers that were shared with the group. NHS Fife Case Ascertainment for 2019-2020 was 120% (Cervical), 94.3% (Endometrial), 131% (Ovarian). <u>Cervical Cancer 2019-2020</u> NHS Fife met 5 of the QPIs for Cervical cancer. QPIs not met: • QPI 6: 56 Day Treatment Time for Radical Radiotherapy (1 case). Unable to deliver brachytherapy due to failure of radiotherapy server, patient completed radiotherapy in 66 days. • QPI 7: Chemoradiation (3 cases). All patients were treated with radiotherapy and brachytherapy, no concurrent chemotherapy due to comorbidities. • Clinical Trials *QPI: 6.8% uptake.* There were no specific individual actions identified for NHS Fife. It was noted that small numbers generate disproportionate percentages. With regards to clinical trials, it was noted that: "Number of patients consented for clinical trials was low due to suspension of clinical trials in 2020 following Covid-19 pandemic. A new clinical trial for metastatic cervical cancer opened in 2019 and performance is expected to improve." <u>Endometrial Cancer 2019-2020</u> NHS Fife met 6 of the 8 QPIs for Endometrial cancer. QPIs not met: • QPI 6 Chemotherapy / Hormone therapy (1 case). Patient with advanced disease, not fit for active treatment. • Clinical Trial QPI. 3.8% uptake. There were no specific individual actions identified for NHS Fife. For QPI 6 it was noted that small numbers generate disproportionate percentages. With regards to clinical trials for Endometrial cancer, it was noted that: "Number of patients consented for clinical trials was low due to suspension of clinical trials in 2020 following Covid-19 pandemic. In SCAN we are now actively trying to open two clinical trials for endometrial cancer and performance is expected to improve." <u>Ovarian Cancer 2019-2020</u> NHS Fife met 9 out of the 11 QPIs for Ovarian cancer (including sub-QPIs). QPIs not met: • QPI 10 (i): Surgery for Advanced Disease (Ovarian*):* (14 cases). 12 patients treated with neoadjuvant chemotherapy did not have delayed primary surgery for a variety of clinical reasons. 2 patients were for BSC. • QPI11: Genetic testing in non-mucinous epithelial ovarian cancer. (7 cases). 4 patients were radiological diagnoses, not seen in	

	Oncology and for BSC. 1 patient declined BRCA testing. 1 case genetic testing was not required as it was a seromucinous tumour. In 1 case genetic testing was not recommended by oncologist. Two actions for the whole SCAN network were identified for these QPIs: For QPI 10 (i): Higher numbers of patients who progressed on neoadjuvant chemotherapy may be due to describing up front chemotherapy as NACT when in fact the patients not ideal candidates for neoadjuvant chemotherapy and are listed for surgery depending on chemotherapy result. For these cases a surgical opinion should be required prior to recommending neo-adjuvant chemotherapy Action Taken: Consultants will see patients in GOPD after cycle 2 to assess fitness / suitability for surgery For QPI 11: All patients with non-mucinous epithelial ovarian cancer should be considered for genetic testing/referral. Action is required to ensure that all patients on surgical follow up should be referred for testing/referral if non-mucinous histology. Action Taken**:** Consultants will highlight to medical oncology team who usually undertake counselling for this	
7.	**LINKED COMMITTEE MINUTES**	
7.1	**Cancer Managers' Forum (28/01/2022)**	
	This was noted by the group.	
7.2	**Cancer Leadership Team (25/01/2022, 02/03/2022 & 22/03/2022)**	
	This was noted by the group.	
7.3	**Cancer Delivery Board (05/04/2022)**	
	This was noted by the group.	
7.4	**Early Cancer Diagnosis Programme Board Minutes (03/02/2022)**	
	This was noted by the group.	
7.5	**Early Cancer Diagnosis Programme Board Agenda (02/06/2022)**	
	This was noted by the group.	
8.	**Items to Note**	
	No items to note	
9.	**ISSUES TO BE ESCALATED**	
	No issues to be escalated	
10.	**ANY OTHER BUSINESS**	
10.1	*SCAN Update* KN advised the National Cancer Strategy is now available for comment and the link is in the paper that was sent out.	

	KN advised in regard to the SACT and Acute Oncology funding the Scottish Government Cancer Policy Team have advised that £1.5m of recurring funding would be made available for SACT and Acute Oncology services across NHS Scotland, with an upscale of phasing over the next 5 years to £10.5m of recurring funds by 2026-27. KN advised for surgical services, they are still continuing to monitor surgery across the region. KN advised overall surgical services have noted slight improvements over the last month with staff returning to their area of work. Challenges remain due to backlogs in cancer and non-cancer surgical services. KN advised Radiotherapy services across Scotland remain fragile with increasing vacancies being highlighted. KN advised the SACT Programme Board is next due to meet in June. Items to be discussed at this group include the revision on the CEL30 audit guidance. SACT services continues to experience significant challenges across Scotland. Discussions remain ongoing between boards to monitor the impact of the current NHS Scotland oncology mutual aid requests, where NHS Lothian, NHS Greater Glasgow & Clyde and NHS Grampian are supporting NHS Tayside. KN advised Bobby Alikhani left his position as SCAN Network Manager.	
11.	**Date of Next Meeting:**	
	The next meeting would be on Friday 19th August 2022 at 2.00pm via Microsoft Teams.	

Date: 14/06/2022
Enquiries to: Dorothy Gibson
Telephone Ext: Microsoft Teams

CONFIRMED MEETING NOTE OF THE NHS FIFE CLINICAL GOVERNANCE OVERSIGHT GROUP HELD ON TUESDAY 14 JUNE 2022 AT 10.00 via MICROSOFT TEAMS

Attendees

Sue Blair (SB)	Consultant in Occupational Medicine
Pauline Cumming (PC)	Risk Manager
Claire Fulton (CF)	Lead for Adverse Events
Catherine Gilvear – (CG)	Fife HSCP Quality, Clinical Care & Governance Lead
Benjamin Hannan – (BH)	Director of Pharmacy & Medicines
Dr Helen Hellewell – (HH)	Associate Medical Director
Dr Chris McKenna - (CMCK) (Chair)	Medical Director
Dr John Morrice - (JM)	Consultant Paediatrician
Elizabeth Muir - (EM)	Clinical Effectiveness Manager
Nicola Robertson – (NR)	Assistant Director of Nursing, Corporate Division
Amanda Wong – (AW)	Director of Allied Health Professionals
Prof Morwenna Wood (MW)	Consultant Nephrologist – Renal Medicine

In attendance

Dorothy Gibson- DG	Clinical Governance Administrator

Apologies

Lynn Barker – (LB)	Associate Director of Nursing, of Health and Social Care Partnership
Lynn Campbell – (LC)	Associate Director of Nursing, Acute Services Division
Gemma Couser – (GC)	Associate Director of Quality & Clinical Governance
Aileen Lawrie – (AL)	Associate Director of Midwifery
Janette Owens – (JO)	Director of Nursing
Geraldine Smith – (GS)	Lead Pharmacist Medical Governance

	Items	Action
1	**Apologies for Absence**	
	Apologies for absence were noted from the above members.	
2	**Minutes of the last meeting held on 19th April 2022**	
	Amend Item 7.0 change unfortunately to fortunately and add in - We had over 40 complaints “in draft” at the end of February 2022. Once the changes have been made the group agreed the minute.	
3	**Matters Arising/Action List**	
	All matters and actions were closed.	
4	**GOVERNANCE**	
4.1	**NHS Fife Clinical Policy & Procedure Update**	
	At the April meeting the group approved one new Fife Wide Procedure **NHS Fife Wide Procedure for Allied Health Professionals for Student Access and use of Loaned Government Funded IT Equipment**	

	National Education Scotland provided Fife with funding to purchase IT equipment for allied health professionals to have out on loan. At this meeting extension was given to one procedure currently under review. **ASD-R2-01 ASD Procedure For First Response Cardiac Arrest and Acute Medical Emergencies, Queen Margaret Hospital (01/03/2022)** The resuscitation department would like to combine all cardiac arrest procedures to make one procedure for the whole of Fife. An extension was given to this procedure to allow time to write a Fife wide procedure. **Outstanding Policies and Procedures** There is one policy and two procedures past their review date. **Fife Wide Policy** IC-02 - NHS Fife Infection Control Policy for the Risk Assessment for Transmissible Spongiform Encephalopathy Agents including CJD and vCJD (31/08/2021) The Infection Control Manager advised that the policy stays out of date as it is currently not fit for purpose. The policy should be finalised for June meeting of the group **Acute Services Division** ASD-POPI-01 Acute Services Division Pre-operative Patient Identification: the identification and preparation of patients undergoing operative and invasive procedures (18/02/2022) ASD-BP-01 Boarding Procedure for Patients within the Acute Services Division (31/03/2022) **97 %** of all clinical policies and procedures are current and in date.	
4.2	**NHS Fife Activity Tracker (EM)**	
	Reports and Publications – For Information (**Delivering first class medical education and training for Scotland** The 2022 Postgraduate Medical Education and Training Annual Report reviews the work our Medical Directorate, along with our partners in NHS Scotland and Universities do, to ensure safe, effective care for patients, both now and in the future. The report details our main activities and gives an update on: • How we manage the delivery and support of Scotland's doctors in training • **Maintaining the safe and effective staffing learning system** This learning system has been developed to support health and to care for staff who are involved with workforce planning to feel enabled and psychologically safe to make decisions and manage the risks associated with	

	reduced staffing capacity. The learning system is built around the key themes of the Quality Management System Framework.	
4.3	**Annual Assurance Statement (CMcK)**	
	CMcK advised that this is currently on hold until GC is back to work and will be followed up when GC returns to work.	
5	**STRATEGY/PLANNING**	
5.1	**Clinical and Care Governance Framework (CMcK)**	
	CMcK advised that this currently on hold until GC is back to work and will be followed up when GC returns to work.	
5.2	**National Hub for Learning and Reviewing of Deaths of Children and Young People – Healthcare Improvement Scotland Update (JO/EM)**	
	EM advised that a meeting was held with the National Hub from Health care Improvement Scotland, where an update of progress within NHS Fife was given. Since 1st October 2021 NHS Fife has reviewed **all** children's and young people to age 18 or 26 if receiving continuing care or aftercare at its monthly Review of Children's Commissioning Group, chaired by Dr Aniruddhan The first Review of Children's Clinical Governance meeting chaired by Lorna Watson was held in April 2022. We appointed recently an administrative person to support the review of Children who will commence in post on the 4th of July 2022. We recently advertised the post of Review of Children's Coordinator post interviews will take place week commencing the 20th of June 2022 CMcK asked that an update is prepared for the NHS Fife Clinical Governance Committee on the 2nd of September 2022 and asked for this to remain as a standing agenda item at the Clinical Governance Oversight Group meetings. EM advised that an annual report will be issued as part of the terms of reference and will be sent to NHS Fife Clinical Governance Committee.	**EM/CF**
5.3	**NHS Fife Medical Devices Group (CMcK)**	
	CMck advised that a new group is being established. The purpose of the group is to ensure there is a systematic approach to the purchasing, deployment, training and 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. The group will meet on a quarterly basis with the first meeting due to be held on 16 August 2022 The minutes of NHs Fife Medical Devices Group will go to NHS Fife Clinical Governance Committee along with an annual report from the group.	
6	**QUALITY/PERFORMANCE**	
6.1	NHS Fife Integrated Performance & Quality Report May 2022 **(CMcK)**	

	Nothing to highlight from the report.	
6.2	**HSCP Quality Report April 2022 (LB)**	
	Nothing to report the group. CMcK asked why the report comes to this group, as we don't have one for the Acute. CMcK to review this item.	**CMcK**
6.3	**Quality & Safety Board Assurance Framework (BAF) (PC)**	
	This report was viewed at the last Clinical Governance Committee in April 2022. The intention is to move from this approach and to reinstate a corporate risk register. The plan is to transition from this approach of reporting risk through the corporate risk register, which is more conventional and commonly used in other Boards across the country. At the moment we are the stage of identifying and agreeing what those corporate risks are and what will sit on our corporate risk register.	
6.4	Adverse Events Status Update **(CF)**	
	Flash Card The flash card reflects May 2022 and has been shared with staff on "Blink" and will be shared on a monthly basis. This gives an overview of the incidents reported and the top 10 categories and sub categories. The incidents across Acute and Partnership for the month of May, there was an increase with the following: • Violence and aggression is the highest • Followed by patient falls • Followed by tissue viability The sub categories are: • Patient falls by walking – 153 incidents. • Physical assault - 131 incidents • Unwanted behaviours – 107 incidents A second page has been added to look at the SAER and LAER activity, from a KPI perspective, this is the highest month for sign off. There has been a high reduction in the number of outstanding majors and these have been closed off this month. The action plan more will be reflective of what is being input to datix, and looking at how we can get services and review teams to identify whether the action is for that one department, or whether it is for the service or organisational learning. If we can obtain actions this way we will be able to pull support from the Organisational Learning Group. The flash card will be developed into a series so that we would have a third and fourth flash card, where we would have key learning points from the month before.	

	KPI's The SBAR completion and for the first month in May there are 17% not received, at the end of May we had 8 outstanding SBAR's, and cardiac arrests accounted for 6 of them. There is a trigger system in place where the admin team will email out to the services to get an update on any outstanding SBAR's not received. There hasn't been much change in our compliance indicators, minor and moderate over the last six months have been slightly slower. Major there has been 63 closed in the month of May; these would normally sit at high twenties/thirties. .	
7	**PERSON-CENTRED CARE, PATRICIPATION AND ENGAGEMENT**	
7.1	NR asked if this heading could be renamed as 'Patient Experience'. NR advised that the Patient Relations team is being re-launched as the Patient Experience team in the near future. JO has produced a quarterly report for Clinical Governance Committee and this will be reported at EDG 16 July 2022. The report is based on the Model Complaints Handling Process (SPSO 2020), and evaluates the department's current performance and challenges. A recovery and improvement action plan is in place and progress to date is updated. A new manager has been appointed with a start date of Jul 2022 who will be the Head of Patient Experience. The team is benefitting from staff temporarily deployed from the contact tracing team until September 2022 at the latest. Due to strong links with the Organisational Learning Group, there is a real opportunity for both the Clinical Governance Team and the Patient Experience Team to work collaboratively. Datix is used to record complaints however there is an opportunity to develop further to also record progress, rather than this being recorded on a separate spreadsheet which requires timely manual updates. In collaboration with the QI and D&I teams, an automated reporting system is also under development. Regarding patient experience, the amount of Care Opinion posts to NHS Fife over the past year has doubled (400 to 800), and NHS Fife is the top board in Scotland in terms of Fife-resident posting and second top for the number of posts in Scotland. CF stated she would like to explore renaming the Datix 'complaints' module to simply 'feedback', as it captures a range of records that includes complaints, compliments and greatix. The term 'feedback' is something that has been adopted by the naming of the modules across NHS Scotland Organisations, and as we move into Datix Cloud IQ then the module within that and what we capture is called feedback. NR suggested the wording Patient Experience instead of feedback? NR/CF will discuss offline and will advise in due course.	**NR/CF**
8	**LINKED COMMITTEE MINUTES**	
8.1	NHS Fife Clinical Policy & Procedure Coordination & Authorisation Group 25 April 2022.	
	Noted by the group.	
8.2	NHS Fife In Patient Falls Steering Group 11th May 2022	
	Noted by the group.	
8.3	NHS Fife Point of Care Testing Committee 1st June 2022	

	Noted by the group.	
8.4	NHS Fife Tissue Viability Working Group 4th May 2022	
	Noted by the group.	
9	**ITEMS TO NOTE**	
10	**ISSUES TO BE ESCALATED**	
11	**ANY OTHER BUSINESS** SB asked the relevance of Occupational Health Team reporting into this Group. Following discussion it was agreed for SB to organise a meeting with GC to discuss the reporting structure and where it would be a good fit	**SB/GC**
	Date of Next Meeting 16th August 2022 10.00 via Microsoft Teams	

Clinical Governance Committee

DIGITAL AND INFORMATION BOARD
(Meeting on 28 July 2022)

Laboratory Information Management System replacement project to be escalated to Clinical Governance Committee. (Meeting 4 November 2022)

Fife NHS Board
UNCONFIRMED

MINUTE OF THE DIGITAL AND INFORMATION BOARD HELD ON THURSDAY 28TH JULY 2022,1330, VIA MS TEAMS

Present:

Chair - Dr Chris McKenna	Medical Director
Alistair Graham	Associate Director, Digital & Information
Benjamin Hannan	Director of Pharmacy & Medicines
Margo McGurk	Director of Finance & Strategy
Caroline Somerville	eESS Support Teams, (on behalf of Partnership Representative)
Audrey Valente	Chief Finance Officer (on behalf of Director Health & Social Care)
Miriam Watts	General Manager, Emergency Care (on behalf of Director of Acute Services)

In Attendance:	
Andy Brown	Principal Auditor
Sarah Callaghan	Programme Manager (on behalf of Head of Strategy and Programmes, Digital & Information)
Michelle Campbell	Information Governance & Security advisor (on behalf of Head of Information Governance and Security Manager/DPO)
Eileen Duncan	Directorate Solutions Manager H&SCP
Andrew Lam	Cyber Security Consultant
Shelley Marshall	Head of Business & Resource, Digital & Information
Siobhan Mcilroy	Clinical Nurse Manager (on behalf of Nicola Robertson)
Claire Neal	(Minute) PA to Associate Director, Digital & Information
Sally O'Brien	Head of Nursing (on behalf of Associate Director of Nursing)
Lorna Thomson	Senior Project Manager
Torfinn Thorbjornsen	Head of Information Services, Digital & Information
Allan Young	Head of Digital Operations, Digital & Information
Apologies:	
Philip Duthie	General Practitioner
Janette Owens	Director of Nursing
Joy Tomlinson	Director of Public Health
Amanda Wong	Associate Director, AHPs
John Chalmers	Clinical Lead, Digital & Information
Helen Hellewell	Associate Medical Director
Jillian Torrens	Senior Manager, Mental Health & Learning Disabilities Service

1	**WELCOME AND APOLOGIES**	
	Dr McKenna welcomed everyone to the meeting and a round of introductions were provided. Apologies were noted to the Board.	
2	**MINUTE & ACTIONS OF MEETING HELD – 19TH April 2022**	
	Minutes were reviewed and agreed. Updates were provided for completed actions.	
3	**MATTERS ARISING**	
	3.1 Radiology Report – PACS Incident A Young introduced item and provided background to paper. While the incident was led by Radiology Team, A Young and team had provided response support over the period of the incident. The Incident Report has been provided to Board for assurance and also to provide an update to the incident.	

	A Young noted that a lot of learning has been achieved from this event from D&I but also the supplier, Phillips. A Young advised the response over the weekend period from oncall teams and beyond had helped progress to resolution. Dr McKenna queried if this event would happen again, A Young advised they believed it was a one off. This incident was due to an update that had a bug in it, and to protect and provide mitigations in the future the supplier and national teams will now test in development set up rather than in live. We now have consistent processes within Radiology and D&I. A Young advised this incident did not only effect NHS Fife but other NHS Boards also. Unfortunately, there was another incident this week with PACS, but this was a different incident. A Brown queried the continuity plans and how were these implemented during this incident and have these improved since this report was written. A Young noted they were unable to answer as Radiology would have their own contingency plans, but they weren't aware of any issues and at the time plans were put in place. A Graham noted the item of improved continuity plans would be handed of to NHS Fife's Resilience Planning Group. A Graham noted this was a significant incident from a national point of view, and feedback to national teams has been provided. No more comments were raised.	
	3.2 TrakCare – New User Interface L Thomson introduced and delivered a presentation to provide an update, to the implementation of a new User Interface that were due to take place with TrakCare later this year. A brief explanation and demonstration of some of the interface changes which will be undertaken. They hope is that NHS Fife will be one of the first Boards to implement these changes, but this will be dependent on current pressures across services. L Thomson provided some points to the presentation a few of these are listed below: • They have been engaging with stakeholders regarding these changes. • Comments have been requested and feedback has been received and work is ongoing with these suggestions. • Initial feedback received "is it more user friendly". • There will be around 4000 staff that will require training so this will be challenging but commencement of the plan on how to deliver this training has begun and various methods of training tools available. L Thomson noted they hope to have Clinical and Nursing engagement to support this update. Discussions was undertaken with some of these changes that were due to be implemented. It was noted there will be challenges given our current pressures and with the upgrade expected later this year and coming into winter pressures. M Campbell queried if a review has been undertaken with the current DPIA, L Thomson confirmed a refresh will be required and this is ongoing. M Campbell offered assistance.	

	A Graham advised they have been working with supplier for their support and engagement with our plans also. Work is ongoing to look at timings of implementation for this upgrade. Dr McKenna queried if this would tie in with HEPMA, A Graham noted this will in the future. Further discussions were undertaken on the training, availability of staff to provide support and will this be done in stages within departments. L Thomson noted they believe this will be "big bang" as it would be difficult to have different department on different versions. Some testing is still ongoing, and it is hoped that training of staff will commence September/October to possibly go live end of October, but this is still to be confirmed. M Watts noted this appears to be an improvement and provided positive feedback to some training manuals that were provided previously, and it would be helpful to create these quick reference guides again. No more comments were raised. Dr McKenna noted endorsement for this upgrade has been provided by Board but to try and plan for September rather than October due to possible pressures. **Approved.**	
4	**RISK MANAGEMENT**	
	4.1 Risk Management Report A Graham noted this report has been brought to Board to provide assurance that appropriate risk management activities are in place within D&I. A Graham provided a brief update to report, some are highlighted below: • 6 new risks have been added to the report, some of them are associated with the restructure of the Cyber Resilience Risk Structure. Further information will follow in the below agenda item 4.2. • Work is continuing with the mitigations and proximity of these risks. • 2 Risks have improved their status. • Rate equal to 20 or above is cause for concern • Work is continuing to review the digital strategy fund and how this is utilised. • Reviewing of Legacy systems are continuing, and this poses concerns, but this is managed. • Risk 1338, a number of actions have been undertaken and this is now rated as moderate. • Implementation of ITIL framework ongoing and will continue though till 2023. Dr McKenna thanked A Graham for the update provided and note the way this report is laid out it extremely helpful. Feedback was provided if it was possible to add comments within the diagram where the risk numbers are contained any updates/background to these risk. No more comments were raised.	

	Board content with consideration of management of actions and assurance provided for risk management.	
	4.2 Cyber Risk Structure A Young delivered a presentation, noting this paper is to provide a highlight of the review that has been undertaken to the cyber risk alignment as mentioned in previous item. In 2018 the Scottish Government Public Sector Cyber Resilience Action Plan created under key action 2 of the Cyber Security Risks these were aligned to Cyber essentials. This model has now been updated to align with these 4 objectives of the NISD. Work has been undertaken to review these key objectives and align to the objectives. A Young provided update to the presentation on how this has been achieved. Dr McKenna thanks for the helpful layout and presentation of update. No more comments were raised.	
5	**PERFORMANCE**	
	5.1 D&I Performance Summary A Young presented D&I Performance Summary from the last quarter, noting the below: • EOL Servers – these are vulnerabilities within the service but since the report was created, we have shut down to 2 more servers which is great news. It is hope by end of year this will be down to zero. • Server upgrades within GP Surgeries will be reduced by next meeting. • 2 more reporting sections have been added – Service Desk call volumes and Cyber Security configuration score. Cyber Security score we are challenged nationally to provide, and we are currently at green which is good, but continuous work and improvement are undertaken to maintain. A score of 20 is good but would like to improve. Dr McKenna queried the volume of calls to the service desk between various months, as in June this increased by around 1000. Do we need to investigate behaviours or pattern of behaviour? Was there a particular incident that took place in June to warrant the large increase? A Young noted they were no incidents, and this is currently being investigated as to the large increase. A suggestion was provided on whether a chat service was possible, rather than calls. A Young noted they were looking into this as our new desktop function does allow for this. M Campbell noted to Board that Information Governance was added to Service Now in June and was there a possibility these calls are contributing to this figure. Unlikely this number of calls or queries but may be attributed to some increase. A Young thanked M Campbell and they will investigate further. No more comments were raised. Dr McKenna thanked teams for all the hard work and this is visible for the statistics provided within report.	

	5.2 NISD Action Plan – Operational A Lam delivered a presentation and provided a brief background. In 2020 Scottish Health Competent Authority commissioned a three-year audit programme to evaluate Board compliance. The report in 2022 was the final year in this report. Within this report there are almost 500 items. These can relate to patching, user access, how we deal with incidents, and how we respond to these. For this report in 2021 & 2022 we had to gather this evidence to demonstrate how we were obtaining this. We are now going to enter a new cycle and a new supplier is being sought and if a new supplier is confirmed they may ask to gather all this information again, which will cause huge amounts of work. NHS Fife has been the 1st Board to go through this report, so we have had the least amount of time to process these requests. With the report now complete we are already working on the recommendations and actions from this report. There are 4 domains - Manage, Protect, Detect and Response and Recover. We have managed to achieve yellow and green which is good. We hold fortnightly meetings to review and improve the score. A recommendation has been received from NIS on how we present the evidence. Our compliance scores have increased every year from 2020 to 53%, 2021 to 69%, and 2022 was 76% A Lam provided further information to action plan • Action plans are in place for 2022-2023 and work is continuing. • We are continually working with our suppliers regarding ongoing cyber risks and one of these is to improve on patching vulnerabilities. • Cyber awareness and training exercises have been undertaken through the organisation, e.g. EDG. Dr McKenna thanked for the presentation and is great to see the improvements that have been achieved. Assurance is taken from this update. A Brown also noted the assurance is very good, raised a query if the 80% target if this is the end of the financial year. A Young noted this is at the beginning of the audit it is hoped 80% is achieved.	
	5.3 Architecture Review Board A Young introduced item, noting the ToR for Architecture Review Board has been presented for visibility and information. Within D&I they are trying to get ahead of IT Solutions that are received into the organisation. We will have three focuses, new solutions, maintain our current state, and do we have safe controls for decommissioning of data assets. All departments will asked to review these and will be asked questions and provide guidance. The 1st meeting has already been undertaken and has gone well and purpose achieved. A Graham noted we also have a requirement to review existing digital capability to avoid the unnecessary introduction of additional digital systems. Any feedback to ToR and any comments or queries to direct to A Young.	

	No more comments were raised.	
6	**Strategy & Programmes/Projects**	
	6.1 Programme & Projects Update S Callaghan provided an update to this some of the items noting the below: • A new team's structure is in place within Strategy and Programmes which will allow for a more focused approach to delivery. • **Community replacement programme** has been put on hold due to resource challenges, but they are working to resolve. • Engagement has been undertaken with SLT to review the delivery plan for the next 2 years. Working is also continuing with the H&SCP. • **E-Rostering programme** has commenced, with meetings scheduled mid-August for ongoing plan. • **Endoscopy Management System** is now live and therefore removed from update, as well Urgent Care Redesign there is no more funding to support this programme. • New staff members have started, and this will continue with improvements to the digital delivery model. • **Morse,** 10B following migration, this is now paused due to resources. • **Digital Pathology,** New project and work continuing. • **HEPMA,** New business case. Dr McKenna raised a query regarding e-Rostering and what happens with the existing contract with Allocate. Concerns were raised, as two systems maybe being paid for. Discussions were undertaken and S Callaghan will report back to query. No more comments were raised.	
7	**Business Cases / Proposals**	
	7.1 HEPMA – Business Case – Pharmacy B Hannan brought to Board to be provide an update. The business case has now been approved by NHS Board and talks have now commenced on the direction forward. B Hannan provided a brief background to previous challenges faced with the previous supplier. There will be challenges with timescale, but we have the workforce in place and work is continuing with Intersystems to go at pace. This will start to gather at pace in the next few months. Dr McKenna thanked and congratulated everyone for making this happen. Assurance was provided by B Hannan there is a plan and will provide additional information when available. A Graham also confirmed and will provide further update at the next Board meeting. No more comments were raised.	

	7.2 Laboratory Information Management System (LIMS) – Update ***A Graham noted to Board sensitivity to this item and please note only discussion within this group.*** A Graham provided background to paper noting as part of Lims Consortium a successful bid was awarded to Citadel. As a result of this award, Clinisys the supplier that provides Labcentre notified this service will end in April 2023. Clinisys has presented an option to sustain a level of service beyond this date. The assessment for NHS Fife is what is correct solution for us. As highlighted in paper we have 2 options: • 1st option is to commit to Clinisys and accept their proposal. • 2nd option is to accelerate our move to Citadel. We are currently conducting risk assessments and supplier assessments. Within the paper it outlines the choices and costs involved in both options. Our preferred is option 2. This will go to EDG and other Governance bodies as this does pose a significant risk to the organisation. Discussion was undertaken regarding. A Graham noted this is currently being discussed with Chief Executives and will be presented to NHS Fife's Board. A query was raised if this has been raised to our CLO office, A Graham confirmed CLO are currently involved. No more comments were raised.	
	7.3 Medicines Automation – Initial Agreement B Hannan introduced item noting this is for information and awareness only. This is the initial draft and has been provided to Financial Capital Investment Group (FCIG), with feedback provided and this will continue to go through other revisions. It is requested that any comments or feedback forwarded to B Hannan. With these amendments it will then be presented to FCIG in September. No more comments raised.	
8	**Finance**	
	8.1 Quarterly 1 - Finance Report S Marshall presented the monthly report for Digital and Information as the end of June (Qtr. 1) position. S Marshall provided an explanation as to calculations to the figures on report. We are currently awaiting funding to be received and it is hoped with this current trajectory and this funding received we break even. No more comments were raised.	
9	**Items for escalation to Clinical Governance Committee.**	

	A discussion was undertaken, and it was noted that previous item 7.2 is to be escalated via the various Governance Committees. A Graham noted this has been highlighted to EDG and be presented at the next meeting, 4th August. No other items were noted to be escalated.	
10	**AOCB**	
	A Graham highlighted to Board there is a current issue within GP Practices that use the software DOCMAN. This is provided as an update for awareness; this is a live issue. A Graham provided a brief background to issue noting a number of documents were expected from Acute to Primary Care but there is fault with the software, and this has not been happening. A Clinical review is due to commence, to assess if any harm has come to patients as a result of this issue and missing documentation. Many documents continue to be sent electronically and by post to GPs. A Graham provided assurance that NHS Fife has a number of failsafe and risk assessments in place, so this risk is moderate at this stage. This is a national incident and national teams are also currently working on. Dr Hellewell is supporting and providing feedback. A Graham noted this is be tracked carefully. A Young advised there was a network outage on Monday and wanted to provide an update to this incident. An investigation was undertaken, and it appears the fault lies with our supplier. They were working within our telecoms room and dislodged a cable that provides internet to swan. Resilience is built into the system but there was a misconfiguration with this. Contact has been made with supplier and this has now been resolved. Testing has now been undertaken with the failure and this has been successful. We are continuing to look at the impact and ensure we more dynamic. A Young noted a full incident report will be completed and made available should requested, but it was good that nothing more sinister was involved. There were potential markings for a cyber-attack. Dr McKenna requested this report is forwarded to EDG when available as this did have a significant impact on organisation. A Graham advised there were public notifications that were provided on various media platforms, so we are looking to improve our communications regarding incidents, management and plans going forward. Still being mindful about posting information on media platforms due to a security perspective and possible cyber-attacks. M Campbell queried if this event had been added to DATIX, it was confirmed this has. A Young noted to Board that A Lam is leaving NHS Fife and would like to thank A Lam for their great knowledge they have provided and the training they have brought to enable the Cyber Team. Also, for their work and understanding of the NIS audit and the action plans implemented. No more comments or any other business was raised.	

	Dr McKenna thanked everyone for their hard work in production of these papers and their continued work. The meeting was closed with thanks for all their attendance and comments.	
11	**DATE OF NEXT MEETING** 18th October 2022, 0900, via MS Teams	

FIFE DRUG & THERAPEUTICS COMMITTEE (Meeting on 22 June 2022)
No issues were raised for escalation to the Clinical Governance Committee.

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MINUTES OF THE MEETING OF THE FIFE DRUGS AND THERAPEUTICS COMMITTEE HELD AT 1.00PM ON WEDNESDAY 22 JUNE 2022 VIA MICROSOFT TEAMS

Present: Dr Chris McKenna (Chair)
Mr Ben Hannan (Vice-Chair)
Ms Claire Fernie
Dr Iain Gourley
Dr David Griffith
Mr Euan Reid
Ms Olivia Robertson
Ms Rose Robertson
Ms Doreen Young

In attendance: Mrs Sandra MacDonald, Administration Officer (minutes)

ACTION

1 WELCOME AND APOLOGIES FOR ABSENCE

Dr McKenna welcomed everyone to the meeting and introduced Doreen Young who will be deputising for Nicola Robertson on the ADTC going forward.

Apologies for absence were noted for Ms Lynn Barker, Dr Marie Boilson, Ms Claire Dobson, Dr Claudia Grimmer, Dr Helen Hellewell, Dr John Kennedy, Dr John Morrice, Mr David Pirie, Ms Andrea Smith, Professor Morwenna Wood.

The ADTC noted disappointment in the level of attendance at meetings. As the ADTC is the foremost Committee that oversees important medicines governance, attendance from a broad panel of Committee members to allow decisions to be made is vital. Dr McKenna and Mr Hannan to discuss attendance. **CMcK/ BH**

2 MINUTES OF PREVIOUS MEETING ON 27 APRIL 2022

The minutes of the meeting held on 27 April were accepted as a true record.

3 ACTION POINT LOG

The action list was discussed and actions updated/completed as agreed.

4 ANY OTHER MATTERS ARISING FROM THE MINUTES

There were no other matters arising from the minutes.

5 DECLARATION OF INTERESTS

There were no declarations of interests.

6 ADTC SUB-GROUP UPDATE REPORTS

6.1 East Region Formulary Committee

Mr Reid highlighted the minutes from the East Region Formulary Committee meeting on 25 May 2022 and highlighted key points.

A further two revised East Region Formulary Chapters (Eye and ENT) were approved at the May meeting along with a variety of Formulary applications.

A discussion ensued about the process for assessing the potential financial impact of changes to prescribing in Fife as a result of the transition from the Fife Formulary to the East Region Formulary. It was noted that this is being progressed through existing governance routes. The Fife Prescribing Forum which includes representatives from Finance and its remit in the horizon scanning/prescribing efficiency planning process was highlighted. Mr Hannan and Ms R Robertson to discuss the role of Finance in relation to output from the information presented at the Fife Prescribing Forum. **BH/RR**

The ADTC noted the update from the East Region Formulary Committee and the minutes from the meetings on 30 March and 25 May 2022.

6.2 MSDTC

Mr Reid provided a verbal update on behalf of the MSDTC and highlighted key points from the meeting on 15 June 2022.

A number of submissions were approved, including updated Eczema Pathway, Out of Hours Presentation of Diabetes Guidance, updated Management of Diabetes Risk with High Dose Steroids Guidance and Management of Long-Term Medications Guidance. Submissions provisionally approved subject to amendments included the updated Rivaroxaban Counselling Record, Heart Failure Guideline, Anaphylaxis Policy and Ambulatory Human Albumin Infusion Service Guidance.

A discussion ensued about the communication process for Guidance approved through the MSDTC. It was suggested that information be shared on Blink following MSDTC meetings. Mr Reid to discuss with Fiona Forsyth, Communications Specialist (Pharmacy) and Jason Cormack, Pharmacy and Medicines Business Manager. **ER**

The ADTC noted the update on behalf of the MSDTC.

6.3 Antimicrobial Management Team

Dr Griffith introduced the update report on behalf of the Antimicrobial Management Team (AMT).

The ADTC noted that there have been a number of challenges to the work of

the AMT including staffing issues and curtailment of routine activity due to the COVID-19 pandemic.

The achievements since the last update report include preparation for implementation of new sensitivity reporting rules and updating of Antimicrobial Prescribing Guidelines. One of the main items of business in the workplan for the next six months is the rolling schedule for revising regular and more focussed Antibiotic Guidance.

The ADTC noted the update report on behalf of the Antimicrobial Management Group and the pressures within Microbiology. It was agreed that no escalation was required at this stage as staffing issues are expected to be temporary.

7 SBARs

7.1 Regional authorisation procedure for SMC 'Not Recommended' advice issued more than 10 years ago

Mr Hannan presented the paper "Regional authorisation procedure for SMC 'Not Recommended' advice issued more than 10 years ago" and briefed the ADTC on the background to this. It was noted that Dr McKenna and Mr Hannan have indicated support for the proposals on behalf of NHS Fife and the paper has been brought to the ADTC for comments and ratification.

The paper outlines proposals to introduce a new regional governance approval procedure to enable access for an eligible cohort of patients to medicines which have been 'not recommended' by SMC, where the advice was issued more than 10 years earlier, and where the place of the medicine in a therapeutic pathway is considered to have changed, based on significant new evidence, safety, or cost effectiveness. The proposed regional governance approval procedure provides an interim solution pending review of the National Policy for the introduction of new medicines in Scotland (CEL17 - Introduction and Availability of Newly Licensed Medicines in the NHS in Scotland).

The ADTC ratified NHS Fife's decision to approve the proposed regional authorisation procedure for SMC 'not recommended' advice issued more than 10 years ago.

7.2 ERFC Submission - Galcanezumab: Emgality ERFC Submission - Galcanezumab: Emgality

Mr Reid introduced the paper "Galcanezumab - Approval of East Region Formulary Decision" and briefed the ADTC on the background to this.

The ADTCs for Lothian, Borders and Fife have been asked to approve a decision made at the East Region Formulary Committee in relation to Galcanezumab: Emgality for the prophylaxis of patients with migraine. Galcanezumab: Emgality is recommended by the SMC, restricted to the treatment of patients with chronic and episodic migraine who have had prior

failure on **three or more** migraine preventive treatments. Specialists in the East Region propose restriction in line with local prescribing guidelines in adults who have had prior failure on **at least four** migraine preventive treatments and this proposal is supported by Clinical Representatives on the East Region Formulary Committee. On discussion within the NHS Lothian Medicines Governance and Guidance team the East Region Formulary Team agreed to raise this deviation from the SMC restriction with Lothian, Fife and Borders ADTCs for ratification.

The ADTC noted that Guidance from the 'Scottish Headache Interest group' is not yet available and it is unclear whether this will be in line with the additional restrictions proposed over and above the SMC restrictions. Precedent issues and implications from a patient perspective were also highlighted and that potentially the decision could be open to future challenges.

Following discussion the ADTC noted that there was no clear justification for deviating from the SMC approval restrictions and agreed **not to support** the proposals for additional local restrictions. The ADTC would support the addition of Galcanezumab: Emgality to the East Region Formulary in line with SMC guidance, that is for the treatment of patients with chronic and episodic migraine who have had prior failure on **three or more** migraine preventive treatments.

7.3 Working with the Pharmaceutical Industry

The ADTC noted the updated Working with the Pharmaceutical Industry - Guidance for NHS Staff. The Guidance had previously been circulated to ADTC members for comments and a variety of stakeholders had also been consulted.

7.4 Melatonin Prescribing

The ADTC noted the updated paper - Melatonin Prescribing in NHS Fife. The paper had previously been discussed at ADTC and has been updated to include equality and diversity information in Section 2.3.5.

8 Risk Register

Mr Hannan provided a verbal update on proposals for development of a central medicines risk register for the ADTC as well as a separate Pharmacy & Medicines risk register. Dr McKenna and Mr Hannan are progressing this and aim to bring an update to the ADTC in August. **BH/ CMcK**

9 ADTC-COLLABORATIVE/SCOTTISH GOVERNMENT COMMUNICATION

None for consideration by the ADTC.

10 EFFECTIVE PRESCRIBING

10.1 Early Access to Medicine Scheme - Lutetium vipivotide tetraxetan

10.1.1 Risankizumab

The ADTC noted the Early Access to Medicine Scheme operational guidance for Risankizumab for moderately to severely active Crohn's Disease.

10.1.2 Efgartigimod

The ADTC noted the Early Access to Medicine Scheme operational guidance for Efgartigimod for treatment of adult patients with AChR-antibody seropositive generalised myasthenia gravis (gMG), including patients with refractory gMG who have failed, not tolerated or are ineligible for licensed treatment.

10.2 Medicines Procurement Newsletter

The ADTC noted the Medicines Procurement Newsletter May 2022.

11 HEPMA Update

Mr Hannan provided a verbal update on progress with the implementation of HEPMA. A revised business case which is supported by Finance and Clinical colleagues is being presented to the Clinical Governance Committee and the Finance Performance and Resources Committee prior to Fife Board at the end of July. The roll out of an electronic discharge solution ahead of HEPMA is being explored.

12 PACS/SMC Non Submissions

12.1 Latest Submissions

The table detailing the latest PACS/SMC non submissions was noted.

13 POINTS FOR RAISING AT CLINICAL GOVERNANCE COMMITTEE

It was noted that the HEPMA Programme paper will be taken to the Clinical Governance Committee. There were no additional items for escalation to the Clinical Governance Committee.

14 ANY OTHER COMPETENT BUSINESS

There was no other business.

Other Information

a **Minutes of Diabetes MCN Prescribing Group.** Next meeting June 2022.

b **Minutes of Respiratory MCN Prescribing Sub-Group.** Next meeting June 2022

c **Minutes of Heart Disease MCN Prescribing Sub-Group 28 April 2022**. For information.

d **Date of Next Meeting**

The next meeting is to be held on **Wednesday 24 August 2022 at 1.00pm**

via MS Teams. Papers for next meeting/apologies for absence to be submitted by 10 August.

Fife Health & Social Care Partnership

Supporting the people of Fife together

UNCONFIRMED MINUTE OF THE QUALITY & COMMUNITIES COMMITTEE TUESDAY 5TH JULY 2022, 1000hrs - MS TEAMS

Present:	Sinead Braiden, NHS Board Member (Chair) (SB) Councillor Rosemary Liewald Councillor Graeme Downie Councillor Margaret Kennedy Councillor Lynn Mowatt Councillor Sam Steele Ian Dall (ID)
Attending:	Dr Helen Hellewell, Associate Medical Director (HH) Nicky Connor, Director of Health & Social Care (NC Ben Hannan, Director of Pharmacy & Medicines (BH) Kathy Henwood, Head of Education and Children's Services (Children and Families/CJSW and CSWO) (KH) Fiona McKay, Head of Strategic Planning, Performance & Commissioning (FMcK) Lynne Garvey, Head of Community Care Services (LG) Roy Lawrence, Principal Lead for Organisational Development & Culture (RL) Kenny Murphy, Third Sector Representative (KM) Simon Fevre, Staff Side Representative (SF) Rona Laskowski, Head of Complex and Critical Care Services (RLas) Bryan Davies, Head of Preventative and Primary Care Services (BD)
In Attendance:	Jennifer Cushnie, PA to Associate Medical Director (Minutes)
Apologies for Absence:	Chris McKenna, Medical Director Martin Black, NHS Board Member Lynn Barker, Director of Nursing Catherine Gilvear, Quality Clinical & Care Governance Lead Paul Dundas, Independent Sector Lead Ben Johnston, Head of Capital Planning / Project Director Amanda Wong, Director of Allied Health Professionals

No	Item	Action
1	**CHAIRPERSON'S WELCOME AND OPENING REMARKS**	

	HH welcomed all to the meeting and introduced Sinead Braiden, Chair of the newly formed Quality & Communities Committee. SB welcomed all to the meeting, particularly the newly elected members. SB outlined the protocol for the meeting and all meetings moving forward. She highlighted, the focus of the Quality & Communities Committee is on community care, clinical pathways and quality of care, not, ie. Finances, which will be scrutinised directly via other governance groups.	
2	**DECLARATION OF MEMBERS' INTEREST** Councillor Margaret Kennedy wished to declare she is an employee of NHS Tayside.	
3	**APOLOGIES FOR ABSENCE** Apologies were noted as above. BD advised he will be covering for Ben Johnston, with support from Justin Gilbert. He added, he will be focusing on the service model section of the report, rather than the capital build.	
4	**MINUTES OF PREVIOUS MEETINGS HELD ON 04 MARCH 2022** The previous minutes from the C&CGC meeting on 20 April 2022 were approved as an accurate record of the meeting.	
5	**GOVERNANCE**	
	5.1 Quality & Communities Committee Terms of Reference HH introduced the Q&CC Terms of Reference. She stated, those who attended the C&CGC will recall the ToR came to Committee prior to IJB and there was an ask to strengthen the community and localities element. This has been considered and through discussions with Members, changes have been made to reflect this. FMcK added the Remit has been strengthened to clarify the reports which will come to Committee, predominantly around engaging with people within the community and with Carers. This is demonstrated in the Participation and Engagement Strategy. SF drew attention to the non-voting Membership and felt it does not appear as though Staff Representation is included. He advised NC has spoken with all from the Trade Unions and he asked if wording should be changed for clarity. NC and SF will discuss wording off-line. KH felt the ToR read very well, however, felt there should be a mention of The Promise Scotland as other Strategies are specified. It was agreed to discuss further off-line to ensure it does not appear as though some Strategies are prioritised over others. KM questioned wording around Membership, specifically, those representing the community would be 'invited'. He felt 'invited' implied they *may not* be invited to the meeting. As these members	**NC / SF** **NC / SF**

	are integral and necessary to a committee which is focused on communities. HH was happy to meet off-line to discuss wording with KM. A verbal update relating to the Terms of Reference will come back to the next meeting on 09.09.22.	**HH / KM** **HH / FMcK**
	5.2 Mental Health Strategy Progress Report – June 2022 RL introduced the report covering Nov 2021- April 2022 and provided examples of progress against the 7 strategic commitments within Mental Health. She stressed the report does not cover all work which is underway within Mental Health. She pointed out there are areas which have not progressed at the level she would have liked, ie Participation and Engagement. RL told of a P&E Officer who has recently been appointed and stated P&E is a priority. A Mental Health Communications post is currently being recruited to and RL explained the remit of the role. RL advised the Lived Experience Team is being facilitated by Fife Voluntary Action in line with trauma informed principles, which RL outlined. RL referred to a previous commitment to Committee to refresh the Fife HSCP Mental Health Strategy, however, RL told of 3 National Strategies to be launched within the next 6 months. These are a National Refresh of the Scottish Government MH Strategy, the National Self-Harm Strategy and a Refresh of the Suicide Prevention Strategy. She felt it would be premature to refresh the Fife HSCP ahead of these 3 National Strategies. With this in mind, she requested a expansion to the timeline for the Fife HSCP MH Strategy. SB believed capital investment for the estate is expected. She asked if the Strategies are separate or the same Strategy. RL felt the best way to explain them are as complimentary, she described what this entailed. Cllr Kennedy referred to the Neuro Developmental Pathway (page 30) of the report, in particular Education and Diagnosis being key to outcomes around children. She asked if Health Visiting is connected into this. She also queried SAMHS and ED, asking if these will be expanded more in the future. RL advised in terms of the Neuro Developmental Pathway, this is for school age children, investment to date has been into psychology and speech therapies and developing / delivering a training plan to Education and School Nursing. She is unaware if this stretches to Health Visiting but will take this back with the suggestion this be considered. RL advised SAMHS café is a permanent investment made under the Action 15 funding stream. The original investment was extended to cover 7-days a week and told of further investments to expand this work further. SF found the progress report very helpful, he commented solid foundations within the service are fundamental to success moving	

	forward but felt it was important to mange expectations. RL agreed and welcomed SF's comments. KM queried the new resource in Participation and Engagement and questioned the co-ordination and synchronisation of this work. RL advised this post will sit within the Partnership's Participation and Engagement Team and detailed some of the work planned.	
	5.3 Participation and Engagement Strategy FMcK thanked members of the IJB who joined a working group to review the Participation and Engagement Strategy. The group worked to ensure the Strategy is fit for purpose and meets the requirements within the framework for engagement, working with localities, private independent providers and third sector. She highlighted the significant engagement which has taken place to develop a robust Strategy to take forward the many Strategies which will form the Strategic Plan. FMcK confirmed the report is now ready to take through the Committees for final sign off. Cllr Downie asked for further detail relating to individual feedback mechanisms and also clarification around social media activity. He commented there are 3 layers between the public and the IJB, which is quite a bit of filtration possibly hindering the Committee hearing people on the ground. FMcK explained how work is tailored to the specific groups being worked with. She advised on-line can be limiting for some people and it is hoped to return to face-face engagement moving forward. She explained a means for people to engage through the locality groups and carers groups. This feedback will come through to a community engagement forum where people's voices can be heard. FMcK and Cllr Downie will meet to discuss off-line. Cllr Kennedy queried whether elected members would assist to engage members of the public through the various interest groups they are involved in for their views. FMcK felt this would be helpful, bearing in mind this should be around Health & Social Care and questions should be tailored. She added, feedback to people who have engaged is very important and helpful. KM would like to have seen a clearer value around objectivity, transparency and accountability. He felt it is sometimes alleged, the outcome is already decided. Objective work is key, co-design and co-production is encouraging. He acknowledged a degree of co-commissioning and would like to see co-delivery - work to aspire to. He asked for clarity around the use of the word 'volunteers'. FMcK felt co-commissioning and co-production sits within the Commissioning Strategy and people's views must be taken through P&E. She added, a team who is listening and feeding back to particular services about how they can redesign or transform is the aim, along with not being too close to make the distinction around delivery. She advised, the Commissioning Strategy will sit alongside and we will always strive to get the best joined up services possible. FMcK will look again at the wording around "volunteers".	**FMcK / Cllr Downie**

	SB thanked KM for his comments and agreed moving towards co-delivery is where the Partnership need to be. ID felt the Strategy takes a huge step towards achieving many of the improvements sought for many years. He was encouraged to see the move towards continuous improvement within the Strategy.	
	5.4 Workforce Strategy Plan 2022-25 RL advised he was seeking approval from the Committee for the Strategy to be submitted to Scottish Government ahead of the deadline of 31 August 2022. Submission to IJB will be September 2022. SF acknowledge the huge amount of work which has gone into the report and was supportive of the short, medium and long-term actions. Although felt, how these are communicated to staff will be challenging and the Strategy needs to become a living document. RL was supportive of SF's comments and told of consulting and engaging / communicating with the workforce and how the actions will move forward. KM fully endorsed the document and conceded retention of the workforce is becoming more and more challenging. He felt the Strategy is clear and easy to follow. RL told of 2 new recruits joining his Team, bringing extensive knowledge and experience of recruitment and retention and the many challenges involved. He emphasised the Strategy is a growing, working document and spoke of continuous improvement. There was a discussion relating to skills development and staff wellbeing. SB summarised the discussions and stated the Committee were content to recommend the Workforce Strategy Plan 2022-25 to the IJB.	
	5.5 Winter Lessons and Reflections LG introduced the Winter Lessons and Reflections Report and explained the Winter Plan (RNP4) has been presented to IJB and other Committees previously. The 'Situation' section of the Winter Lessons and Reflections report describes arrangements which were in place during Winter 2021-22. She wanted to emphasise, the collaboration and leadership shown has been phenomenal and stressed the challenges and pressures remain today, possibly worse than ever experienced. LG Explained the Opel tool which is used across the System. She advised there is an average increase of 25% in referrals to the Discharge Hub due to frailty and the increasing elderly population, also fallout post-pandemic. Pre-pandemic, on average there were 55 referrals per week, this number is now largely sitting at 89, showing the significant pressure	

	on the System. Despite this, discharges from Acute average at 60 referrals. Every service within HSCP is seeing the result of these demands. Awaiting Guardianship and Legal Aid is holding up patients being released, adding to the additional pressures. LG explained the role of the Complex Care Team, Hospital @ Home, Unscheduled Care Flow and Navigation. Performance rates were outlined which have been very good despite pressures , which the report demonstrates. Looking to Winter 2022/23, LG told of continuous improvement with transformational work which is outlined in the Home First report. ID stated prior to the pandemic, targets were not achieved, he asked if the underlying problem has been identified and hoped this was being investigated. LG commented there are local targets which are exceeded regularly, despite pressures. She felt what ID was referring to is a National target which Fife has reduced significantly and is actually one of the best performing Boards in Scotland. She advised the solution is Home First and explained the investment and work which has/is taking place. KH commented the report exposes the situation pre and post Covid with alarming vacancy rates across the system. She felt preventing people coming into hospital is an area of vulnerability, not just in Fife but Nationally. She acknowledged the recruitment pool is not there and suggested some form of alternative plan could be developed rather than hoping posts will be filled. She offered to assist in any way she can. She felt lived experience also needs to be considered and should guide future plans. There was discussion around 'winter pressures' and it was agreed pressure is now felt throughout the year, particularly of recent years. LB advised she planned to bring forward 'Winter Plans' sooner to IJB and the name may be revised. Lessons learned and hearing what stakeholders have to say are taken on board and LG spoke of the workshops/events which take place. HH explained the historical reasons for specific 'winter plans' however, as Covid is not a seasonal illness, the pressures on the system are now constant.	
	5.6 Home First Update LG introduced the Home First Update to the Committee for Awareness. She stated this is a significant transformation change within the Partnership, with the overarching principle of assisting people of Fife to live longer and healthier lives at home or within a homely setting. She spoke of alignment with Scottish Government policies and the governance around Home First. Future Plans were outlined with LG describing a vision to improve co-ordination and streamline the model. LG spoke of roadshows which are being arranged with assistance from FMcK, in terms of Engagement and Participation. She added stakeholders support is crucial to the success of the new Home First. KH voiced concern around alignment with the move towards Place Based Leadership and local areas having an understanding of the	

	community profile in each specific area. KH was keen to bring together without causing a tension across Council and HSCP, she did not see this as barrier but important to consider. LG agreed and this will be further discussed. There was much discussion around single point of access, accessing services and promotion and prevention. KM felt the EqIA should be appended to papers and come to Committee. Also, the format of the report was inconsistent with other papers with Implications, etc missing. LG explained she removed some sections in the report as they were blank, also the EqIA was exceptionally large, however, will circulate.	**LG**
	5.7 Business Cases for Lochgelly and Kincardine BD presented the two business cases for the health and wellbeing hubs at Lochgelly and Kincardine. He explained, these were put on hold in Jan 2022, due to the pandemic. BD introduced the Capital Investment Proposal and the Service Model component of the Proposal, which is relevant to this Committee and the IJB. He advised the two locations for the hubs were identified using the SG Place Based Needs Planning Tool. He described the strategic approach being used and plans for similar developments. The news of the developments was enthusiastically received and there was support for the list of services which will be provided within the hubs. The benefit to the communities was felt to be very positive.	
	5.8 Development Work A separate development session will be arranged for the near future.	
6	**EXECUTIVE LEAD REPORTS & MINUTES FROM LINKED COMMITTEES**	
	6.1 Minute of the Quality Matters Assurance Group Unconfirmed Minute from 01.04.22	
7	**ITEMS FOR ESCALATION** KM asked if there is a documented process for complaints which may require escalated to IJB Board members, ie for significant risk reasons? NC advised there is a formal complaints process which links with both FC and NHS, also for complaints for services not manage by HSCP, through wider partners. In terms of risk, she referred to an overarching report which highlights themes coming through complaints. NC is sighted of this report. She stated, if anything comes through as a complaint which she thought relevant to IJB, she would ensure this is escalated accordingly. She advised, she is not aware of complaints which have required escalation to IJB but gave examples of complaints which have prompted change. KM felt there may be complaints which should be escalated which could shape future direction. There was much discussion around Complaints and Duty of Candour and transparent investigation.	

8	**AOCB** No further items raised.	
9	**DATE OF NEXT MEETING – Friday 9th September, 1000hrs MSTeams**	

Health & Safety Sub-Committee (Meeting on 10 June 2022)
No issues were raised for escalation to the Clinical Governance Committee.

Health & Safety Sub-Committee

UNCONFIRMED Minutes of the Health & Safety Sub Committee held on Friday 10 June 2022 at 12:30 within Microsoft Teams

Present:

Neil McCormick (NM) Director of Property & Asset Management
Conn Gillespie (CG) Staff Side Representative
Linda Douglas (LD) Director of Workforce
Paul Bishop (PB) Head of Estates

In attendance

Anne-Marie Marshall (AMM) Acting Health and Safety Advisor
David Young (DY) Minute Taker

1. Chairperson's Welcome and Opening Remarks

NM Welcomed everyone to the meeting.

2. Apologies for absence

Dr Chris McKenna (CM) Medical Director

3. Minutes of previous meeting Action

3.1. APPROVAL OF PREVIOUS MINUTES

The minutes of the previous meeting were reviewed by the group and agreed as accurate.

3.2. Matters Arising

3.2.1. Health and Safety Policy review

DY informed the group that he now has a list of Health & Safety related policies and will send a copy to the team. DY

4. COVID 19 Update

NM told the group that NHS Fife is no longer on an emergency footing, so decisions now rest with NHS fife. However, this doesn't appear to have made a major difference, as national policies are still being adhered to, particularly in terms of social distancing and testing for staff. He does expect these measures to be stepped down at some point, but doesn't know when that might be.

LD informed the group that she is aware that work is actively being undertaken through the Scottish Partnership Forum, the Scottish Terms and Conditions Group and the Scottish Workforce and Governance Group and anticipates that we may have a clearer picture of the stepping down of those policies and guidance that where devised for COVID towards the end of the month and added that for a number of those, it is likely to be a transitional step back into extant policies and procedures.

NM asked CG how he thought frontline staff were feeling. CG said Staff are tired and morale was low, he thought that some changes in regard to the wearing of masks and social distancing may help. NM thanked CG and agreed that this is an issue and everyone's Mental Wellbeing is important.

5. Governance Arrangements

5.1. Incident Statistics Annual Review (Apr 21- Mar 22)

AM discussed report which covers the period From April 1st 2021 to March 31st 2022.

5.1.1. Sharps Incidents

AM report a total of 180 shaaps incidents. Of those, only one was reportable to the HSE under as a dangerous occurrence because the source patient had was known to have a BVD. The highest amount incidents took place within acute at 88.

5.1.2. Slips, Trips and Falls

AM informed the Group that a total of 78 slips, trips and falls incidents recorded on DATIX. 15 from VHK in the same level 1 high and one was a water spillage on the floor in level 11.Of those 21

incidents, 2 have triggered RIDDOR

5.1.3. RIDDOR reportable incidents

Total of 25 incidents, physical assault attended for six of those for an over 7 day absence and one recorded is major in terms of harm triggered the SAER which is still ongoing.

5.1.4. Manual Handling Incidents

For manual handling injuries and we had a total of 78 manual handling injuries. 52 of those were for patient handling and the remaining 26 due inanimate load Handling

5.1.5. Violence & Aggression

Physical assault

Total recorded incidents = 70 87% proportion directed towards Staff = Actual figure of 61 incidents. Remaining balance of 9 incidents were patients fighting with each other or relatives.
Verbal abuse
Total recorded incidents =75
87% proportion directed towards Staff =Actual figure of 65 incidents. Remaining balance of 10 incidents were patients arguing with each other or relatives.
NHS Fife Mental Health and Learning Disabilities Services
Physical assault –Total recorded incidents = 1316
54% proportion were directed towards Staff = Actual figure of 710 incidents. Remaining balance of 606 incidents were patients fighting with each other or relatives Verbal abuse - Total recorded incidents = 262
54% proportion were directed towards Staff = Actual figure of 141 incidents. Remaining balance of 121 incidents were patients arguing with each other or relatives.
The most at risk areas to exposure to violence and aggression in NHS Fife Services is within Mental Health & Learning Disabilities which experiences 92% of all recorded incidents, with Acute Services experiencing 8%.

NM thanked AM and commented that the graphs were very powerful and just showed exactly why we're concentrating on the things that we're concentrating on

5.2. Fire Advisory Service Annual Report

5.2.1. Training

Face to face training has recently recommenced and uptake has been huge. Multiple sessions have been arranged and the process is 'as before' with staff prebooking and recording attendance.

The video presentation which was developed for use during COVID is still in use and is now a part of TURAS learn.

5.2.2. eESS reports

The eESS system has developed and we now have a 'non compliance' report. This was intended to show how many staff in each department and directorate have not had training opposed to previously only being able to show how many staff have had training.

Training on the above report in eESS has recently been completed by our compliance admin and we have still to test it out by running the organisation wide figures.

5.2.3. Smoking & Datix

Staff are continuing to report smoking related incidents as per policy. This is good and will allow us to run a full datix report to capture the whole year. This has only started happening across the board since the fire advisors started attending the specific wards and supporting the staff to ensure they understand the process for reporting.

5.2.4. Fire risk assessments

These are continuing as per the annual plan and full details will be in the report. Actions are uploaded to a separate file for the Estates Officers and Managers to either repair or escalate to EAMS for funding.

5.2.5. Policy

Just before COVID, we introduced a new structure within the policy to ensure commitment and accountability across the organisation following close working with internal audit. It was circulated

via some forums but now requires refreshed and sent out and fully approved. I have been working with Hazel Thomson on policies to get this round the board again, planned completion end of year.

5.2.6. UFAS

We are continuing to monitor unwanted fire alarm signals as per NHS Fife SOP and work closely with SFRS on this subject. Meetings used to be quarterly and have stretched a little lately, but intention is to reinstate to quarterly. Full UFAS figures are also entered into EAMS as per national requirements.

5.3. Review of Outstanding Audit Actions

5.3.1. Sharps Strategy Group

AM told the group that she has attempted to restart the sharps in on two occasions. Invites have been sent for meetings scheduled in April and June but due to holidays and staffing pressures, the meetings have been cancelled. AM has also had major problems trying to formulate a training package to meet the needs of the Sharps Improvement Notice that were served on us a few years ago. AM asked that, moving forward, could she have some assistance from this group if possible, to obtain a list of all the medical sharps used in NHS Fife. She can use this list to create another list of the suppliers and the list of the sharps that NHS Fife use, then contact each of the suppliers and see if the suppliers could come in and train senior charge nurses and other areas who then can filter down the training into their staff, which is a stainable process moving forward.

AM has written the paper for acute services Division, LPF and has asked again for assistance, to encourage and promote the needs for the sharp safety strategy group and if we can get some new Members, that would be absolutely fantastic. And then we could review the terms of reference.

Some discussion by LD and AM around the difficulty obtaining a list which shows the Sharps that are actually used by NHS Fife as opposed to a List of all Sharps supplied by Procurement.

LD has suggested that either her or NM email their peers to inform them of the issue and ask for help and then AM can describe the issue properly.

5.3.2. Manual Handling

AM discussed the audit carried out 2021 which had raised some areas of concern and, In particular, the cessation of manual training for staff during the pandemic. One of the things the audit focused on was how the organisation was going to capture any staff who hadn't been trained. AM confirmed that retrospective manual Handling Training has been completed for staff who started with NHS Fife at the beginning of the pandemic and the respective induction of staff already in post both fully contracted and bank staff. The Manual Handling Team also reintroduced professional courses for both fully contracted and bank Staff. AM informed the group that she intends to move away from Competency Based Assessors and plans to introduce Manual Handling Link Workers which will give a more robust system and support and resilience.

Training slots have now been built-in to the Manual Handling Training Rota to allow for bespoke training requests to become more flexible and accommodate training at short notice and immediate needs of the organisation.

The Team implemented a new process for New NHS Fife Staff. Workforce development have agreed to direct any new starts who require Patient Handling Training to email the OHSAStrng Hub email address to book on training. We also have access to report on eESS so we can cross check the names of new starts against our database and capture anyone who may need training but hasn't requested it.

AM told the group that she was aware that the H&S Team had no process to see if the training they are delivering was actually meeting the needs of the service, So, a process has been implemented where anyone who has attended a Manual Handling or Health and Safety Course can scan a QR code on their mobile phone which links them straight to a course evaluation document. They can fill in anonymously and the data is stored straight into a spreadsheet. So we've got real time information from the staff at the end of training to see how they felt about the training and if they have any ideas that we want moving forward. As a result of this, the team now have continued training needs analysis which was lacking in the manual handling side. Any staff that don't have a mobile phone or don't want to do electronically can be given a paper copy or we email it out to them for them to complete.

LD thanked AM for the report as this gives real substance and evidence on which to gain assurance and direct connectivity.

LD suggested that it might be worthwhile altering the line in the report that states 'the retrospective induction for staff already in post' to indicate that was Face to Face training to avoid any misdirection that there wasn't appropriate training given electronically. New staff were triaged on commencement and given some training but it didn't cover all of the elements they required.

AM agreed and will the amend wording as requested

LD also suggested that as OHSAS no longer exists, we need to divest ourselves of references of OHSAS, and asked that, in future, when we talk about occupational health services in Fife, we refer to it as Occupational Health, not OHSAS.

AM said that the OHSAS training email address has been in use for many years, so the staff are aware that it's used for booking Manual Handling & Health & Safety Training. She also said that staff who attend training are informed that the Health & Safety Team aren't part of Occupational Health but sit within Estates & Facilities. However, she can look into the possibility of changing the hub address if necessary

LD said that she thought that the idea of the QR code was fantastic and asked if it can be shared with the workforce development team.

AM said she would be more than happy to do this.

5.4. Health & Safety Report

5.4.1. Monkey Pox and Face Fit Testing

NM asked if AM could update the Team on some of the issues around monkey Pox and, in particular, an issue regarding the use of PPE in sexual health.

AM informed the group that when the guidance was initially released, the thoughts were that the most likely presentation of patients would either be through A&E or through sexual health. The guidance then was for staff to wear the full PPE (an FFP3 mask, a gown and gloves). The H&S Team were contact by the Sexual Health Team with an emergent plea to have the staff face Fit Tested. The H&S Team were able to schedule FFT sessions at short notice and carry out testing for 21 nurses and healthcare support workers. Some Doctors still need to be tested. We have subsequently received further guidance which states that an FFP3 mask may not be required.

5.4.2. FFP3 Mask Concerns.

AM advised the group that NHSF the remaining stock for the 3030V will run out around the end of July this year. The new replacement mask is the 3530V. Any staff who have been passed to wear a 3030V do not need to be re-tested and can swap to a 3530v. The H&S Team have tested some staff already on the 3530V. There is an issue concerning the 3530V masks as they cannot be ordered on PECOS yet. There will be a transition phase from the 3030V PECOS code and that will change over to 3530V. AM hoped that Procurement will facilitate the transition will happen quite smoothly.

5.4.3. Face Fit Testers Audit

AM told the group that the H&S Team recently conducted Face Fit Testing Audits throughout Phase 3 at VHK, concentrating on the all of the Wards in the 20s, 30s, 40s and 50s.

The Audit showed that support required, so the H&S Team carried out the following actions;

- Four sessions organised in May for the initial training of Face Fit Testers
- Four sessions have been scheduled in June for Refresher Training.
- A new Face Fit Tester hub address in place, so staff could book on Face Fit Testing directly. The face fit testing hub address has been given to workforce colleagues, so they add that into the induction.

As a result of the audit the H&S Team have trained 27 staff as Face Fit Testers for the Acute Service and four additional Testers for critical care, so that has significantly increased the portfolio of trained Face Fit Testers who can provide Testing, ordering masks for their area if a COVID type event occurs again.

There is also MS Teams page for Face Fit Testers so they can come and talk to us there and we could give them any advice and support and guidance.

Audits have now been carried out in Queen Margaret Wards 01 to 08, and the H&S Team are starting to organise training sessions for QMH staff.

LD thanked AM for the report and asked if, In light of guidance from Health Workforce @ Scottish Government which talked about people having a preference to use a FFP3 mask, we have assurance

of the connections being made between that guidance and the reality and practicality about ensuring people are appropriately Fit Face Tested.

AM said that because of the work carried out by the H&S Team after the Audit, she thinks it has given assurances to the staff and they feel more protected because the process has been tightened. AM said that it's a work in progress and we're on the right track to give these assurances as best as possible at the moment regarding Face Fit Testing.

NM thanked AM for her and the H&S Team for the work, which is a useful piece of assurance for this group to pass up to clinical governance.

5.4.4. Ligature Works

AM informed the group that since September 2021, a considerable amount of work has been carried out to have a program in a process in place so that the assessments were tighter, better and more consistent . The H&S Team focused on five particular areas that AM wanted to tighten up on.

- The Ligature Risk Assessment Document
- The Ligature Risk Assessment Process
- The Ligature Risk Assessment Tool
- An Immediate High Risk Action Plan
- Setting Up the Ligature Management Oversight Group

AM told the HHSC that the Ligature Management Oversight Group has been set up and includes leads from Health & Safety, Estate Sector Managers, Service Managers and Heads of Nursing for the partnership. She reported that A Ligature Management Spreadsheet has been excel document. Discussed the Elective Assessment Tool and the implementation of a rolling program of Ligature Works for 2022. AM feels that the changes she has made have made the ligature work more streamlined and more collaborative, thinks that the changes have been well received by both Estates and Clinical Staff and definitely feels like it's more of a team approach rather than just Health and Safety.

LD said she thought this is fantastic piece of work. I think it's great that that kind of quality improvement piece very supportive of the work that's been done.

NM raised two points; Firstly that risk assessments have of changed over the years and AM is using the most well respected kind of risk assessment methodology now. but that wasn't necessarily available or in widespread use in previous years, so every now and again when we refresh the risk assessments in these areas are view on risk is changing as best practice is changed over the years as well.

Secondly, he informed the group that had a paper at FC yesterday from the Health and Social Care Partnership and there's a million pounds of revenue and which was made available by Scottish Government to address the high risk areas and for ligature as well. And hopefully that will help to address some of the highest risk issues across NHS Fife

6. NHS Fife Enforcement Activity

AM reported that there is no HSE activity at present. However, she has been informed that the HSE visited NHS Grampian in May 2022 and looked at the management of Violence & Aggression. As a result of the visit, three Improvement Notices have been served in relation to the risk of violence & Aggression and how it's been managed at Aberdeen.

AM pointed out that normally, when the HSE visit one area for a particular topic, it can lead to them visiting other areas. AM informed the group that the V&A Advisor for NHS Fife retired last month and the post has still to be filled. AM suggested that in the meantime, if she receives any V&A Queries, she can consult Bill Coyne, Kirsty Cairns or Ian Deas.

7. Policies & Procedure

Nil

8. Other business

Nil

9. FOR INFORMATION/ NOTING

Nil

10. Next Meeting

The next meeting will take place on Friday 09 September 2022 @ 12.30pm on Teams

NHS FIFE INFECTION CONTROL COMMITTEE
08TH JUNE 2022
VIA MICROSOFT TEAMS

Present	
Paul Bishop (PB)	Head Of Estates
Pauline Cumming (PC)	Risk Manager
Janette Owens (Chair) (JO)	Director of Nursing
Elizabeth Dunstan(ED)	Infection Control Surveillance Audit Nurse
Lynn Burnett (LB)	Nurse Consultant Health Protection
Pamela Galloway (PG)	Head of Midwifery and Nursing W&C
Julia Cook (JC)	Infection Control Manager
Stephen Wilson (SW)	Consultant Microbiologist
Norma Beveridge (NB)	Head of Nursing
Catherine Gilvear (CG)	Fife HSCP Quality, Clinical & Care Governance Lead
Prya Venkatesh (PV)	Consultant Microbiologist
Fiona Bellamy (FB)	Senior Health Protection Nurse Specialist
Craig Webster (CW)	Deputy Infection Control Manager
Apologies	
Jim Rotheram	
Aileen Lawrie	
David Griffith	
Sue Blair	
Midge Rotheram	
Esther Curnock	
Lorna Elridge	
Lynn Campbell	
Norma Beveridge	
Sharon Dobbie	
Christine Law	
In Attendance	
Bev Young	Minutes

1	**APOLOGIES** Apologies were **noted** as above.	
2	**MINUTE OF PREVIOUS MEETING – 02ND March 2022** Group approved previous minute as accurate reflection	
3	**ACTION LIST**	**ACTION**
	Action list updated to reflect.	
4	**STANDING ITEMS**	
4.1	HAIRT Report ED updated with regards to achievements for SABs in Q4 NHS Fife was below the national rate for both HCAI and CAI. For CDI during Q4 NHS Fife was below the national rate for both HCAI. ED updated with regards to challenges there are ongoing challenges with VAD SABs and Covid 19. There are challenges trying to achieve targets a DL letter was published in may for March 2022 have been extended for a further year. SABS improvement work continues, PWID, have had three so far and will be monitored and IPC continue to support addiction services. Ed advised that E.coli numbers seem to be up in 2022 and will be an ongoing challenge, 25% reduction and has been extended to next year. We have gotten fairly close and will have to work closely in order to	

	maintain and reach the target set. CDI: NHS Fife sitting well compared to all health boards, however we still have our own reduction target and has been extended for a further year. Will be a challenge to achieve. Caesarean Section/ Large Bowl SSI/Orthopaedic Surgery SSI : has been put on hold, a DL letter was published in May and surveillance will commence in quarter 4 and we will have put resources back in place and will prove a challenge Covid: NC cases largest wave was in March 2022 and will be gone over in more detail later on in the meeting. ED updated with regards to SABS demonstrated that NHS fife are sitting below national average for both HCAI and CAI. Initial target date has been extended for another year. Local work and SAB surveillance remains the same Improvement initiatives remain the same. ED: advised supporting PWID and Addictions services lead by addiction services and IC are supporting this service which has resumed ED updated on screening and we have seen fantastic improvement in MRSA and CPE Screening, this has been incorporated into patienttrack and our rates have really improved and most recent Jan to March 2022 98% of patients have been successfully screened. ED: CPE has also been completed and currently have a 100% rate and we are keen to share as a success story. ED updated on CDI our own local record only 7, up 2 from previous quarter. And we are well within the target and we are the lowest health board in both acute and community. Ongoing challenge to maintain and has also been extended for a further year. ED: E.coli Local data 66 from Jan to March and up 6 cases from previous cases. 7 of those have been Catheter and we have made great headway to reduce this and one of which had a traumatic related CAUTI. Nationally we are sitting slightly below for both acute and community and rates will be ongoing and a further 25% reduction is needed. NHS CAUTI ECB'S data shows for Q! We have had no hospital CAUTI, for 2021 15.4% were from hospital. HCAI patients who have acquired out with a hospital setting and for those patients who have care at home and have care professionals at home and Q! 2022 24% however 2021 was 36%. Still ongoing work for improvement and a change coming about this year as there will now be an electronic recording of UCI insertion on Patientrack. UC Improvement Group, last meeting was in May and pushing forward to have bundles implemented. ED updated with hand hygiene and observations were completed and updated on LanQIP, Ward dashboard is no longer updated and hand hygiene audits have been submitted ED: Cleaning compliance and estates, domestic services was 96.2% and estates was up to 96.8% JC; Outbreaks from March to end of April 2022, 2 norovirus outbreaks at QMH and links between the two wards. No outbreaks with influenza This period was very challenging and this has been the highest we have had to report total of 39. Acute, HSCP, W&C. full reports are available on the main body of the agenda, Key learning aspects poor compliance with patients with FRFM and screening compliance, positive visitors, HCW, different cohorts of patients including patients who walk with purpose and patients who are out in the community. Isolating was very difficult with lack of side rooms to isolate patients, National Guidance was changed during this time to help elevate these pressures across Scotland. If any teams would like a more in-depth run down we are happy to support this also.	

	JO: thanked JC for the update and noted that it is very positive that patient trak is supporting with the CAUTI work and patient care ED: Patient track will require ownership from acute services. This is being trailed with ward 54 Urology, JO: Norma please can you link in to support Members **noted** the update.	
4.2	Care Home update JC advised that we have some workforce challenges and Suzanne is looking after care homes today With care home fantastic work and DL has come out regarding HAI IPC Standards with a three month bedding in period. It is being supported with Webinars and have been circulated with care home managers, Referrals are coming in to IPC Care Home Team. IPC Team will be presented at large scale investigations where there are IP practice concerns. We have recruited two new IPCN for care home and are now back up to full a compliment for the care homes. JP: I have reived positive feedback for the Care home team Members **noted** the update.	
4.3	NHS National Cleaning Services Specification JO: Anne circulated the document JC: Nothing to raise. Members **noted** the update.	
4.4	Risk Register PM updated members ventilation risks would be presented at this group and also to consider the way forward on how reporting of risks was to be completed. High risks remain the same and also the water safety. No risks within an increased risk. Group to consider future reporting and the risks have been highlighted in the reports provided on the agenda JC: Possibly a more detailed report every quarter instead and can meet up to discuss with Julia, Members **noted** the update	
4.5	Learning Summaries No learning summaries for this ICC Members **noted** the update	
4.6	National Guidance JC: I have included the national changes into the agenda. We have had a DL to advise the Winter 2021-2022 Winter covid 19 will be in place until July 2022 and we will be reverting back to the National Manual and have added new appendices and continues to be developed. In preparation NHS Fife have set up SLWG and sub groups for this implementation date on 11th July 2022. AST testing is being reviewed at SG level and we are expecting an update next week. Members **noted** the update	
4.7	HEI Inspections JC: Letter added to agenda, there has been changes throughout Covid, has addressed older people and are going for an observation approach, engaging with all staff and the pressures we are facing and reporting. The website has changed and finding it difficult to filter which is also on the agenda, Key issues identified was adequate placing of patients, PPE	

	storage, hand hygiene, ensuring equipment cleaning and wash basins for hand hygiene only. JO: I am aware some other boards have had concerns highlighted it was not a HAI issue more of a patient safety concern and has been escalated but no HAI. We may get a visit from them soon for them to complete an inspection. Members **noted** the update.	
4.8	Quality Improvement Programmes (For Information Only) **UCIG** CG: This is fife wide and will have Shona liaise with Norma and Marie Shona is now taking over this and will be helpful having a chair for this group for acute and HCSW going forward. E.coli and CAUTI new processes being looked at with regards to the reviews JO: Claire Fulton has advised and I will follow up to check if this has gone to EDG CG: we are looking at the diagram and the suggestion is one group under the UCIG Group and key stakeholders around the table Keen to move forward and Shona has been brought up to date. **PWID** JC: Covid impacted this service and head of nursing Olivia Robertson has taken this over and the project has been exploring which associated infections in this vulnerable cohort of patients in injection sites, Looking to have a skin assessment questionnaire as part of the MORSE and working with E Health unsure of a date and the addiction services currently using a paper copy to ensure this is part of patient care and antibiotics can be prescribed. We have PGD going on and progressing well and IPCT offering refresher training to addiction services for swabbing sites. Members **noted** the update.	
4.9	Education JD: programme is being looked at and current material is being reviewed with reverting back to the national manual. NES communication been received and all on Turas and are under review and ICT are helping with the updates also Members **noted** the update	
4.10	Infection Prevention & Control Audit Programme JC: This is on track and Rosemary Shannon is supporting us, this is a two year rolling programme and no concerns. Members **noted** the update	
4.11	Prevention and Control of Infection Work Programme 2021-2022 (for noting) JC: update attached and official version will be available by next ICC meeting. Members **noted** the update.	
5.	**NEW BUSINESS**	
5.1	COVID-19 DL's: JC I have added the changes to the agenda for the ICC committee awareness for changes to testing, isolation, face masks and the key messages in the DL's Members **noted** the update	

5.2	Incidents/Outbreaks and Triggers Covid 19 ASD Covid 19 W&CS Covid 19 HSCP Norovirus HSCP National Report Reports for information. Members **noted** the update	
5.3	Monkey Pox JC: Monkey pox is becoming a global concern, and we have over 300 cases in UK and 900 Worldwide LB: National IMT with PH Scotland that PH are being involved in. AS far as fife we have a Monkeypox section and there is a pathway on blink and have also added in a community testing team pathway guide in there also. Vaccination side have been addressed and resolved with AMP prescribing. Awaiting update regarding classification of HCID this week. Cases in England are starting to level out unsure if this is a reflection of the Jubilee and non-testing or a reflection of the spread. Pre exposure vaccination will be getting looked at in London for staff. Won't be service wide and may only be certain groups. Members **noted** the update	
6	**NHS FIFE INFECTION CONTROL COMMITTEE'S SUB GROUPS**	
6.1	Infection Prevention & Control Team Nothing from this meeting to highlight to group. Members **noted** the notes of the meeting	
6.2	NHS Fife Decontamination Steering Group Nothing from this meeting to highlight to group. Members **noted** the notes of the meeting	
6.3	NHS Fife Antimicrobial Management Team Nothing from this meeting to highlight to group. Members **noted** the notes of the meeting.	
6.4	NHS Fife Water Safety Management Group Nothing from this meeting to highlight to group. Members **noted** the notes of the meeting.	
6.5	NHS Fife Ventilation Group Nothing from this meeting to highlight to group. . Members **noted** the notes of the meeting.	
6.6	HAI SCRIBES JC: this post is advertised and closing date is today. Hope to appoint very soon and interviewing WC 20th June. Members **noted** the notes of the meeting	
6.7	Quality Reports Quality reports attached to agenda for information. Reports are for **noting** only	

7	**ANY OTHER BUSINESS** New IPC Standards: JO: I will take a paper to EDG for update of new standards JC: I think the biggest change will be for the care homes but we have been advised to wait on the national WEBINAR to ensure we can support the role out and healthcare is the sense check and ensure we have all the governance. I am hoping to present at Organisational Learning Group and QMAG. Launch of Chapter 4 NIPCM Hand Hygiene Day 2022 JC: was very successful to meet staff and public and hope to get to do this often. Thanks for all who attended Members **noted** updates.	
8	**DATE OF NEXT MEETING** The next meeting of the Committee will be held 03rd August at 1400 via Microsoft Teams.	

NHS FIFE INFECTION CONTROL COMMITTEE
03RD AUGUST 2022
VIA MICROSOFT TEAMS

Present	
Paul Bishop (PB)	Head Of Estates
Pauline Cumming (PC)	Risk Manager
Elizabeth Dunstan (ED)	Senior Infection Prevention and Control Nurse
Pamela Galloway (PG)	Head of Midwifery and Nursing W&C
Julia Cook (JC Chair)	Infection Control Manager
Stephen Wilson (SW)	Consultant Microbiologist
Catherine Gilvear (CG)	Fife HSCP Quality, Clinical & Care Governance Lead
Jamie Gunn (JG)	Health Protection Nurse Specialist
Craig Webster (CW)	Deputy Infection Control Manager
Sue Blair (SB)	Consultant in Occupational Medicine
Lynn Campbell (LC)	Associate Director of Nursing
Keith Morris (KM)	Consultant Microbiologist
Lynn Barker (LB)	Associate Director of Nursing
Apologies	
Esther Curnock	
Aileen Lawrie	
David Griffith	
Stephen Mcglashan	
Bev Young	
Neil McCormick	
Priya Venkatesh	
Jim Rotherham	
Norma Beveridge	
Janette Owens	
Lynn Burnett	
Fiona Bellamy	
Midge Rotherham (MR)	

1	**APOLOGIES** Apologies were **noted** as above.	
2	**MINUTE OF PREVIOUS MEETING – 08th June 2022** Group approved previous minute as an accurate reflection, JC advised any amendments to be emailed to herself or Bev Young.	
3	**ACTION LIST**	**ACTION**
	Action list updated to reflect and JC advised updates to be forwarded	
4	**STANDING ITEMS**	
4.1	**HAIRT Report: All data up until end of June 2022** JC; IPCT have managed to promote hand hygiene and Biomedical since day with information stands at the VHK. Three more team members have also completed University of Highland and Islands MSc module IPC Built Environment, with 5 of the team who have now successfully completed. Representatives of the IPCT attended IPS Scotland branch Conference in Glasgow. Also team members attended the Infection Prevention & Healthcare Facilities Management event.	

	ED updated with regards to achievements for SABs in Q1 2022 NHS Fife was below the national rate for both HCAI and CAI. For CDI during Q1 NHS Fife was below the national rate for both. For E.coli we were above for Q1. Our agreed standards have been extended until 2023. ED updated with regards to challenges. PWID there have been no further reports. ECBs: Jan to June 2022 number has risen substantially compared to previous year 104 ECBs and remains a challenge. CDI was significantly lower for the same time period and C Section and SSI nothing to report as currently paused and awaiting for an update Covid 19: JC demonstrated the graph, rise in cases march to April and then again in June and July 2022. ED: Local data for SABs results for Q2 are the same as Q1, we are just below the national target line, and however Fife is just above national rate for Q1. Target reduction of10% has been extended for a further year. Local Device related SAB surveillance: CVC SAB 47 days, PWID 79 days, Renal 235 days, Acute Services PVC, 82 days. Initiatives remain the same and electronic recording is completed and fed back. MRSA: CRA is completed is now electronic, ~~and an~~ improvement can now be seen and the most recent is 98% compliance and we are currently sitting well above the national rate. CPE: previous quarter we achieved 100% and this quarter we are currently at 98%. CDI~~F~~: local data 12 for Q2 and previous quarter reported 7. We are sitting below for both community and acute. A 10% reduction target continues. ECB: In Q2 70 ECBs this was up from Q1. 12 CAUITS in Q2 which is an increase from 7 in Q1.Improvement work is ongoing. Nationally- above the national rate. The community acquired ECB, there is ongoing work to address this issue (UCIG). Our baseline is 44.00 per 100,000 and need to get to 33 per 100,000, current rate is 40.8 per 100,000.~~0~~ Data we receive back from ARHAI is split into HAI and community. There is much work to be completed in both areas. Catheter maintenance and insertion module is to be trialled in VHK and Urology Also the senior IPCN for Care Homes will be working with 5 care homes to implement CAUTI bundles to optimise catheter care Hand Hygiene: all data added to lanquip, ED also noted that National Cleaning Services Specification – quarterly compliance has increased this quarter. Estates monitoring also has a green status at 96.8 for Jan to March. JC: For norovirus NHS Fife had one ward closure V6 and V31 bay which was ~~a~~ suspected. For influenza no closure's to report. Covid 19 we have had a spike in cases however this has improved from last report from 39 to 17, HSCP and Acute. Lessons learned identified - Positive visitors and non-face mask use has ~~also~~ been an issue, screening has also been an issue ~~has~~ (either been missed or not completed at the correct times), Day 5 screening has identified positive patients. A lot of areas are MOE, MH with patients who walk with purpose KM: noted that he is very concerned about ECB and the numbers we are having at the moment JC: we will keep an eye on report and see how we can support and how other boards compare.	
4.2	**<u>Care Home update</u>** JC: The Care home team have been promoting attendance at national webinar in preparation of the new HAI Standards to come live in	

	September 2022. They have been receiving referrals via HPT, care home hub, and care home managers, SICPs training continuing with very positive feedback. Winter preparedness has begun and team have also been supporting with a CPE patient within a care home. Members **noted** the update.	
4.3	**NHS National Cleaning Services Specification** Members **noted** the update.	
4.4	**Risk Register** PC: Current position of the risks for IPC. From last meeting report to be discussed and report format to be reviewed. Two high risks have been previously reported one is a 20 and the other is a 15. No risks have increased or reduced and one is closed. For other groups the data has been reported in a more graphical way to ensure all risks are being captured and considered. JC: to discuss with Janette before next meeting	
4.5	**Learning Summaries** No learning summaries for this ICC Members **noted** the update	
4.6	**National Guidance** JC: The biggest change is the cessation of Winter 2021-2022 respiratory addendum back to the national infection prevention control manual. However we now have appendix 18,19, 20, 21 and 22, with many pandemic measures are still in place NHS Fife still have measures in place such as social distancing, face masks and admission testing. Biggest change in acute is LFD for AST and will then follow up with a PCR. Feedback has been the reduction in number of contacts identified with the rapid testing in AU1 & 2. National guidance is in the very early stages of review for next winter and will keep the committee up to date of any changes. KM: we are all trying to understand the new normal and it is learning for us all. Members **noted** the update	
4.7	**HEI Inspections** JC: No inspections have been completed since last reporting periods within NHS Fife. When agenda was distributed I was made aware that a national inspection was completed and I will prioritise for the next ICC meeting. Members **noted** the update.	
4.8	**Quality Improvement Programmes (For Information Only)** **UCIG:** CG: Meeting organised to look at the E.coli CAUTI infections to map out the process for the next steps. ED: Every CAUTI will now be entered into DATIX for all cases and for all staff involved to review. Positive feedback from a SCN with this process and the learning achieved by the staff. CG: Proposal for a new meeting to incorporate and look over initial diver diagram and plan to scale it back. KM: the presentation I gave was on how I saw the development of the Catheter ECB in a diagrammatic format	

	PWID: JC advised that the ~~lead~~ IPCN has been on annual leave however, some changed has been made; Ian Davidson and Sarah McFarlane are going to be involved moving forward, the PGD and supported documents have been updated for the nursing team, storage has been requested and reviewing if a form for Morse is needed. Most recent chart indicates we have not had a new SAB in PWID in a while. KM: I'm afraid we have had one at the weekend. Members **noted** the update.	
4.9	**Education** JC: NHS Fife induction presentation has been updated in line with the change to the IPCT manual, junior Dr training ongoing, as well as volunteers orientation, voiced over presentations and reviewing winter preparedness, so all staff have access. Education Strategy is also under review and out for final comments. Members **noted** the update	
4.10	**Infection Prevention & Control Audit Programme** JC: Rosemary continues to support and remain on track for audits. Members **noted** the update	
4.11	**Prevention and Control of Infection Work Programme 2021-2022 (for noting)** JC: I have highlighted the main changes in amber: audit programme- is being supported by Rosemary COIM - new PA/Office Manager is working with the IPCNs to ensure this is all up to date and available on blink. Members **noted** the update.	
5.	**NEW BUSINESS**	
5.1	**COVID-19** KM: renal dialysis unit final report and it was confirmed via whole genome sequencing this outbreak was unique to the VHK. Confirmed to an outbreak associated with one unit. KM: This report highlights and demonstrates the value of the vaccination programme. It reduces severity but does not reduce or remove infection. It also highlights if you contract wild type, the immunity doesn't last very long and also shapes what we will be doing with vaccines in the future. Members **noted** the update	
5.2	**Incidents/Outbreaks and Triggers** Covid 19 ASD Covid 19 HSCP JC: Offered the associates an opportunity to further discuss any of the outbreaks, key learning or review if anything needs to be done differently including changes to the environment. KM: VHK 5, 6, 9 and surgical short stay unit are very difficult to manage during an outbreak. We have introduced fairly drastic measures in preparation for the Winter. National Report Reports for information. Members **noted** the update	

5.3	**Monkey Pox** JC: HPT have been leading, initial difficulty with waste, is now resolved with recent changes that have now been implemented. The UK strain is a category B waste. If any links to central of central west Africa these cases is a category A case as of 1st august there was been 65 cases. Public Health Scotland now have a dedicated web page. And the HPT are working to finalise community testing team. Also sexual health team may be involved in screening Members **noted** the update	
5.4	**Legionella** ED: In June routine water testing completed as per water safety group and legionella was detected in AU2. Pipe work was decontaminated and changed. Re testing advised, nil detected on 2 follow-up tests, however testing again and is been detected at a low level, a PAG has been held and are doing further work and testing to be completed. Side room remains closed and work is ongoing. SM: further testing in the AU2 area will be completed in the shower and wash hand basin.	
5.5	**Endophthalmitis:** ED: Patient reported in June following Cataract surgery. A PAG was completed with Keith Morris and ~~also~~ Dr Peter Wilson. Result was a SSI and not an endophthalmitis. Other contributing factors as the surgery became more complicated and the patient had other underlying health issues including a urinary catheter which in conclusion may have resulted in the surgical site infection.	
5.6	**MS Nurses** EH: antimicrobial stewardship is recommencing in the near future	
6	**NHS FIFE INFECTION CONTROL COMMITTEE'S SUB GROUPS**	
6.1	**Infection Prevention & Control Team** Nothing from this meeting to highlight to group. Members **noted** the notes of the meeting	
6.2	**NHS Fife Decontamination Steering Group** Nothing from this meeting to highlight to group. Update will be given at next ICC meeting. Members **noted** the notes of the meeting	
6.3	**NHS Fife Antimicrobial Management Team** Nothing from this meeting to highlight to group. Members **noted** the notes of the meeting.	
6.4	**NHS Fife Water Safety Management Group** JC: Group meeting on Monday and they are looking at high risk/augmented areas and plan for those areas. Members **noted** the notes of the meeting.	
6.5	**NHS Fife Ventilation Group** Nothing from this meeting to highlight to group. Members **noted** the notes of the meeting.	

6.6	**HAI SCRIBES** JC: Senior IPCN has been appointed to lead on HAI Scribe the SBAR will be refreshed Members **noted** the notes of the meeting	
6.7	**Quality Reports** Quality reports attached to agenda for information. Reports are for **noting** only	
6.8	**Capital Planning** JC: A new topic added to the agenda. For the committees awareness ~~part~~ NHS Assure was formed 2021 ~~and~~ process and assurance is now in place for capital built environment works. Our board can give assurance to NHS Assure. The derogation reports for the orthopaedic centre and also the Lochgelly and Kincardine Community Health and Wellbeing Centres. More information will be proved at future ICC meetings.	
7	**ANY OTHER BUSINESS** **NHS fife CJD and variance policy** JC: overdue for review as the group ceased a year ago. There has been questioning over the CJD questionnaire and liaising with ARHAI as this is still a requirement, comments have been compiled and it has been submitted to the decontamination group also for comments and final approval. **ARHAI Briefing Pseudomonas in contaminated** JC: Craig contacted procurement team and was advised no products were ordered as well as ICU assured ~~us~~ they do not use any of these products. Members **noted** updates.	
8	**DATE OF NEXT MEETING** The next meeting of the Committee will be held 05th October 2022	

IRMER BOARD

(24/05/2022)

Item 6

Following an Inspection from HIS (in Lothian) one recommendation was using Q Pulse to share documents across Boards. The IRMER BOARD are seeking clarity about using QPulse in Fife.

Insert Name of Committee/Group

MINUTES OF THE IRMER BOARD HELD ON TUESDAY 24 MAY 2022 AT 2PM VIA MICROSOFT TEAMS

Chair: Dr Christopher McKenna

In Attendance:

Dr Christopher McKenna (Chair) (CMK)	Medical Director, Acute Services Division/Executive Lead Radiology
Jane Anderson (JA)	Radiology & Diagnostic Services Manager
Dr Katharine Jamieson (KJ)	Clinical Lead, Radiology
Victoria Bassett-Smith (VBS)	Head of Nuclear Medicine Physics/ RPA and DGSA .
Nicola MacDonald (NMD)	RPA/MPE
Dawn Adams (DA)	Clinical Director, Public Dental Service
Nick Weir (NW)	Head of Imaging Physics
Debbie Harries (DH)	
Emma Hall (EH)	Lead Radiographer for Education & Quality
Laura Cluny (LC)	Principal Clinical Scientist

Apologies:

Murray Cross (MC)	General Manager, Planned Care
Satheesh Yalamarthi (SY)	Clinical Director, Planned Care
Sally McCormack (SMK)	Clinical Director
Claire Lee (CL)	Theatres Manager
Clare Parry (CP)	Clinical Scientist, Medical Physics

NO **ATTACHED ACTION**

1. APOLOGIES FOR ABSENCE

As noted above.

2. PREVIOUS MINUTES OF THE IRMER BOARD MEETING

Accepted.

3. ACTION PLAN

Action log to be reinstated as meeting going to move to twice yearly.

4. Outpatient Iodine 131 Service (LC)

Lothian looking to repatriate Iodine therapy service to Fife. NHS Fife patients previously attended a 'one stop shop' clinic at WGH. This was service was ceased in January 2022 due to logistical and other problems. Have come up with a solution to bring these services back to Fife but this means changes to Level 1 procedures (entitlement and procedure changes) for which we need approval

from the board.

DMK happy to go along with bringing services back to Fife.

Have to let Endocrinologists know. The Lothian Consultant will need an honorary contract.

Please see attached report for detailed description.

5. UPDATE TO NHS FIFE IRMER EMPLOYERS PROCEDURES (JA/NMD)

JA and NMD have worked through procedures. (attached).

Significant incidents – some things are tricky to manage, anaphylaxis contrast reaction, poor clinical choice for test i.e. patient referred for CT when a CXR would have sufficed. Any of those kinds of incidents should be Datixed. We should have a separate meeting to discuss further.

Within procedures we have scope to limit access for FY1's and 2's. Juniors don't seem to know what to do to refer out of hours and no-one really knows the pathways. KAJ to discuss further with CMK.

6. 2020 HIS IRMER INSPECTION

A recommendation following the IRMER inspection in Lothian was using Q Pulse to share documents. Do we have the support to take this forward. Check with CGC, perhaps invite Gemma to come to these meetings, need a solution but not sure Q Pulse is the way to go. Need to make sure we keep track of authors/versions etc.

7. DEPARTMENT REPORTS – EQUIPMENT INVENTORY AND CLINICAL AUDIT

a. Radiology

Inventory up to date, have submitted 5 year plan to the Board. Since then have received a couple of 'end of life support' notices for equipment. Good progress with replacement CT scanners. In terms of audit, good work done around extravasation of contrast, a noticed reduction in incidents.

b. Dentistry

CMK happy to take forward any problems with Tayside refusing scans for Fife patients. They say they can't do this because there are no Radiologist to report them.

IT issues with OPG's still causing problems.

Radiograph audit attached.

Lothian OPG being replaced and will share any information about options for kit.

c. Theatres

8. ANNUAL COMPLIANCE REPORTS – NEW STRATEGY

IRMER Level 1's new compliance forms to complete annually, looking to make this electronic version, looks easy to navigate. NMD showed the group through the document. Should be good to go in October.

9. NON MEDICAL REFERRERS

a. Possible Pharmacy Referrals.

With lots more and varied roles throughout the Board it's difficult to manage numbers, needs tightened up. Pharmacy should go through EC/DC or GP, no skill set to refer, signpost back to GP. MD and Director of Pharmacy not keen.

b. General Issues

Looking for additional admin as group becoming huge. MD supportive.

10. RADIATION INCIDENTS AND NEAR MISSES

a. Radiation Incidents – Jan-Apr report (NMD)

NMD talked through the report (attached). Notifiable incidents – one at QMH sporadic images, carestream changing some detector components today, hopefully resolving the problem. One at VHK - CT head, JA has dealt with this.
6 incidents on the same site within 6 months should be notifiable 'multiple incidents on a stream'.
IRIC want to know about incidents involving pieces of equipment that cause harm
HIS says any 'wrong side' patient exposure is notifiable.

b. MPE Report - incidents. See attached

11. MPE REPORTS

a. Imaging (NW)

New equipment commissioning carried out – room 2 at QMH – CR at VHK. 2 CT's over the summer, P3 mid June and P2 August/September. New ortho centre at VHK 2 DR rooms August.

b. Nuclear Medicine (VBS)

ARSAC licence required to be renewed every 2 years instead of 5.
Calibrator being replaced – testing next week.

Lack of MPE for NM a problem, 2 in Lothian and 2 in training to cover Lothian and Fife Need to think how to satisfy ARSAC. CMK will take to the Operational Team. Need to understand this further if not enough MPE anywhere. VBS to share documents/letter from ARSAC Board.

Outpatient Iodine therapy was suspended during covid. Lothian have re-opened but not Fife. Working with the Endocrinologist team to resolve problems over protocols.

12. PATIENT DOSE AUDIT AND OPTIMISATION

a. **Summary of patient dose audit undertaken** (CP) Please see attached.

b. Updates to Local DRL's (CP)

Finalising following this meeting.

c. Image Optimisation Team (NW)

There was an IOT meeting last week. ToR was updated to encompass MRI service. The group meet bi-monthly and would identify as a quality improvement team. Looking for recruits, more Radiographers needed. More Radiologist needed too for head CT quality benchmarking. Dr Lei has taken on for MR safety.

CPD sessions for people have fallen behind at St Johns and RIE, but drop in sessions going well, can put on bespoke sessions if needed.

13. INCLUSIVE PREGNANCY CHECKS (JA)

RCR guidance came out in 2020 questioning

technique's in asking questions (TRANS etc) staff made aware, work in progress, update at next meeting.

14. A.O.C.B.

None

15. Date of Next Meeting

Tuesday 22nd November 2022 via Teams

INFORMATION GOVERNANCE AND SECURITY STEERING GROUP
(Meeting on 6 July 2022)

No issues were raised for escalation to the Clinical Governance Committee.

NOTE OF THE INFORMATION GOVERNANCE AND SECURITY STEERING GROUP HELD ON WEDNESDAY 6TH JULY 2022, 1300, VIA MS TEAMS

Present:

Chair - Margo McGurk	Director of Finance & Strategy
Frances Quirk	Assistant RIK Director
Susan Fraser	Associate Director of Planning and Performance
Alistair Graham	Associate Director Digital & Information
Linda Douglas	Director of Workforce
Duncan Wilson	Lead Pharmacist on behalf of Director of Pharmacy & Medicines
Joy Tomlinson	Director of Public Health

In Attendance:	
Andy Brown	Principal Auditor
Kirsty MacGregor	Head of Communications
Margaret Guthrie	Head of Information Governance and Security Manager/DPO
Gillian MacIntosh	Head of Corporate Governance
Claire Neal	(Minute) PA to Associate Director, Digital & Information
Allan Young	Head of Digital Operations, Digital & Information,
Apologies:	
Nicky Connor	Director of Health & Social Care
Philip Duthie	General Practitioner
Claire Dobson	Director of Acute Services
Elizabeth Gray	Patient Relations Officer (on behalf of head patient relations)
Janette Owens	Director of Nursing
Helen Hellewell	Associate Medical Director
Dr Chris McKenna	Medical Director

1	**CHAIRPERSON'S WELCOME AND APOLOGIES**	
	M McGurk welcomed everyone to the meeting and apologies were noted. M McGurk noted the meeting scheduled for 8th April was postponed due to the pressures within the Health Board at that time but papers were shared via email with comments made.	
2	**MINUTE & ACTIONS OF PREVIOUS MEETING 04/03/22**	
	Minutes were reviewed and agreed they were a true record, however C Neal noted to the Group there were spelling errors and they have been corrected and saved as the corrected version. Update of actions were provided and updated.	
3	**MATTERS ARISING**	
	3.1 ECS Data Sharing Arrangements A Graham provided a brief background to paper noting M McGurk seen this request from the Scottish Government asking to complete questionnaire and felt it appropriate to bring to this Group for visibility and awareness. An element of the early pandemic response was the requirement to share additional data with Primary Care contractor groups, including Optometrists and Community Pharmasists. The request from Scottish Government (SG) was to complete a question and the response was considered by the Group. A Brown raised queries regarding staff leaving NHS Fife and the process involved in monitoring of dormant accounts. A Graham responded there is short life working group currently operating within this movement where this is discussed, and work is ongoing. A brief discussion within the Group was undertaken and it was noted it is the responsibility	

	of line managers to inform of staff leaving or if going on extended leave. Further communications have been issued to remind of this. M McGurk queried if any feedback had been received regarding, A Graham was not aware of any feedback. No more comments were raised.	
	3.2 Subject Access Request Procedure M Guthrie provided a brief background to paper noting they previously reviewed the processes for FOI's and implemented a revised system which has significantly changed the figures and improved the process. A short life working group has been established for subject access requests (SARS) but there is still inconsistency. Some departments are holding information on shared drives and some on excel spreadsheets, so we are looking to work on this consistency. The aim is to have a single point of contact to receive and co-ordinate the responses from different departments so that the record keeping is consistent, and this would reduce the risk of information being incorrectly directed which is hoped will increase efficiency. Also having one point of contact will have someone who is knowledgeable to deal with SARS. A dedicated system for recording of SARS would allow a more streamlined process. There is a functionality within Service Now that could be used, with no cost implications. L Douglas, thanked for paper and will take some points offline but raised a concern on having a single point of contact, as the organisation is too large and would be better with smaller individual departments. There would be a suggestion for a global email address where individuals could action, and this could cover for staff leave etc. Discussion was held and it was noted this would be a good idea to have skilled staff for this purpose and will be good to have processes in place for new staff. M Guthrie advised that strong training would be put in place. M McGurk queried if we currently have a policy in place. M Guthrie noted there is no policy and the reason for coming to this Group is to approve and upon this a policy will be created. A Graham also advised this will assist departments that are receiving but not knowing what to do. With analysis we can put everything into this route and allocate to the correct person. With efficiencies across the process. No more comments were raised. **Approved by Group**	
	3.3 NISD 2022 Audit Review A Graham advised that a NIS audit was undertaken in April, this being the third review carried out by the competent authority. The scores achieved this time was yet another improved score of 76%, which is great as there has been an incremental improvement, with 2021, 69% and 2020, 53%. This report is covered by 176 control areas. A Graham provided a brief background to the NIS audit and noted an action plan has been put in place and the teams are working on this plan and this will then be fed through this Group and other Governance meetings. This report is to evidence the work that is ongoing and where the priorities lie. A Graham advised the group due to information contained to keep this report in their own distribution. M Guthrie noted the actions received has already been included into the action plan and this is due to go out to managers shortly. This will then be provided more advanced next time, rather than a few months prior to this NIS audit. M McGurk advised it was great to see the increasing compliance score but also it was great to see the sustained status as green rather than a quick increase but then decreases.	

	A Brown also noted they were encouraged by the auditor's comments that were provided. The level of detail in the documentation is also great. Next year's audit will be the full audit and not just a review. L Douglas queried the employment space and was surprised that we only achieved partially meets, thought we would have been stronger. Good to see document and for the assurance this is confirming. A Young provided feedback and noted we do have processes and mitigations in place, but we need to be stronger in evidencing these. Out next focus is supplier management. We are currently above average than other NHS Boards which is encouraging. Discussions were undertaken regarding the continued assurance and evidencing of this. Should a possible highlight report be provided and feedback from the IG&S Operational Grp. M Guthrie noted this is in discussions at present and hope to provide more information at next meeting. **Action** - A Graham and M Guthrie to have further discussions on how to set out further updates for the level of assurance and progress obtained. No further comments raised.	**AG/MG**
4.	**IG&S ASSURANCE ACTIVITY TRACKER**	
	4.1 Activity Tracker A Graham provided a brief overview to paper noting this is continually maturing as we progress through updates and continuous improvements are made to the tracker. The activity is made up of 4 domains, A Graham provided a brief update to each domain • **Data Protection and GDPR** – Asset register update ongoing, now resource has increased within department this will be updated. Review of Procurement contract to ensure compliance documentation is in place. • **FOI** – there is a sustained level of performance for last 6 months. • **Public Records Management** – Records management is a sizable challenge and work is continuing. There is an item to come back to Group, the team have been reviewing technology to assist. It is the whole organisation that requires to be reviewed for records management and this needs to tie in with the Record Keeper. • **NIS D –** Action tracker is on target; any updates will be provided for next meeting. This has been discussed in earlier item. Discussions were undertaken regarding if a deadline should be added for the data protection action and the RAG rating and tracker. A Graham noted the status is against the original target. L Douglas thanked for report as this is very informative and queried if there would be value in this tracker being used in other committees. A Brown queried at the previous meeting there was a discussion on the ICO Framework and the format of report to the Group. A Graham noted there are some changes to the framework and ongoing discussion are continuing within the IG dept. G MacIntosh queried the compliance performance as it was confirmed we have sustained a level of compliance; the level 1 notification received from ICO and has this now been removed with improved performance. M Guthrie confirmed this has now been closed. Discussions were held on adverse events and what is in place within D&I. M Guthrie noted these are followed through on DATIX, feedback/recommendations are provided on how to improve. This is then followed up to ensure the department is following these measures. A Graham noted this was the first time this has added this into the report to provide awareness.	

	Action - discussion to take place on how we mature the reporting and assurance to the Group. **A Graham/M Guthrie** No more comments were raised.	
	4.2 IG&S Key Measures A Graham noted this paper has been brought to Group for assurance and awareness only. There is currently a review on the SAR policy, this has been discussed in earlier item. The policy will be brought forward to policy group for review and then to EDG. Work continuing the key measures. Further information will be provided in next report from closed ICO reports, what the outcome was and whether these are now closed or still open. No other comments were raised.	
5	**RISK MANAGEMENT**	
	5.1 Risk Report A Graham advised this report has been brought to Group for assurance and awareness**.** A brief update was provided: • Previous reports now provided we can continue to review the history. • 2 risks have been closed but we still have a static risk rating. • Cyber risks have been reprofiled. • Highest risk rating is towards the lower rating, and this is aligned to the BAF. • Discussions are continuing with department re public records and the challenge on space. • Response to a Cyber Intrusion, we have managed to introduce an operational system that scans for this. • Technical controls are to be reviewed for our procurement and a resilience Board has been established. L Douglas queried risk 2109, use of unauthorised apps, do we have a fair warning system and is this reflected in this item. A Graham advised it would be very complex for fair warning to monitor, this has been reviewed. Discussion was held on the risk rating and to ensure the right conversations are taking place to keep challenging on our processes. **Action** - to review if commentary should be added on risks that do increase. **Action** - to review and provide continuous improvement on this document with the discussion noted on how this report is provided. M McGurk noted it would prefer; we are asking Group to take assurance from the risk profile in report opposed to report is for noting. No more comments were raised.	**AG** **AG**
6	**DOCUMENTS FOR APPROVAL / COMMENT**	
	6.1 Annual Statement of Assurance for IG&S Steering Group	

	A Graham advised this has been brought back to Group for assurance and awareness as confirmation of the assurance statement was completed via email. All comments that were received and have been updated. A Brown noted there were 2 ICO incidents. A Graham advised these have been closed and no further action required. At this time of providing this document there were 2 current incidents. **Action** - A Graham to provide an update offline to A Brown. **Action** - C Neal to remove watermark of draft from Assurance Statement. **Approved** by Group	**AG** **CN**
7	**MATTERS FOR ESCALATION TO CLINICAL GOVERNANCE COMMITTEE** M McGurk asked the Group if there are any matters of escalation from other committees. No comments were received from Group. M McGurk noted any items that were highlighted within the meeting have been discussed in earlier items.	
8.	**AOCB** M Guthrie would like to highlight the itinery of the ICO has been received and feedback will be provided, and they will be arranging meetings with M McGurk and Dr McKenna to review. Audit will take place September/October 2022. No other comments were raised. M McGurk thanked all for their continued hard work and improvements for this Group.	
8	**DATE OF NEXT MEETING:** Tuesday 4th October 2022, 0900, via MS teams	